



Department of Budget and Finance

RELEASE DATE: January 14, 2014

REQUEST FOR PROPOSALS No. RFP-14-001

SEALED OFFERS
FOR

Medical Benefits

(Including fully insured prescription drug plan and chiropractic plan
integrated with medical)

STATE OF HAWAII
DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS
TRUST FUND (EUTF)

WILL BE RECEIVED UP TO 12:00 NOON (HST) ON

FEBRUARY 19, 2014

IN THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND, CITY FINANCIAL TOWER,
201 MERCHANT STREET, SUITE 1520, HONOLULU, HAWAII 96813. DIRECT QUESTIONS
RELATING TO THIS SOLICITATION TO SANDRA YAHIRO, TELEPHONE (808) 586-7390,
FACSIMILE (808) 586-2320 OR E-MAIL AT EUTFADMIN@HAWAII.GOV.

Sandra Yahiro
Procurement Officer

Re: Request for Proposal – RFP 14-001, Medical Benefits

Proposal Due Date: February 19, 2014, 12:00 Noon, Hawaii Standard Time

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) is issuing this Request for Proposal (RFP), for its active and retiree Medical benefits, and optional fully insured chiropractic and prescription drug plans integrated with the medical benefits.

This RFP has been divided into Sections which outline the items that are to be included in your submission (refer to Table of Contents). OFFEROR will be E-mailed census and claims information upon receipt of a completed and signed Intent to Bid Form (Attachment 2) and signed Confidentiality Agreement (Attachment 3) that are included in this RFP.

OFFEROR may complete and submit proposals for multiple options by completing and signing the appropriate forms. Where there are multiple funding options requested for the same plan, an OFFEROR may submit both requested options or only one of the options requested. The EUTF reserves the right to award multiple contracts as a result of this RFP. Separate contracts will be issued for Active and Retiree Plans.

Each proposal must anticipate that the OFFEROR will provide those services outlined in this RFP without exception unless said exception is specifically identified in the proposal and identified in Attachment 5, *Exceptions*. Any deviations from the specifications should be clearly noted in Attachment 5 and may disqualify the proposal from consideration as not responsive.

Respond to **all** questions in this RFP. **DO NOT ALTER THE QUESTIONS.** Misnumbered, incomplete, or unanswered questions may disqualify a proposal from consideration as not responsive.

The Fee Proposal Form(s) included in the RFP shall be used for all cost and rate information. Information provided in any other format will not be accepted. Footnotes to the form(s) may be used to provide supplemental explanations, if necessary.

A network disruption analysis may be necessary in order to award a final contract with respect to coverage where a network of providers is utilized. In order to be considered, the OFFEROR must provide the appropriate data regarding your providers in the format that is requested.

All proposals must be submitted without any commissions included. No commissions, over-ride payments, finder's fees, or ancillary payments are to be made to any party on behalf of a contract issued to your company to provide these benefits. Violation of this requirement will invalidate your proposal or contract with the EUTF.

This RFP is the property of the EUTF. It is to be used by those companies, organizations, and individuals to whom copies have been sent solely for the purpose of preparing quotations for the plans described herein. Also, note Section 164.514(g) of HIPAA privacy rules states that the issuer or HMO may not use or disclose individually identifiable health information for any other purpose, except as may be required by law.

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ADMINISTRATIVE OVERVIEW

1.1 BACKGROUND

This Request for Proposals (RFP) is issued by the Hawaii Employer-Union Health Benefits Trust Fund (EUTF), an agency of the State of Hawaii (State). The EUTF was established by Act 88, 2001 Session Laws of Hawaii. Act 88 was partially codified as Chapter 87A, Hawaii Revised Statutes (HRS). Under HRS Chapter 87A, the EUTF is authorized to design, provide, and administer health and other benefit plans for State and county employees and, retirees, and their dependents (aka “employee-beneficiaries” and “dependent beneficiaries”). The benefit plans include medical, prescription drug, vision, dental, chiropractic, and life insurance. The EUTF currently provides benefit plans to over 111,000 subscribers which include employees and retirees. When dependents are included, the participant count is approximately 189,000. The EUTF’s fiscal year is July 1 through June 30. Active employees’ plan year is July 1 to June 30. Retirees’ plan year is January 1 to December 31.

The EUTF is administered by a board of ten Trustees (Board), who are appointed by the Governor. Five Trustees represent the employee-beneficiaries, one of whom represents retirees. These five Trustees are selected by the Governor from a list of candidates provided by exclusive employee representative organizations. The remaining five Trustees represent the public employers. The Board’s responsibilities include determining the nature and scope of benefit plans, negotiating and entering into contracts to provide such plans, establishing eligibility and management policies, and overseeing all EUTF activities. The Board has adopted rules to implement the administration and purposes of the EUTF, see Exhibit C, *Administrative Rules*.

The EUTF’s day-to-day operations are administered by an administrator appointed by the Board (Administrator). The Administrator is assisted in managing the EUTF by an Assistant Administrator, a Financial Management Officer, a Member Services Branch Manager, and an Information Systems Analyst. The EUTF is organized under three branches: Financial Services, Information Systems, and Member Services. The Member Services Branch Manager oversees the Member Services Branch and is supported by employees assigned customer service duties such as answering phone calls and e-mails from members and handling all processing for active employees and retirees. The Financial Management Officer is supported by accountants and account clerks who reconcile employee accounts, collect employer/employee contributions for health benefits, and process all payments. The Information Systems Analyst is supported by IT specialists and provides internal IT support services, HIPAA security responsibilities, and coordinates additional support services provided by Department of Accounting and General Services/Information and Communication Services Division.

In 2005, the Legislature enacted Act 245, partially codified as Chapter 87D, HRS. Act 245 temporarily permitted employee organizations to establish voluntary employees' beneficiary association (VEBA) trusts to provide health and other benefits plans to their members, including retirees. The stated purpose of Act 245 was to establish a pilot program to evaluate the costs and benefits of VEBA trusts against the EUTF. One employee organization, the Hawaii State Teachers Association (HSTA), formed a VEBA trust effective March 1, 2006 and withdrew their members from the EUTF health and other benefit plans. Effective January 1, 2011 the VEBA trust was terminated and all employees receive benefits through the EUTF. In December 2010, a State court ruled that HSTA VEBA members (actives and retirees) were entitled to the same standard of coverage in benefits when they were transitioned to EUTF on January 1, 2011. The enrollment of HSTA VEBA (HSTA VB) members into these new EUTF-created health and other benefit plans was

done solely to comply with the Court’s ruling and does not create any constitutional or contractual right to the benefits by these plans. The State does not agree with the Court’s ruling. If the ruling is overturned, stayed, or modified, the EUTF reserves the right to move HSTA VEBA members into regular EUTF plans.

The current Annual Report for the EUTF can be found on-line at *eutf.hawaii.gov*.

Active employees (also referred to as “actives”) and retirees are currently offered medical plan options through HMSA, Kaiser, and Royal State. The Employer currently pays a portion of the premium cost for medical coverage for actives, retirees, and their dependents and 100% of the premium for most of the retirees and their dependents. For actives, the Employer’s share is determined by the applicable collective bargaining agreements. Any remaining balance is paid by the employees through payroll deductions. For retirees, benefit plan contribution amounts are established by Chapter 87A-33 to 87A-36, HRS.

A description of the current benefits is provided in Section V (evidence of coverage documents are provided in Exhibit E).

1.2 PURPOSE

The EUTF is soliciting proposals from qualified OFFERORS to provide medical benefits and optional fully insured chiropractic (for active employees and HSTA VB retirees) and fully insured prescription drug plans integrated with the medicals plan to the EUTF’s active employees, non-Medicare retirees, Medicare retirees, and eligible dependents. EUTF seeks to maintain the current level of benefits and produce the most competitively priced plans with as little disruption to participants as possible. OFFERORS shall indemnify the EUTF insomuch that they will exactly duplicate the benefits currently offered by the EUTF if they assume the plans from a previous carrier and hold the participants in a no loss, no gain position.

1.3 TERMS AND ACRONYMS USED THROUGHOUT THE SOLICITATION

BAFO	=	Best and Final Offer
CPO	=	Chief Procurement Officer
EUTF	=	Hawaii Employer-Union Health Benefits Trust Fund
GC	=	General Conditions, issued by the Department of the Attorney General
GET	=	General Excise Tax
HAR	=	Hawaii Administrative Rules
HRS	=	Hawaii Revised Statutes
Offeror	=	Any individual, partnership, firm, corporation, joint

venture, or representative or agent submitting an offer in response to this solicitation

- Procurement Officer = The contracting officer for the State of Hawaii, EUTF
- RFP = Request for Proposal
- State = State of Hawaii, including its departments, agencies, and political subdivisions
- Employee Beneficiaries = An employee or retired employee of the state or counties that is eligible to enroll in the health plans offered by EUTF

1.4 CONTRACT PERIOD

The active employee plans are on a fiscal year term of July through June and the retiree plans are on a calendar year term. The term of any contracts resulting from this RFP, subject to approval by the State, shall be as follows: (All contract periods referenced throughout this RFP will be for these effective dates including proposal sheets)

- a. Active Employee Plans: (Certain requested services are proposed to commence January 1, 2015*)
 - i. First Contract Period – July 1, 2015 – June 30, 2016
 - 1. * Active Part-Time and Temporary Employee Plan (January 1, 2015 – June 30, 2016)
 - ii. Optional Second Contract Period - July 1, 2016 - June 30, 2017
 - iii. Optional Third Contract Period - July 1, 2017 - June 30, 2018
- b. Retiree Plans (Non-Medicare and Medicare):
 - i. First Contract Period – January 1, 2015 – December 31, 2015
 - ii. Optional Second Contract Period - January 1, 2016 – December 31, 2016
 - iii. Optional Third Contract Period - January 1, 2017 - December 31, 2017

1.5 AUTHORITY

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

1.6 CONTRACT ADMINISTRATOR

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

Ms. Sandra Yahiro
Hawaii Employer-Union Health Benefits Trust Fund
City Financial Tower
201 Merchant Street, Suite 1520
Honolulu, HI 96813

1.7 RFP SCHEDULE AND SIGNIFIGANT DATES

Proposals must be received by February 19, 2014, 12:00 noon, Hawaii Standard Time (HST). Late proposals will be rejected and not considered. The table below represents the schedule that will be followed. All times indicated are based on Hawaii Standard Time (HST). EUTF reserves the right to change any date(s) as deemed necessary and in the best interest of the State of Hawaii.

Release of Request for Proposals	<i>January 14, 2014</i>
Pre-proposal Conference	<i>January 21, 2014</i>
Due date to submit Intent to Bid Form and Signed Confidentiality Agreement	<i>January 24, 2014</i>
Due date to submit written questions	<i>January 29, 2014</i>
State's response to written questions distributed	<i>February 7, 2014</i>
Proposals Due (date/time)	<i>February 19, 2014 12:00 Noon, HST</i>
Priority-listed Offeror Interviews (if required)	<i>March 13, 2014</i>
Best and Final Offers Due (if required)	<i>March 19, 2014</i>
Estimated date for notice of award	<i>March 26, 2014</i>

1.8 PRE-PROPOSAL CONFERENCE

The purpose of the pre-proposal conference is to provide OFFERORs an opportunity to be briefed on this procurement and to ask any questions with respect to this RFP. All OFFERORs are invited to attend the pre-proposal conference. Attendance at the pre-proposal conference is NOT a requirement to submit a proposal and shall be at the OFFERORs expense.

A pre-proposal conference will be held as follows:

Date: January 21, 2014
Time: 9:00 AM, HST until 11:30 AM HST
Location: EUTF Conference Room
Hawaii Employer-Union Health Benefits Trust Fund
City Financial Tower
201 Merchant Street, Suite 1520
Honolulu, HI 96813

1.9 COMMUNICATIONS WITH THE EUTF

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

All questions regarding the RFP document shall be submitted in writing to the authorized contact person noted below in Section 1.10, *Issuing Office and Contact Person*. To facilitate a meaningful response, written questions shall reference the page, paragraph, and line or sentence to which the question relates. Such inquires must contain identification of the OFFEROR, its email address, telephone and fax numbers, and the RFP number. Questions will be accepted until the due date to submit questions specified in Section 1.7 *RFP Schedule and Significant Dates*. No telephone calls will be accepted.

The State will respond to questions through addenda/amendments by the date specified in Section 1.7 *RFP Schedule and Significant Dates*. The EUTF is not responsible for delays or non-receipt of such responses or any communications by the OFFERORs.

1.10 ISSUING OFFICE AND CONTACT PERSON

This RFP is issued by EUTF. The issuing office is:

Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1520
Honolulu, HI 96813

The individual listed below is the sole point of contact from the date of release of this RFP until the selection of the winning contractor. Questions will be accepted only if submitted in writing and received on or before the day and time specified in Section 1.7, *RFP Schedule and Significant Dates*.

Ms. Sandra Yahiro

State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1520
Honolulu, HI 96813
Telephone: (808) 586-7390
Fax: (808) 586-2320
Email: eutfadmin@hawaii.gov

1.11 SUBMISSION OF PROPOSALS

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

Each qualified OFFEROR may submit only one (1) proposal, although OFFERORS may propose to offer multiple plans within this RFP by completing and signing the appropriate forms. OFFERORS may submit proposals under all requested funding options, or only one for any plan. Proposals for alternate benefit plans will **not** be accepted.

OFFERORS shall submit all of the following:

- One (1) signed master proposal. The master proposal must be single sided, unbound, and clearly marked, "Master."
- Ten (10) hard copies of the proposal. Each copy shall be marked, "Copy ___ of 10." Copies may be bound and double sided.
- Twelve (12) electronic copies (on 12 CDs) of the proposal. Electronic copies of the proposals shall be submitted in Word format for the completed proposal sheets and Word format for the questions with answers.
- One (1) signed hard copy which redacts any propriety and confidential, trade secret information in the form of marked out pages (blanked out) of the master proposal for submission to the public under any request compliant with the public information disclosure laws of the State.

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

Proposals shall be mailed or hand delivered by **February 19, 2014, 12:00 noon, HST** to:

Ms. Sandra Yahiro
State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1520
Honolulu, HI 96813

If proposal is to be hand delivered, the outside envelope shall be marked, "hand delivered, proposal due February 19, 2014, 12:00 noon, HST."

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

State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
Proposal submitted in Response to:
RFP 14-001, Medical Benefits

In addition to the proposals submitted to EUTF, OFFEROR shall submit, as a courtesy, two signed hard copies of the proposal to SEGAL to be received no later than February 19, 2014, 12:00 noon, HST to the attention of:

Mr. Thomas M. Morrison, Jr.
The Segal Company
330 North Brand Boulevard, Suite 1100
Glendale, CA 91203

1.12 RECEIPT, OPENING AND RECORDING OF PROPOSALS

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

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

1.13 MODIFICATION PRIOR TO DEADLINE OR WITHDRAWAL OF OFFERS

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

- **Modifications** – a written notice accompanying the actual modification received by the Procurement Officer; or a written notice accompanying the actual modification by email to eutfadmin@hawaii.gov, provided that the OFFEROR submits the written notice accompanying the actual modification within two working days of the Procurement Officer's receipt of the electronic notification.
- **Withdrawal** – a written notice received by the Procurement Officer; or a notice by email to eutfadmin@hawaii.gov.

1.14 DISCUSSION AND PRESENTATIONS

Discussions may be conducted with PRIORITY-LISTED OFFERORS, i.e., OFFERORS who submit proposals determined to be reasonably susceptible of being selected for award. Such OFFERORS may be invited to make presentations to the Evaluation Committee to clarify their proposals, to promote understanding of the EUTF's requirements and the OFFEROR's proposal, and to facilitate arriving at a contract that will provide the best value to the State. Whether such discussions and

presentations will be held will be at the discretion of the Evaluation Committee. OFFEROR shall bear all responsibility for any and all costs related to making the presentations.

1.15 BEST AND FINAL OFFER

If the State determines a best and final offer (BAFO) is necessary, it shall request one from the OFFEROR. Any BAFO must be received by the Issuing Office no later than the date and time specified in Section 1.7, *RFP Schedule and Significant Dates*, or as may be amended by RFP addendum. If a BAFO is not requested by EUTF, or if requested and not submitted by an OFFEROR, the previous submittal will be construed as its best and final offer. After BAFOs are received, final evaluations will be conducted for an award. All proposals become the property of EUTF.

1.16 PREPARATION OF PROPOSAL AND COSTS

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

Expenses for the development and submission of proposals and other responses to the RFP are the sole responsibility of the OFFEROR submitting the proposal or other response, whether or not any award results from this RFP. Travel and expenses to and from the State of Hawaii are also the sole responsibility of the OFFEROR submitting a proposal or otherwise responding to this RFP.

1.17 DISQUALIFICATIONS OF PROPOSALS

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

Grounds for disqualification include:

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

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

1.18 RFP AMENDMENTS AND ADDENDUM

The EUTF reserves the right to amend this RFP at any time, prior to the closing date for best and final offers.

1.19 CANCELLATION OF REQUEST FOR PROPOSALS/REJECTIONS OF PROPOSALS

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

1.20 UNCERTAINTIES BEYOND THE CONTROL OF THE EUTF

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

1.21 PROPOSAL BONDS; PERFORMANCE AND/OR PAYMENT BONDS

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

1.22 EVALUATION OF PROPOSALS

An evaluation committee of at least three (3) qualified State employees selected by the Procurement Officer shall evaluate proposals. The evaluation will be based solely on the evaluation criteria set out in Section III of this RFP.

Prior to holding any discussion, a priority list shall be generated consisting of OFFERORs determined to be acceptable or potentially acceptable. However, proposals may be accepted without such discussions.

If numerous acceptable and potentially acceptable proposals are submitted, the evaluation committee may limit the priority list to the three highest ranked, responsible OFFERORs. The priority listed OFFERORs may be afforded the opportunity to submit Best and Final Offers (BAFO). If a BAFO is requested, final evaluations will be conducted after BAFOs are received. If Best and Final Offers are requested and are not submitted, the previous submittals will be construed as the Best and Final Offer.

1.23 AWARD OF CONTRACT

Award will be made to the responsible OFFEROR whose proposal is determined to be the most advantageous to the State based on the evaluation criteria set forth in the RFP. If award is made, the successful OFFEROR will be required to enter into a formal written contract with the State and shall be required to sign a business associate agreement (BAA). The RFP, the OFFEROR's accepted proposal, and the executed contract comprise the contract. A copy of the contract form and applicable general conditions can be found in Exhibit D. A copy of the business associate agreement can be found in Exhibit F. The RFP and the successful proposal will be incorporated in the resulting contract by reference; to the extent that they conflict, the terms of the RFP shall govern, unless otherwise agreed upon by EUTF in the contract.

1.24 CONTRACT EXECUTION

Successful OFFEROR receiving award shall enter into a formal written contract in the form as in Exhibit D, *Contract Form and AG General Conditions*. In submitting the proposal, the OFFEROR will be deemed to have agreed to each provision set forth in Exhibit D, *Contract Form and AG General Conditions* unless the OFFEROR specifically identifies the provision to which objection is made and submits alternative language. The EUTF shall have no obligation to accept terms and conditions that vary from those set forth in Exhibit D, *Contract Form and AG General Conditions*, the contract awarded pursuant to this RFP and any amendments thereto.

Upon selection and award of the contract(s), EUTF will send the formal contract(s) and BAA to the successful OFFEROR for signature. The contract and BAA shall be signed by the successful OFFEROR and returned with any required documents, within 7 calendar days after receipt by the OFFEROR or within such time as EUTF may allow. Failure to keep this deadline may result in a cancellation of the award and contract. EUTF reserves the right to cancel any contract, and request new proposals or negotiate with remaining OFFERORS, if EUTF is not satisfied with the awarded contractor's performance.

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

If an option to extend the contract is mutually agreed upon, the Contractor shall be required to execute a supplement to the contract for the additional extension period.

1.25 REQUIREMENTS FOR DOING BUSINESS IN THE STATE OF HAWAII

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

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

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

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

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

1.26 PUBLIC EXAMINATION OF PROPOSALS

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

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

1.27 DEBRIEFING

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

A written request for debriefing shall be made within three (3) working days after the posting of the award of the contract. The Procurement Officer or designee shall hold the debriefing within seven (7) working days to the extent practicable from the receipt date of written request.

Any protest by the requestor following a debriefing, shall be filed within five (5) working days after the date that the debriefing is completed, as specified in Section 103D-303(h), HRS.

1.28 PROTEST PROCEDURES

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

Ms. Sandra Yahiro
201 Merchant Street, Suite 1520
Honolulu, HI 96813

A protest shall be submitted in writing within five (5) working days after the aggrieved person knows or should have known of the facts giving rise thereto; provided that a protest based upon the content of the solicitation shall be submitted in writing prior to the date set for receipt of offers. Further

provided that a protest of an award or proposed award shall be submitted within five (5) working days after the posting of award or if requested, within five (5) working days after the PO's debriefing was completed.

The notice of award, if any, resulting from this solicitation shall be posted on the Procurement Awards, Notices and Solicitations (PANS), which is available on the SPO website:

<http://www.hawaii.gov/spo2/source/>.

1.29 SPECIAL CONDITIONS

The following Special Conditions will supplement the General Conditions of the Contract Exhibit D.

1. Certificate of Authority/License. Prior to the effective date of the contract and during the entire term of the contract, the contractor shall obtain and maintain all certificates of authority, licenses, and other approvals necessary to lawfully provide all benefit plans required under the contract and/or to lawfully provide all services required under the contract. By accepting the award of contract, contractor certifies that: (a) it has all certificates, licenses, and approvals necessary to lawfully provide all benefit plans and/or services required under the contract; and (b) if applicable, that its benefit plans comply with all applicable federal, state, and county laws.
2. Compliance with EUTF Laws and Rules. The contractor shall comply with: Chapter 87A, HRS, as the same may be amended from time to time; all rules, including, but not limited to, EUTF's administrative rules, policies, standards, procedures, and directives adopted by the Board; and all policies, standards, procedures, and directives of the Administrator. The contractor shall be bound by the Board's interpretation of Chapter 87A, HRS, and the EUTF's rules, policies, standards, procedures, and directives.
3. Records. Consistent with industry standards and practices, the contractor shall maintain reasonable records pertaining to the contractor's provision of all the benefit plans and/or services required under the contract and contractor's performance of the contract including, but not limited to: (a) enrollment and eligibility records; (b) claims records; and (c) financial and accounting records showing all financial transactions pertaining to contractor's provision of benefit plans and/or services, contractor's performance of the contract, and all payments received or due to contractor under or relating to the contract. Unless otherwise agreed by the EUTF, all such records shall be kept and maintained in the State of Hawaii. Except as otherwise required by law, contractor shall maintain all records for at least three (3) years from the date of final payment under the contract. Records which relate to an appeal, litigation, or settlement of claims arising out of the contract shall be retained by contractor for at least three (3) years after the subject appeal, litigation, or claim has been disposed of or otherwise resolved.
4. Accounting. Except as otherwise required by law, the contractor's accounting procedures and practices shall conform to generally accepted accounting principles consistently applied and all fees and costs applicable to the contract shall be readily ascertainable from the contractor's records.
5. Inspections and Audits. At all times that it is required to maintain records under the contract, contractor shall make such records available at its local office for inspection or audit by authorized representatives of the EUTF, the State Auditor, and/or the State Comptroller. Such inspections and audits may include, but are not limited to: (a) claims audits; (b) audits relating to the performance standards and guarantees required under the contract; (c) audits relating to contractor's performance of the contract and compliance with the contract's terms and conditions; and (d) the contractor's claimed fees, costs, and expenses. To the extent that contractor proposes to use or uses any

subcontractors to fulfill its obligations under the contract, those subcontractors must agree to abide by the record keeping, accounting, and audit requirements of the contract.

6. Liquidated Damages. In the event of any breach of the contract by contractor, liquidated damages shall be assessed against contractor in the sum of Five Thousand and No/100 Dollars (\$5,000.00) per calendar day until the breach is remedied by contractor.
7. Insurance. At its sole cost and expense, the contractor shall obtain and keep in force throughout the entire term of the contract and any extensions thereof, the following types of insurance, in the minimum amounts specified and in the form hereinafter provided for:
 - a. An insurance policy or policies that cover claims resulting from the contractor's negligent or willful acts, errors or omissions, breach of contract, breach of fiduciary or other duty, violation of statute or other law, in providing services under the contract. The policy or policies shall have limits of liability, per occurrence and in the aggregate, in amounts that are reasonably satisfactory to the Board. Initially, the insurance policy must have limits of liability in the amount of at least FIVE MILLION AND NO/100 DOLLARS (\$5,000,000), per occurrence and in the aggregate. The insurance policy shall be endorsed to provide that it is primary insurance and not contributing or excess over any coverage that the EUTF, Board or State of Hawaii may carry.
 - b. A fidelity bond, commercial crime policy, or other equivalent insurance that provides insurance coverage or similar protection to the EUTF against forgery, theft, robbery, fraud, dishonest and criminal acts committed by any of the contractor's employees that causes the EUTF to sustain monetary loss. The limits of such bond or policy shall be FIVE MILLION AND NO/100 DOLLARS (\$5,000,000) per occurrence and in the aggregate.
 - c. Commercial general liability insurance coverage against claims for bodily injury and property damage arising out of all operations, activities or contractual liability by the Contractor, its employees and subcontractors during the term of the Contract. This insurance shall include the following coverage and limits specified or required by any applicable law: bodily injury and property damage coverage with a minimum of \$1,000,000 per occurrence; personal and advertising injury of \$1,000,000 per occurrence; broadcasters' liability insurance of \$1,000,000 per occurrence; and with an aggregated limit of \$2,000,000. The commercial general liability policy shall be written on an occurrence basis and the policy shall provide legal defense costs and expenses in addition to the limits of liability stated above. The Contractor shall be responsible for payment of any deductible applicable to this policy.
 - d. Automobile liability insurance covering owned, non-owned, leased, and hired vehicles with a minimum of \$1,000,000 for bodily injury for each person, \$1,000,000 for bodily injury for each accident, and \$1,000,000 for property damage for each accident.
 - e. Any and all other insurance that is required by applicable law and that is reasonably necessary in order for contractor to perform the work and services required under the contract. The insurance policies shall have limits of liability, per occurrence and in the aggregate, in amounts that are reasonably satisfactory to the Board, as measured by what a reasonably prudent trustee would require of a contractor in similar circumstances.

The adequacy of the coverage afforded by the contractor's insurance shall be subject to review by the Board, from time to time, and if it appears that a reasonably prudent trustee, operating a trust fund similar to that operated by the Board, would require an increase in the limits of

liability of such insurance, contractor shall to that extent take all necessary actions to increase such limits.

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

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

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

- (1). "This insurance shall not be canceled, limited in scope of coverage or non-renewed until after 30 days written notice has been given to the Hawaii Employer-Union Health Benefits Trust Fund, 201 Merchant Street, Suite 1520, Honolulu, Hawaii 96813."
- (2). "The State of Hawaii, the Hawaii Employer-Union Health Benefits Trust Fund (EUTF), the EUTF Board of Trustees, and trustees of the EUTF Board are added as additional insureds with respect to operations performed for the State of Hawaii and the EUTF."
- (3). "It is agreed that any insurance maintained by the State of Hawaii and/or EUTF will apply in excess of, and not contribute with, insurance provided by this policy."

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

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

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

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

The procuring of such required insurance shall not be construed to limit contractor's liability hereunder nor to fulfill the indemnification provisions and requirements of this contract. Notwithstanding said policy or policies of insurance, contractor shall be obliged for the full

and total amount of any damage, injury, or loss caused by negligence or neglect connected with this contract

8. Transition Procedures. At no cost to the EUTF, the contractor shall comply with the following provisions upon receipt of a notice of termination or upon the expiration of the contract:
- (a) As directed by the EUTF, the contractor shall terminate or assign to the EUTF or its designee any outstanding orders or contracts that relate to contractor's performance under the contract.
 - (b) The contractor shall transfer title and deliver to the EUTF or its designee any and all completed or partially completed goods, materials, reports, information, data or other work product of the contractor that were made under the contract or as part of the contractor's performance of the contract.
 - (c) As directed by the EUTF, the contractor shall destroy and/or deliver to the EUTF or its designee all confidential or proprietary documents, information, and data that contractor has received under the contract and all copies thereof.
 - (d) The contractor shall provide to the EUTF or its designee all records, documents, information, and data reasonably necessary to allow the EUTF or its designee to continue to provide and/or administer, without interruption, all health and other benefit plans to EUTF beneficiaries, and to comply with all federal, state, and other legal requirements to which the EUTF is subject. Such records, documents, information, and data shall include, but not be limited to, eligibility information and data, claims experience or history data, and administrative records.
 - (e) As directed by the EUTF, the contractor shall handle retroactive enrollments for persons who should have been enrolled prior to the effective date of the termination or expiration, the run-off of all claims incurred prior to the effective date of the termination or expiration, and any other requirements of the contract that apply to the period of time prior to the effective date of the termination or expiration.
 - (f) The contractor shall provide the EUTF with a final accounting of claims, premiums, reserves, and retention covering the last unreported period of time up to and including the effective date of termination or expiration, a final monthly operation report, a final plan performance and paid accounting report, and a final quarterly report on financial operations and performance standards.
 - (g) With respect to the proposal for self-insured plans, the OFFEROR must include in its fees the cost of payment of all run-out claims after the termination of the contract for a period of no less than 12 months, with a final reconciliation of the self-funded accounts at this 12 month period. No additional fees will be paid and all cost of the run-out claim administration must be included in the monthly fees during the contract period.

PROPOSAL INSTRUCTIONS

SPECIFIC INSTRUCTIONS FOR COMPLETING THIS REQUEST FOR PROPOSAL

1. CONTENT OF PROPOSAL

The OFFEROR shall adhere to all instructions listed in Section 1.11, *Submission of Proposals*, and prepare a written proposal that will fully describe the qualifications and availability of the OFFEROR to provide the services requested and the compensation the OFFEROR proposes in response to this RFP. The proposal shall include, without limitation, the following:

- Cover letter
- Offer Form, OF-1 (Attachment 1)
- Plan Comparison Summaries and Fee Proposal Forms (Section V)
- Offeror Information Sheet (Section VI)
- Completed Questionnaire (Section VII)
- Network Analysis (Section VIII)
- Required attachments:
 - Confidential Information, Attachment 4
 - Exceptions, Attachment 5
- Compliance certificates (as required in Section 1.25, *Requirements for Doing Business in the State of Hawaii*)
- Documents to demonstrate OFFEROR's financial stability (Section III)
- Any additional attachments/marketing information not required but that you want to present

2. COVER LETTER

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

- Contact Information – The cover letter shall include the OFFEROR's name, address, telephone/fax numbers, and e-mail address.
- Terms and Conditions of RFP – A statement that the OFFEROR fully understands and will comply with all terms and conditions contained in the RFP. The OFFEROR must include written acknowledgment of receipt of any and all amendments or addenda made to this RFP.
- Legal Entity – A statement indicating that the OFFEROR is an individual, a partnership, a limited liability company, a corporation or other legal entity (as identified). If the OFFEROR is a corporation, a partnership, a limited liability company or other legal entity, include a statement indicating the jurisdiction where the OFFEROR is organized.
- Authorized Signature - The cover letter must be signed, in blue ink, by an individual or individuals authorized to legally bind the OFFEROR. If the OFFEROR is a corporation, evidence in the form of a certified copy of a corporate resolution or certified copy of articles of incorporation or bylaws shall be submitted showing the individual's authority to bind the corporation. If the OFFEROR is a partnership, the proposal must be signed by all the partners, or evidence in the form of a certified copy of the partnership agreement shall be submitted

showing the individuals' authority to bind the partnership. Similar evidence must be submitted for an individual signing the proposal letter on behalf of any kind of entity.

- Current Licenses and Registration - A statement that the OFFEROR maintains the current licenses necessary to provide the services required. In addition, an OFFEROR must provide evidence that the OFFEROR is registered to do business in the State of Hawaii prior to commencement of the work. True and accurate copies of the OFFEROR's license(s) and certificates must be provided. See Section 1.25, *Requirements for Doing Business in the State of Hawaii*.
- Subcontracting of Services - A statement by the OFFEROR indicating that that the work described in the RFP will not be subcontracted, except as described in the proposal, or assigned. The extent to which the work will be subcontracted and the qualifications of any subcontractor will be considered in evaluating the OFFEROR's ability to perform the service referred to in the RFP.
- Non-Discrimination - A statement that the OFFEROR does not discriminate in employment or business practices with regard to race, color, religion, age (except as provided by law), sex, sexual orientation, marital status, political affiliation, national origin, disability, or any other characteristic protected by federal, state or local laws.
- EUTF Rights Regarding Contractor's Recommendations - A statement that the OFFEROR understands that the EUTF reserves the right to disapprove contractor recommendations without penalty when they conflict with the policy or fiscal interests of the EUTF, as determined by the EUTF Board.
- Terms and Conditions of Contract - Affirm that the provisions of the sample contract in Exhibit D, *Contract Form and AG General Conditions* are acceptable or state any proposed modifications in Attachment 5, *Exceptions*. The EUTF reserves the right to decline or classify as "unresponsive" any substantive changes, modifications, or revisions to the provisions of the sample contract.

3. OFFER FORM, OF-1

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

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

4. CONFIDENTIAL AND PROPRIETARY INFORMATION

The OFFEROR shall list in Attachment 4, *Confidential Information*, those portions of the proposal that contain trade secrets or other proprietary data/information that the OFFEROR wishes to remain confidential. The OFFEROR shall follow the instructions under Section 1.11, *Submission of Proposals*, for submitting a redacted copy of its proposal. The OFFEROR must also include on Attachment 4 a detailed explanation as to why this information is considered confidential, with respect to the requirements of Chapter 92F, HRS. Any request for public inspection is subject to the requirements of Chapter 92F, HRS. The entire proposal CANNOT be considered confidential. The

fee proposal CANNOT be considered confidential. With the indication of sections that are deemed proprietary and confidential, the OFFEROR must include a written explanation of the nature and rationale for considering the information as confidential.

5. AWARD OR REJECTION

Any award will be made to that OFFEROR whose proposal is deemed to be in the best interest of the EUTF. The EUTF reserves the right to reject any or all proposals. Proposals will not be returned.

6. NO COMMISSIONS

No commissions will be paid and none are to be included in any proposal and no designation of “Broker of Record” will be issued to any OFFEROR in order for the OFFEROR to procure a quotation from an insurance company. No override payments, volume bonuses or other indirect payments to agents or producers are allowed.

7. INTENT TO BID FORM AND CONFIDENTIALITY AGREEMENT

All OFFERORS must submit a completed signed Intent to Bid Form (Attachment 2), and signed Confidentiality Agreement (Attachment 3) in order to receive the claim data and employees’ census. These documents are required for the OFFEROR to receive the census and claim data, but are not required to be eligible to submit a proposal.

8. ORAL EXPLANATIONS

The EUTF will not be bound by oral explanations or instructions given during the competitive process or after the award of the contract.

9. TIME FOR ACCEPTANCE

The OFFEROR agrees to be bound by its proposal for a contract effective date as stipulated in Section 1.4, *Contract Period*, the EUTF and/or Segal may request clarification of the proposal for the purpose of evaluation. Late proposals will not be accepted.

10. ELIGIBILITY RULES

The OFFEROR agrees to the eligibility rules established by the EUTF, and as amended by the EUTF from time to time. Any proposed modifications to the specified eligibility rules are unacceptable.

11. EXCEPTIONS

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

12. ASSUMPTIONS OR UNDERWRITING PROVISIONS

It is required that all proposals **exclude** any language referring to the right of the OFFEROR to change rates due to changes in expected versus actual enrollment for any period of the term of the contract. Failure to comply with this requirement will be a significant adverse consideration in the proposal evaluation.

13. CLAIMS REPRICING

As a condition of the final award of contract and determination of net cost to the EUTF, all PRIORITY-LISTED OFFERORS must agree to provide re-priced claim information as provided by Segal to the PRIORITY-LISTED OFFERORS in the format and including the information requested in the claim re-pricing worksheet if this is requested by the Evaluation Committee.

14. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

All OFFEROR systems and services must be in compliance with the HIPAA EDI, Privacy, and Security regulations on the appropriate dates established by the Department of Health & Human Services. A copy of EUTF's standard Business Associate Agreement (BAA) is contained in the Exhibit F to this RFP. The successful OFFEROR shall be required to sign the BAA.

15. Submission of a signed proposal shall be construed as the OFFEROR's strict adherence to this RFP, unless otherwise noted in writing in the required Attachment 5 marked "EXCEPTIONS". Failure to meet any of these conditions may result in disqualification of proposals. This RFP and the OFFEROR's proposal, including all subsequent documents provided during this RFP process, will become part of the contract between the parties.

16. REQUESTED PLAN DESIGN AND FUNDING ARRANGEMENTS

Current Funding Arrangements

The current plans and funding arrangements are provided in Section V.

You are required to match the EUTF's current plan of benefits for any of the options for which you are submitting a proposal. Benefit plans are summarized in Section V. In cases where a discrepancy may exist, the OFFEROR must agree to administer benefits on a "no loss, no gain" adjudication of the benefits when compared to the current contractors and insurance companies including reasonable and customary schedules, administrative interpretation of the benefits, covered services and prior authorizations. Contractor shall be responsible for fully complying with the Patient Protection and Affordable Care Act (PPACA) for fully insured plans.

If the OFFEROR is submitting a fully insured bid for pharmacy benefits, the OFFEROR will be responsible to administer pharmacy benefits for retirees where either the retiree or the dependent of the retiree is covered under the Medicare EGWP contract and the other dependent or the retiree is non-Medicare (orphaned dependents). A fully insured pharmacy benefit must comply with all of the requirements contained in the RFP for self-insured Pharmacy benefits.

PROPOSAL EVALUATION

1. **INTRODUCTION:** The EUTF seeks the highest quality organization to provide medical service benefits. Throughout the selection process, the EUTF reserves the right, in its sole discretion:
 - a. To not award the contract to the lowest cost OFFEROR.
 - b. To not award the contract at all.

2. **EVALUATION PROCESS:** An Evaluation Committee selected by the Procurement Officer will review and evaluate all proposals submitted by the deadline specified in this RFP. The evaluation process will be conducted in up to six phases:
 - Phase 1 – Evaluation of Mandatory Requirements
 - Phase 2 – Establishment of PRIORITY-LISTED OFFERORS
 - Phase 3 – Discussions with PRIORITY-LISTED OFFERORS, if any
 - Phase 4 – Best and Final Offers (Optional)
 - Phase 5 – Final Evaluation of Proposals
 - Phase 6 – Award

3. **EVALUATION CRITERIA AND POINTS:** The evaluation criteria listed below will be used to evaluate and rank OFFERORS’ proposals.

Criteria	Points
Fees/Rates/Network Discounts	30
Network Disruption	25
Agreement to Perform Services Requested in RFP and satisfaction of all minimum qualifications (Including the Special Conditions in Section I)	25
Experience offering services to similar sized Entities and References including Prior Engagements with the EUTF	10
Medical Management Programs, Wellness Program and Total Health Management Approach	10
Total	100

Description of Evaluation Criteria:

- **Fees/Rates/Network Discounts:** For the fully insured options, the cost will be calculated as the rates times the annual estimated enrollment for plan of benefits for which a proposal sheet is submitted using the enrollment that is contained in the Exhibit H of this RFP. For the self insured options, the cost will be calculated as the combination of the monthly administrative fees, times the annual enrollment for each plan plus the value of the network discounts which is determined from the repricing of the claims that are submitted to the PRIORITY-LISTED

OFFERORS in the best and final phase of the RFP process. The evaluation will exclude all ACA fees and tax.

- **Network disruption:** Network disruption will be evaluated based upon the information that is submitted in this RFP and will be measured upon the providers, facilities, and sources of care and services used by the active and retired participants in the plans for which a proposal is being submitted, as measured from the experience of the plan over the past 3 years (or the existence of the plan if less than 3 years) Special consideration will be made of the OFFEROR's ability to provide a network of providers for all of the Islands on which EUTF plan participants reside. The census files submitted to OFFERORS include residence zip code locations. Network disruption will be analyzed on two bases:
 - The overall percent of the plan enrolled population that will be not be required to change providers from those that had been used over the past three years or from inception of the plan
 - The result of the geo access analysis that is submitted with the proposal on an Island by Island basis with equal weighting provided to each Island
 - The results of the addition of these two percentages will provide a total score for this category
- **Agreement to perform services requested in RFP and satisfaction of all minimum qualifications:** This category reflects the OFFEROR's thoroughness of response contained in the proposal submission, ability and agreement to provide the required services, adherence to the instructions contained in this RFP and inclusion of all requested information in its proposal.
- **Experience offering services to similar sized entities and references including prior engagements with the EUTF and the State:** The analysis of this category will be the result of reviewing the list of referred Entities for which the OFFEROR is providing identical or very similar services including any prior contracts of the OFFEROR or its affiliates or precedent corporation with the EUTF or the State and prior litigation with the EUTF and or the State, and references that are comparable in the number of enrolled participants, benefit plan comparability, complexity of administration and a similar form of administrative entity (Trusted Board with dedicated Administrative Organization) and geographic dispersion of participant population. Each supplied reference will be interviewed for an evaluation of the performance of the OFFEROR with respect to the contracted services performed including any work performed for EUTF in a prior contract.
- **Medical management programs, wellness program, and total health management approach:** This category will be evaluated upon the demonstration in the OFFEROR's response of an integrated, well developed program of managing the total health and disease management of the participants, as well as an integrated wellness program that is directed at improving the health outcomes of the participants and overall health status of the participant population. This includes the agreement to exchange meaningful data on the health status of EUTF participants with the EUTF and its designated vendors and consultants.

Phase 1 – Evaluation of Mandatory Requirements

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

- Meet all requirements for doing business in the State of Hawaii (Section 1.25, *Requirements for Doing Business in the State of Hawaii*). To meet this requirement, OFFERORS shall demonstrate compliance through Hawaii Compliance Express or by submitting paper compliance certificates to the EUTF.
- Adhere to all proposal submission guidelines (Section II)
- Follow proposal submission timeline
- Financial Stability of the OFFEROR as demonstrated by external rating services or documentation of a similar nature which attests to OFFEROR’s financial stability.

Phase 2 – Establishment of PRIORITY-LISTED OFFERORS

All OFFERORS who pass Phase 1, Evaluation of Mandatory Requirements, shall be classified as “acceptable” or “potentially acceptable.” If there are more than three “acceptable” or “potentially acceptable” OFFERORS, the Evaluation Committee may evaluate all proposals and establish a priority list of OFFERORS who received the best preliminary evaluations. The order, priority and points to be applied to each evaluation criteria are as listed above.

Phase 3 – Discussions with PRIORITY-LISTED OFFERORS (Optional)

In this phase, the Evaluation Committee may conduct interviews with the PRIORITY-LISTED OFFERORS as listed in the timeline provided in Section 1.

Phase 4 – Request of Best and Final Offer (Optional)

In this phase the PRIORITY-LISTED OFFERORS may be asked to submit a BAFO for the services that are being proposed.

Phase 5 – Final Evaluation of Proposal (Optional)

In this phase, the Evaluation Committee will conduct final evaluations of the PRIORITY-LISTED OFFERORS’ BAFOs in accordance with the criteria listed above.

Phase 6 – Award

The EUTF Board will make the final selection.

SCOPE OF WORK

BACKGROUND

A description of the current benefits is provided in Section V (EOCs provided in Exhibit E). Effective January 1, 2011 the EUTF began providing separate plans to all members of the HSTA who were formerly enrolled in the HSTA VEBA plans (“HSTA VB”).

INSTRUCTIONS

This Section sets out specifications for the benefit plans and services that the EUTF is seeking through this RFP. Unless an OFFEROR expressly and specifically makes an exception to or identifies a deviation from these specifications in its proposal, and identifies such exceptions on Attachment 5, *Exceptions*, the OFFEROR’s proposal will be deemed to offer to meet and abide by all specifications set forth in this Section. If an OFFEROR proposes an exception to or a deviation from any of the contractual requirements set forth in this RFP, the OFFEROR’s proposal must specifically and completely describe and delineate that exception or deviation in Attachment 5, *Exceptions*. EUTF reserves the right to accept or reject any request for exceptions. Otherwise, the OFFEROR’s proposal will be deemed to accept and agree to all the contractual requirements. The EUTF is under no obligation to agree to any exception or deviation proposed by an OFFEROR, and will take any such exceptions and deviations into account in evaluating the OFFEROR’s proposal. All proposals are to be all inclusive of expenses and charges. The EUTF will not pay an additional amount for any ancillary charges for any items, including, for example, overhead, travel, telephone, local office expenses, shipping or printing.

1. Basic Services

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) is issuing this Request for Proposal (RFP), for its active and retiree Medical benefits and optional fully insured chiropractic and prescription drug plans integrated with the medical benefits. Contractor shall provide the benefits and services that are: (1) required under this RFP; (2) proposed by contractor and accepted by the EUTF; and (3) otherwise required under the contract between the contractor and the EUTF.

2. Customer Service Office

During the entire term of the contract and fully operational by Open Enrollment Period for Retirees in October, 2014, the contractor must maintain the following located in the State of Hawaii :

A customer service office in Honolulu to respond on a daily basis to the EUTF staff.

Personnel, systems, and equipment at the customer service office that is reasonably sufficient to provide all the customer services proposed by contractor and required under the contract.

An employee and retiree telephone service center to respond to telephone inquiries from participants, with staffing sufficient to manage the call volume of the employee and retiree participants and their dependents. The call center shall be open and available between the hours of 7:00 AM to 7:00 PM, HST Monday through Friday, and 9:00 AM to 1:00 PM, HST on Saturday, excluding State observed holidays. The call center must record all calls and retain same for a minimum of one year from the date of the call.

A walk in customer service center located in the downtown civic center of Honolulu to service participants in the plans. The walk in customer service center shall be open between the hours of 7:45 AM to 4:30 PM, Monday through Friday, except State observed holidays.

See number 6, Provision of Information/Telephone Access, below.

3. Key Personnel

Within thirty (30) calendar days of the award of contract, the contractor shall notify the EUTF in writing of the names, titles, business addresses, e-mail addresses, telephone numbers, and areas of responsibility of all of its authorized representatives. The authorized representatives shall be available to answer questions from or hold discussions with the Board or its designee in person, the Administrator, EUTF staff, EUTF's consultants, including, but not limited to, Segal, or the Attorney General's office with respect to contractor's benefits plans, contractor's performance of the contract, or any matter pertaining to the EUTF. The contractor shall give the EUTF at least ten (10) days notice in advance of any change in the authorized representatives.

Among the authorized representatives, contractor shall designate a contract liaison officer who shall be responsible to the EUTF for contractor's performance of the contract. The contract liaison officer shall attend in person all meetings as requested by the board, its subcommittees, or its designee, the Administrator, or the EUTF's consultants. OFFEROR must provide responses to EUTF staff phone calls and e-mails within the same business day, or if the call or e-mail is sent after 3:00 PM HST, by the morning of the following business day. Sufficient backup personnel must be in place to assure that this requirement is met on a consistent basis.

4. Eligibility

Eligibility of EUTF employee beneficiaries and dependent-beneficiaries for enrollment in and coverage by contractor's benefit plans shall be determined under HRS chapter 87A. Contractor shall be bound by the EUTF's determinations regarding eligibility of EUTF employee beneficiaries and dependent-beneficiaries.

Contractor shall accept enrollment, HIPAA life event changes, and cancellation dates as stated in EUTF transmissions, reports, or files. Contractor shall accept enrollment eligibility dates for Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") coverage in accordance with federal law as determined by the Administrator.

Contractor shall waive all pre-existing conditions provisions and all actively at work and dependent deferment requirements for EUTF employee and retiree beneficiaries and dependent-beneficiaries to be covered on the effective date.

5. Processing Enrollments, Cancellations and Terminations

Weekly, the EUTF will provide a Health Insurance Portability and Accountability Act of 1996 ("HIPAA") compliant electronic data transmission that shows new enrollments, cancellations, terminations, and other changes applicable to contractor's benefits plan(s). Subject to the following, contractor shall process such enrollments, cancellations, terminations, and changes in a timely manner as described below. Contractor shall agree to accept all of the enrollment and enrollment change information provided by the EUTF benefits administration system, in 834 file format, using the codes that are provided in this file, to maintain all eligibility and process

transactions. Contractor shall process the transaction file noting member enrollment changes (additions, deletions, and changes of address, employment, etc.) and the full file showing all members that are eligible for benefits. A sample of the full file and transaction file in 834 file format is contained in Exhibit G. Contractor agrees to incur all expenses of any modifications that are necessary to its systems in order to process the information provided by EUTF. EUTF will not make any modifications to its current system or file content or structure to accommodate the contractor. All changes necessary to comply with the requirement of this section shall be made prior to the commencement of this contract.

Within forty-eight (48) hours of the electronic data transmission or hard copy enrollment form, a contractor for health benefits shall process all transactions in its health benefits plan(s), or process any changes and mail I.D. cards to the new enrollees. In addition, contractor shall process all cancellations and termination of enrollments within forty-eight (48) hours of the electronic data transmission or transmission of a hard copy enrollment form.

Between the dates that the EUTF makes the electronic data transmissions, the EUTF may request the contractor to perform new enrollments or other changes to enrollment, including accepting and processing manual paper forms which may be submitted in order for an enrollment change to be expedited. Contractor shall accept such requests and perform the requested enrollments or other changes in a timely manner. New enrollments and other changes shall be performed no later than forty-eight (48) hours after receipt of the EUTF's request.

6. Provision of Information/Telephone Access

Contractor shall have a local, knowledgeable staff available to answer inquiries from EUTF staff and EUTF employee-beneficiaries and dependent beneficiaries regarding: (1) the benefits provided by contractor; (2) contractor's benefit plans, forms, and procedures; (3) enrollment status; (4) premium costs; (5) claims and claim procedures; (6) COBRA; and (7) other matters pertaining to the benefit plans provided under the contract. If contractor does not maintain an office on a particular neighbor island, contractor shall provide a toll-free telephone line to answer inquiries from members on such island and in any state between the hours of 7:00 AM to 7:00 PM HST, Monday through Friday, and 9:00 AM to 1:00 PM HST on Saturday, excluding State Holidays. A walk in customer service center located in the downtown civic center of Honolulu to service participants in the plans shall be open between the hours of 7:45 AM to 4:30 PM, HST Monday through Friday, except State holidays.

At its own cost, contractor shall draft, print, and regularly update written information that describes its benefit plan(s) in detail and a list of its providers. Upon request, the written information and list shall be provided to the EUTF's employee-beneficiaries and dependent-beneficiaries.

7. Open Enrollment

Each year, the EUTF holds at least one open enrollment period for active employees and one period for retired employees. Historically, the active open enrollment period begins in the spring and, the retiree open enrollment period is conducted in the fall. The EUTF may also hold special open enrollment periods during other times of the year.

Prior to open enrollment periods, the Administrator solicits summary benefit plan information from all contractors that explains and updates their benefit plan coverages, exclusions, limitations, service locations, networks and mail order providers, HMO health centers, etc. The Administrator then coordinates the publishing and distribution of benefit plan booklets, news

bulletins, notices, enrollment applications, and other forms related to the open enrollment. Contractor shall provide all information requested by the Administrator in a timely fashion.

During the open enrollment period, the EUTF holds various informational sessions for employee-beneficiaries and dependent-beneficiaries and retirees throughout the State on most Islands. At its own cost, contractor shall provide staff and written informational materials for such informational sessions.

Contractor shall provide any other assistance as may be reasonably requested by the Administrator in connection with any open enrollment period.

8. Other Enrollment Assistance

From time to time, the EUTF may hold training sessions for its staff and/or other government personnel involved in EUTF operations, e.g., the public employers' departmental personnel officers. In addition, the EUTF holds informational meetings at various places around the State of Hawaii for its employee-beneficiaries and dependent beneficiaries, e.g., periodic pre-retirement and retirement informational meetings for employees, "benefits fairs" and/or informational meetings for employees facing a reduction in force. Upon EUTF's request and at its own cost, contractor shall provide staff and written informational materials for these training sessions, benefits fairs and informational meetings.

Upon request and at no additional cost to the EUTF, contractor shall provide information to the EUTF necessary to update its eligibility and enrollment files, e.g., current addresses of employee-beneficiaries.

Contractor and its staff shall reasonably cooperate with and provide timely information and assistance to EUTF employee-beneficiaries and dependent-beneficiaries who are applying for State and county employee benefits including disability retirement.

9. Coordination of Benefits/Medicare Claims

Contractor shall provide all services necessary to coordinate benefits ("COB") between its health and or pharmacy benefits plans (or any self-insured plans it administers on behalf of the EUTF) and other health benefit plans of the EUTF's employee-beneficiaries and dependent-beneficiaries without any additional claim form submissions by the beneficiaries. It will be the responsibility of the contractor to pursue 100% compliance with disclosure of COB information from participants. In addition, the contractor shall on behalf of the EUTF perform all services necessary to reconcile reimbursement claims made by Medicare to the EUTF or any public employer that arise with respect to contractor's health benefits plans (or any self-insured plans it administers on behalf of the EUTF). Compliance will be in accordance to the National Association of Insurance Commissioner Guidelines.

10. Active Part-Time and Temporary Employee Plan Administration

Commencing January 1, 2015, the Employers participating in the EUTF, in order to comply with the requirements under the Patient Protection and Affordable Care Act (PPACA), will offer temporary and part-time employees the opportunity to enroll themselves and their dependent children to age 26 and optionally, the spouse of the employee, in the lowest cost plan of the EUTF (currently the 75%/25% PPO Plan and/or Kaiser Standard Plan) at the time of initial employment and during the annual open enrollment period. The premium will entirely be paid by the employee. The EUTF requires the services described below from the contractor for the

75%/25% plan and the Closed Plan Standard HMO plan. Separate rates will be developed for this group, and the experience for this group may not be applied against the experience of the EUTF plans. The rates for this group should be community rated and guaranteed for each of the contract periods of the active plan. The EUTF will not bear any of the expense of offering these plans. The premiums charged must be self supporting and the plan agreement must be structured as a group plan offered by the employer so as to prevent the employers from exposure to the penalties under PPACA, Section 4980(H)(a). *NOTE: OFFEROR is requested to offer a bid with and without including the spouse in the bid*

Contractor shall:

- Conduct all open enrollment sessions
- Receive enrollment election form from the Employer
- Process enrollment and maintain database of enrolled employees and dependents
- Distribute all ID cards and enrollment material to the enrollee
- Provide full customer service with respect to questions from the participants with regard to eligibility, billing, claims and benefits
- Report enrollment to the individual employers and EUTF if required
- Send premium billing to participant and collect all premiums monthly
- Comply with all continuation requirements under COBRA and administer same for this group
- Send cancellation notices upon non-payment of premium
- Process any change of enrollment requests during the plan year due to the permitted addition or deletion of dependents as required under all applicable laws, including but not limited to HIPAA
- Separately account for the claim experience of this group in reporting to the EUTF
- Process terminations when reported by the individual employers
- Provide all federal and State required communication and information to the participants
- Provide written notification to the EUTF of any annual rate changes 120 days prior to the commencement of the EUTF annual open enrollment for Active Employee Plans subject to the rate maximum included in the response to this Request for Proposal.
- Include in the rates, all taxes, fees and all ACA fees as required under PPACA
- Perform all reporting to the federal and State agencies as required under PPACA and,
- Issue annual insurance certificates as required under PPACA in order for the participants to comply with the Individual Mandates under PPACA

11. Reports and Accountings

All reports that the contractor is required to give to the EUTF under the contract shall be in form and substance reasonably satisfactory to the EUTF. Upon reasonable advance notice, the EUTF may require changes in the form of the reports or may request that the reports contain different or additional information.

Contractor shall provide monthly operation reports to the EUTF. The monthly operations reports shall initially be in a letter format and each report shall be due on or before the 10th day of the month following the month that is the subject of the report. The monthly operations reports shall include information including, but not limited to, the following: (1) operational issues pertaining

to EUTF members participating in the contractor's plans such as member mailings or network changes; (2) issues raised by or with the contractor and correspondence to or referred to the contractor; (3) publications or press releases relating to the contractor's plans that may be of interest to EUTF members; (4) community activities relating to the contractor that may be of interest to the EUTF members; (5) any legal actions or proceedings involving EUTF members; and (6) any complaints by EUTF members to the contractor or the Insurance Division relating to the contractor's plans or the contractor's administration of EUTF self-insured plans.

Contractor shall provide monthly reports on financial operations in hard copy and electronically. The monthly financial reports shall be due on or before the 10th day of the month following the month that is the subject of the report.

Contractor shall provide quarterly reports on performance standards in hard copy and electronically. The quarterly reports shall be due on or before the 30th day following the end of the quarter that is the subject of the report. Contractor shall also provide quarterly financial and enrollment reports by bargaining unit.

Contractor shall provide an annual plan performance report with the incurred and paid accounting report within 120 days after each contract year, as well as any recommendations to improve the plan design or plan administration. The report shall be provided in hard copy and electronically. There shall be two (2) separate reports, one for actives and one for retirees. The retiree report shall be split between Medicare and non-Medicare retirees.

Upon request, contractor shall provide to the EUTF a report containing information on all claims received and/or processed by contractor during a specified period of time. Such a report shall be provided electronically.

Upon reasonable advance notice, the EUTF may request special reports on matters pertaining to contractor's benefit plans and/or contractor's performance of the contract.

Contractor shall also provide electronic data upon request by the EUTF or its contractor on specific claim utilization and cost data in order to analyze medical risk and utilization. Contractor may be required to provide the utilization, cost and claim data as frequently as quarterly throughout the term of the contract. All cost of preparing the data in a format required by the EUTF shall be included in the Contractor's proposal.

12. Confidential Information

Contractor shall protect all information, records, and data collected in connection with this contract from unauthorized disclosures. The EUTF and contractor shall determine if and when any other party may have authorized access to such information.

Contractor shall guard the confidentiality of participant information. Access to participant information shall be limited by contractor to persons or agencies that require the information in order to perform their duties in accordance with the contract. Any other party shall be granted access to confidential information only after compliance with the requirements of all federal, state, and county laws pertaining to such access, e.g., HIPAA.

Contractor is required to know and understand the confidentiality laws that pertain to its benefit plan and its performance under the contract. This includes knowledge and understanding of laws specific to certain groups (i.e., HRS chapter 577A relating to minor females and pregnancy and family planning services, HRS §325-101 relating to persons with HIV/AIDS, HRS §334-5

relating to persons receiving mental health services, and 42 CFR Part 2 relating to persons receiving substance abuse services).

Nothing in this section shall prohibit the contractor from disclosing information to the EUTF or its designee.

13. Electronic Data Transmissions

Contractor shall have and maintain HIPAA compliant hardware, software, and systems that are capable of picking up or receiving electronic data transmission from the EUTF regarding enrollments, changes to enrollments, premiums, and other matters related to the contract.

Contractor shall accept the EUTF's HIPAA-compliant, weekly electronic data transmissions as the official membership eligibility/enrollment records, subject to adjustments as authorized by the EUTF.

Contractor shall also provide the exchange of medical claim information with the Pharmacy Benefit Management contractor, if any, on a quarterly basis throughout the term of the contract in order to develop a coordinated and integrated medical management process and to assist the EUTF with the overall management of medical expenses, including pharmaceutical expenses. Contractor shall exchange on a daily basis out of pocket expense information with the Pharmacy Benefit Management contractor in order to comply with the mandated maximum out of pocket expense regulations contained in the PPACA.

14. Payment to Contractor

Payment to contractor will be done in arrears, after the month is completed. Such payments shall be made by the 15th day of the following month. If the 15th day of the month falls on a weekend or holiday, the payment will be made on the next succeeding weekday that is not a holiday.

For purposes of calculating the amount of premiums or fees due the contractor, the number of employee-beneficiaries enrolled in contractor's plans shall be determined as of a given date of the month, to be selected by the Administrator. Retroactive additions and terminations shall be accounted for in future payments.

Contractor shall accept the monthly summary enrollment reports provided by the EUTF as the basis for the amount of premiums due the contractor under the contract. Contractor shall notify the EUTF in writing within ninety (90) calendar days after the end of the report month of any transaction or premium computation discrepancy or other problem in the monthly summary report. The contractor shall provide specific information that is necessary to resolve any noted discrepancy or problem. If the EUTF is not notified in writing within the ninety (90) days, the EUTF reports shall be considered as final and accepted by the contractor.

15. Availability of Funds

The contract shall be enforceable only to the extent that funds are available to the EUTF to make payments to contractor. All payments to contractor are subject to the EUTF's actual and continuing availability of funds. No damages or interest shall accrue against the EUTF, the State, the counties, or any other public employer as a result of the non-availability of funds.

Contractor acknowledges that the funds available to the EUTF come from public employer and employee-beneficiary contributions. With respect to retirees, HRS chapter 87A establishes the amount of the public employer contributions. However, with respect to active employees, the public employer contributions are generally established by collective bargaining between the public employers and public sector unions, and such contributions are subject to appropriation by the legislative bodies of the State and counties. See HRS §§ 87A-32, 89-9(a), 89-9(e), 89-10(b), and 89-11(g). Thus, a significant portion of the EUTF's availability of funds is contingent upon future collective bargaining between the public employers and public sector unions, the terms of any resulting collective bargaining agreements, and future appropriations by the legislative bodies of the State and counties.

The EUTF shall have the following rights should there not be available funding for contractor's contract: (a) to cancel the award of contract; (b) to renegotiate the award of contract to purchase reduced or modified services; (c) to delay the commencement date of the contract; or (d) to terminate part or the entire contract.

16. Health Data Reporting Requirement: Contractor shall agree to provide the following with respect to health data information
 - a. The Contractor shall submit encounter data to EUTF at least once per quarter in accordance with the requirements and specifications defined by the EUTF
 - b. The Contractor will agree to submit data to the All Payor Claim Database established by the State of Hawaii
 - c. Data shall be in compliance with all NCQA compliant benchmarking

17. Self-Insured Claim Administration. Fees proposed for all administrative services under a self-insured proposal must include the payment of all run-out claims after the termination or expiration of the contract. The fees charged during the term of the contract are to include all of the post termination services in addition to claim adjudication and payment, including financial reporting, claim appeal processing, management of the self-funded banking arrangements, eligibility and retroactive adjustment to eligibility and continuation of COBRA processing for the participants enrolled in COBRA benefits at the time of termination Run Out Claim Administration. Upon termination of the contract, OFFEROR will be required to pay all run-out claims for 12 months after the termination. All fees in this Offer are to include the cost of all post termination administration of the self-insured plan, if the option of self-insured plan administration is elected by the EUTF. No charges other than benefit cost will be paid after the termination of the contract

18. Auditing Responsibility. The OFFEROR must include in its fees the cost of annual audits with respect to:
 - a. Claim accuracy and coding and those aspects listed in the performance standards of this RFP
 - b. Customer Satisfaction
 - c. Telephone Center performance metrics, as listed in the performance standards of this RFP
 - d. The cost of the annual audit must be borne by the OFFEROR
 - e. The audit firm must be engaged by the OFFEROR and not contracted with the EUTF.
 - f. The audit firm must be independent of the OFFEROR with no financial, subsidiary relationship with the OFFEROR or present an opportunity by the OFFEROR to exercise a real or perceived conflict of interest between it or the OFFEROR.
 - g. The EUTF reserves the right to approve the claim and customer service audit firm that is used by the OFFEROR, however, the EUTF will not contract with the audit firm, or issue an RFP for an independent auditor

19. Fully Insured COBRA administration: OFFEROR is required to administer all aspects of compliance under the Continuation provision of the Consolidated Omnibus Reconciliation Act (COBRA), including eligibility, election of coverage, billing and collection of premium, termination and annual and termination notification.

The EUTF currently offers a choice of medical plans as outlined below:

1) HMSA – Fully Insured*:

Active EUTF

- PPO 90/10 (Prescription Drug with CVS Caremark, Chiropractic Plan with Royal State)
- PPO 80/20 (Prescription Drug with CVS Caremark, Chiropractic Plan with Royal State)
- PPO 75/25 (Prescription Drug with CVS Caremark, Chiropractic Plan with Royal State)
- HMO (Prescription Drug with CVS Caremark, Chiropractic Plan with Royal State)
- Supplemental Medical Plan and HMSA Prescription Drug and Vision**

Active HSTA VB

- PPO 90/10 (Prescription Drug with CVS Caremark, Chiropractic Plan with Royal State)
- PPO 80/20 (Prescription Drug with CVS Caremark, Chiropractic Plan with Royal State)
- Supplemental Medical Plan and HMSA Prescription Drug and Vision**

Retiree EUTF

- PPO 90/10 (Non-Medicare Prescription Drug with CVS Caremark, Medicare Prescription Drug with Supplemental Wrap Plan (EGWP) with SilverScript,)

Retiree HSTA VB

- PPO 90/10 (Non-Medicare Prescription Drug with CVS Caremark, Medicare Prescription Drug with Supplemental Wrap Plan (EGWP) with SilverScript, Chiropractic Plan with Royal State)

**CVS Caremark prescription drug benefits are self-funded.*

*** HMSA Supplemental Medical Plan and HMSA HSTA VB Supplemental Medical Plan will be eliminated 6/30/14.*

2) Royal State – Fully Insured:

Active EUTF

- Supplemental Copayment Reimbursement Plan

3) Kaiser – Fully Insured:

Active EUTF

- Comprehensive HMO and Kaiser Prescription Drug
- Standard HMO and Kaiser Prescription Drug

Active HSTA VB

- Comprehensive HMO and Kaiser Prescription Drug

Retiree EUTF

- Comprehensive HMO and Kaiser Prescription Drug

Retiree – HSTA VB

- Comprehensive HMO and Kaiser Prescription Drug

Additional Requested Plans:

- 1) Plan Option for Open Panel Medicare Advantage Plan(s) for EUTF Retirees:** EUTF is requesting bids and plan design proposal(s) for an additional retiree option for an Open Panel Medicare Advantage Plan, with benefits as closely approximating the value of the 90%/10% as is practical. This option may be introduced effective the first contract period for retiree plans, in addition to the current plan offerings. Please provide the rates and plan design attached to Proposal Sheet 17.
- 2) Plan for Part-Time and Temporary Employees:** EUTF is requesting bids for temporary and part time employees and their dependent children to age 26. Please provide a rate on Proposal Sheet 7A-1 and 9A-1. OFFEROR shall provide plan rates for a two options: the first of which includes the employee and dependent children and another option which includes the employee, spouse, and dependent children.
- 3) Fully Insured Chiropractic Integrated with the Medical Plan:** EUTF is requesting bids for a fully insured chiropractic plan for all active employees and HSTA VB retirees.
- 4) Fully Insured Prescription Drug Plan Integrated with the Medical Plan.** EUTF is requesting bids for active employee prescription plans, Non-Medicare prescription plans with supplemental (wrap) and Medicare (EGWP).

Dental benefits are provided through Hawaii Dental Service (HDS) to actives and retirees. Vision Service Plan (VSP) provides the vision benefits to actives and retirees eligible under the EUTF. A fully insured chiropractic care plan is offered to all actives and HSTA VB retirees only through a contract with Royal State. Life Insurance benefits are provided under a contract with Royal State.

PURPOSE

The EUTF's objective is to provide comprehensive healthcare coverage for its employees and retirees. A key desire of the EUTF is to maintain current level of benefits and through this proposal request process, produce the most competitive alternatives to the current plans for consideration.

The EUTF is soliciting contracts for actives and retirees as contained in Section I, 3.

Separate contracts will be issued for active and retiree plans.

ELIGIBILITY

All active employees and spouses are eligible for benefits as determined by the EUTF. Dependent children are eligible until age 26 for active employees. Also eligible are retired employees and their dependents (spouses and dependent children to age 24 if unmarried and full-time students). Domestic partners and their dependents, and civil union partners and their dependents are also eligible. EUTF Active and HSTA VB Active Plans are considered to be Non Grandfathered Plans under the ACA. EUTF

and HSTA VB Retiree Plans are considered to be exempt under the ACA as excepted plans. Effective December 2, 2013, the Hawaii Legislature enacted the Marriage Equality Act of 2013.

Census and claim data will be provided ONLY upon the completion and return of the Intent to Bid Form (Attachment 2) and a signed Confidentiality Agreement (Attachment 3).

Exhibit H shows the enrollment count as of September 2013, by carrier. NOTE: Because of PPACA, the HMSA Supplemental Medical and the HMSA HSTA VB Supplemental Medical Plans will be terminated as of June 30, 2014.

PREMIUM HISTORY

The monthly tiered employer and employee contribution rates for current and previous years are shown in Exhibit B by carrier and subscriber type for all plans.

PLAN COMPARISON SUMMARIES AND FEE PROPOSAL FORMS

PROPOSED BENEFITS

Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. **Unless noted it will be assumed that proposed benefits match the requested benefits exactly.**

[NOTE: For all of the following Sections, please read the instructions to OFFERORS concerning the disclosure of “trade secret” or “confidential” information and mark your responses in this RFP accordingly. Failure of the OFFEROR to appropriately identify the responses as such may result in the disclosure of any such information] Please refer to the instructions for the submission of a redacted copy of your proposal in Section 1.11, *Submission of Proposals.*

Notes Applicable to Insured/Risk Sharing Proposed Rates

1. All proposals must include fees and taxes and exclude fees mandated under PPACA which are to be listed separately.
2. All proposals should guarantee a maximum administration, plus retention and profit as a percent of paid claims. This guarantee must be separately stated for the initial contract term and the optional contract extensions.
3. You must separately list the guaranteed retention/administrative cost and profit on your proposal sheet for the fully insured options
4. For the fully insured plans, if the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. Each Plan must be separately accounted and surpluses from one plan may not be applied to offset deficits of another plan, even though they are covered under the same contract.
5. Deficits may not be carried forward to subsequent contract periods to be recovered from any future surplus. Each contract period must be separately accounted and surpluses must be returned 12 months after the conclusion of each contract period.
6. The financial experience of each plan must be independent of the financial experience of any other plan that may be awarded to a contractor. Gains or losses from one plan may not be applied to the gains or losses of another plan, and active plans must be rated separately from Retiree plans. For example, the Active EUTF 90%/10% plan must be accounted for separately from the EUTF Active 80%/20% plan. Likewise, the HSTA VB 90%/10% plan must be accounted for separately from any other plan.
7. The EUTF reserves the right to offer multiple options.
8. No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.
9. Rates must be quoted on a three tiered basis (self, two-party, and family). If this is not possible due to federal filing requirements, please note that exception clearly on each rate table that you are completing, but you must guarantee your retention/administrative fee and profit for the entire contract period and successive periods.

10. All underwriting rules/restrictions that apply to rates quoted must be listed as an attachment to the rate exhibit
11. All rates quoted must exclude any commissions or payment to any third party.
12. Please list any rating method which uses a credibility factor less than 100% in your underwriting assumptions.
13. Rates shown must be valid for the contract periods contained in Section 1.4, *Contract Period*.
14. Rates must be filled out in the proposal sheets provided.
15. All rates must be guaranteed for the term of the contract, including the proposed extensions.
16. If your proposal is accepted by the EUTF, the following additional rates will be required for various self-pay categories: Tiered Cobra Rates.

Important Self Insured Proposal Instruction and Information

1. The EUTF reserves the right to offer multiple options.
2. All Administrative fees must include all fees, taxes and exclude fees mandated under PPACA which are to be listed separately.
3. No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.
4. All services to be provided for the quoted fee should be listed including quantities and frequencies.
5. Fees must exclude commissions and payments made to any third party
6. Proposals must be filled out in the proposal sheets provided
7. Individual fee components will be assumed to be self-supporting stand alone services.
8. Your fees must include any fee for PPO Leasing/Network Access.
9. All rates must be guaranteed for the term of the contract, including any extensions.
10. List services/supplies not covered under the fees quoted above (i.e., custom reports, printing, etc.).
11. Fees quoted are to cover services for claims incurred on or after the contract effective date. All fees for the payment of run-out claims must be included in the monthly fees charged during the contract period.

**ACTIVE
EUTF - 90/10 PPO PLAN
TABLE AND PROPOSAL SHEETS #1**

PLAN COMPARISON CHARTS
PROPOSED BENEFITS

Detailed benefits information is provided in Exhibit E. Please note any deviation in proposed benefits in the charts below. Unless noted it will be assumed that proposed benefits match the requested benefits exactly. You must agree to a “no loss, no gain” provision with the current benefit plan.

TABLE 1 – ACTIVE			
PLAN DESIGN	EUTF 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network**	
Deductible Single/Family	None	\$100 per person; \$300 per family	
Out-of-pocket limit - Single/Family	\$2,000/\$6,000		
Lifetime Benefit Maximum	Unlimited		
Policy Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Primary Care Office Visit	10%	30%	
Specialist Office Visit	10%	30%	
Routine physical exams	No Charge	No Charge*	
Screening Mammography	No Charge	30% *	
Immunizations	No Charge	No Charge*	
Well Baby Care Visits	No Charge	30% *	
Maternity	Same as any other condition	Same as any other condition	
Second opinion – surgery	10%	30%	
Emergency Room (ER care)	10%	10% *	
Ambulance	10%	30%	

*Deductible does not apply.

** Out-of-Network benefits are limited to usual customary and reasonable charges.

TABLE 1 – ACTIVE (continued)

PLAN DESIGN	EUTF 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network	
INPATIENT HOSPITAL SERVICES			
Room and Board	10%	30%	
Ancillary Services	10%	30%	
Physician Services	10%	30%	
Surgery	10%	30%	
Anesthesia	10%	30%	
OUTPATIENT SERVICES			
Chemotherapy/Radiation Therapy	10%	30%	
Surgery	10%	30%	
Diagnostic Lab	10%	30%	
Diagnostic X-ray	10%	30%	
Anesthesia	10%	30%	
MENTAL HEALTH SERVICES			
Inpatient Care	10%	30%	
Outpatient Care	10%	30%	
OTHER SERVICES			
Durable Medical Equipment	10%	30%	
Home Health Care	No Charge	30%	
Hospice Care	No Charge	Not Covered	
Nursing Facility – Skilled Care	10%, 120 days/CY	30%, 120 days/CY	
Physical and Occupational Therapy	10%	30%	
PRESCRIPTION DRUGS			
	Provided by CVS Caremark		
Retail - 30 day supply	Participating Pharmacy	Non-Participating Pharmacy	
Generic	\$5 co-pay	\$5 co-pay + 20% of eligible charges	
Preferred Brand Name	\$15 co-pay	\$15 co-pay + 20% of eligible charges	

TABLE 1 – ACTIVE (continued)

PLAN DESIGN	EUTF 90/10 PPO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
	Provided by Caremark	
PRESCRIPTION DRUGS	Participating Pharmacy	Non-Participating Pharmacy
Retail - 30 day supply		
Other Brand Name	\$30 co-pay	\$30 co-pay + 20% of eligible charges
Injectables & Specialty Drug	20% of eligible charges, up to \$250 maximum; \$2,000 out-of-pocket annual maximum; \$30 co-pay oral oncology specialty medications	Not a benefit
Insulin -		
Preferred	\$5 co-pay	\$5 co-pay + 20% of eligible charges
Other	\$15 co-pay	\$15 co-pay + 20% of eligible charges
Diabetic Supplies -		
Preferred	No charge	No charge
Other Supplies	\$15 co-pay	\$15 co-pay
Mail Order and Retail - 90 Day Supply		
Generic	\$10 co-pay	Not a benefit
Preferred Brand Name	\$35 co-pay	Not a benefit
Other Brand Name	\$60 co-pay	Not a benefit
Insulin -		
Preferred	\$10 co-pay	Not a benefit
Other	\$35 co-pay	Not a benefit
Diabetic Supplies -		
Preferred	No charge	Not a benefit
Other Supplies	\$35 co-pay	Not a benefit

NOTE: Prescriptions are currently provided under a separate contract

**90/10 PPO Plan - Active EUTF - All Bargaining Units Except Bargaining Unit 12 and HSTA VB
Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)**

Complete the following table on a monthly, per capita tiered basis ONLY

HMSA 90/10 PPO Plan	Contract Period 1	Contact Period 2	Contract Period 3
Medical Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____%	_____%	_____%
Total Medical Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
Prescription Drug Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____%	_____%	_____%
Total Prescription Drug Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

Indicate adjustment to proposed rates if BU12 is included with the above _____%

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

** If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

90/10 PPO Plan - Active EUTF - Bargaining Unit 12
Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)
Complete the following table on a monthly, per capita tiered basis ONLY

HMSA 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Medical Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____%	_____%	_____%
Total Medical Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
Prescription Drug Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____%	_____%	_____%
Total Prescription Drug Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

* If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

(1) The EUTF reserves the right to offer multiple options.

(2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of OFFEROR

Date

Self-Insured 90/10 PPO Plan ASO Fee – EUTF ACTIVE

Target Claims, Retention and Fees Tables (Self Insured)

Complete the following table based upon enrollment census and claims assumptions provided.

HMSA 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
PPO Leasing /Network Access Fees			
Claim Adjudication Fee			
Utilization Management Fees			
Disease Management			
Other*			
Total ASO Fees			
Total ASO Fees by Tier			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc.

Authorized Signature

Title

Name of Company

Date

**ACTIVE
HSTA VB - 90/10 PPO PLAN
TABLE AND PROPOSAL SHEETS #2**

TABLE 2 – ACTIVE			
PLAN DESIGN	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network**	
Deductible Single/Family	None	\$100 per person; \$300 per family	
Out-of-pocket limit - Single/Family	\$2,000/\$6,000		
Lifetime Benefit Maximum	Unlimited		
Policy Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Primary Care Office Visit	10%	30%	
Specialist Office Visit	10%	30%	
Routine physical exams	No Charge	No Charge	
Screening Mammography	No Charge	30% *	
Immunizations	No Charge	30%	
Well Baby Care Visits	No Charge	30% *	
Maternity	Same as any other condition	Same as any other condition	
Second opinion – surgery	10%	30%	
Emergency Room (ER care)	10%	10% *	
Ambulance	10%	30%	
INPATIENT HOSPITAL SERVICES			
Room and Board	10%	30%	
Ancillary Services	10%	30%	
Physician Services	10%	30%	
Surgery	10%	30%	
Anesthesia	10%	30%	

*Deductible does not apply.

** Out-of-Network benefits are limited to usual customary and reasonable charges.

TABLE 2 – ACTIVE (continued)

PLAN DESIGN	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network	
OUTPATIENT SERVICES			
Chemotherapy/Radiation Therapy	10%	30%	
Surgery	10%	30%	
Diagnostic Lab	10%	30%	
Diagnostic X-ray	10%	30%	
Anesthesia	10%	30%	
MENTAL HEALTH SERVICES			
Inpatient Care	10%	30%	
Outpatient Care	10%	30%	
OTHER SERVICES			
Durable Medical Equipment	10%	30%	
Home Health Care	No Charge	30%	
Hospice Care	No Charge	Not Covered	
Nursing Facility – Skilled Care	10%, 120 days/CY	30%, 120 days/CY	
Physical and Occupational Therapy	10%	30%	
PRESCRIPTION DRUGS			
	Provided by Caremark		
Retail (30 days supply) -			
Generic and Insulin	\$5	\$5 + 30% of remaining eligible charge	
Brand Name	\$15	\$15 + 30% of remaining eligible charge	
Mail Order and Retail(90 day supply)			
Generic and Insulin	\$9	Not covered	
Brand Name	\$27	Not covered	

NOTE: Prescriptions are currently provided under a separate contract.

90/10 PPO Plan – Active HSTA VB
Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)
Complete the following table on a monthly, per capita tiered basis ONLY

HMSA 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Medical Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____ %	_____ %	_____ %
Total Medical Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
Prescription Drug Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____ %	_____ %	_____ %
Total Prescription Drug Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

** If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

**Self-Insured 90/10 PPO Plan ASO Fee – ACTIVE HSTA VB
Target Claims, Retention and Fees Tables (Self Insured)**

Complete the following table based upon enrollment census and claims assumptions provided.

HMSA 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
PPO Leasing /Network Access Fees			
Claim Adjudication Fee			
Utilization Management Fees			
Disease Management			
Other*			
Total ASO Fees			
Total ASO Fees by Tier			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc.

Authorized Signature

Title

Name of Company

Date

**ACTIVE
EUTF - 80/20 PPO PLAN
TABLE AND PROPOSAL SHEETS #3**

TABLE 3 – ACTIVE			
PLAN DESIGN	EUTF 80/20 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network**	
Deductible Single/Family	None		
Out-of-pocket limit - Single/Family	\$2,500/\$7,500		
Lifetime Benefit Maximum	Unlimited		
Policy Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Primary Care Office Visit	\$14	\$14	
Specialist Office Visit	\$14	\$14	
Routine physical exams	No Charge	No Charge	
Screening Mammography	No Charge	No Charge	
Immunizations	No Charge	No Charge	
Well Baby Care Visits	No Charge	No Charge	
Maternity	10%	10%	
Second opinion – surgery	\$14	\$14	
Emergency Room (ER care)	\$20	\$20	
Ambulance	20%	20%	
INPATIENT HOSPITAL SERVICES			
Room and Board	20%	20%	
Ancillary Services	20%	20%	
Physician Services	\$20	\$20	
Surgery	20%	20%	
Anesthesia	20%	20%	

*** Out-of-Network benefits are limited to usual customary and reasonable charges.*

TABLE 3 – ACTIVE (continued)

PLAN DESIGN	EUTF 80/20 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network	
OUTPATIENT SERVICES			
Chemotherapy/Radiation Therapy	20%	20%	
Surgery	20%	20%	
Diagnostic Lab	No Charge	No Charge	
Diagnostic X-ray	20%	20%	
Anesthesia	20%	20%	
MENTAL HEALTH SERVICES			
Inpatient Care	20%	20%	
Outpatient Care	20%	20%	
OTHER SERVICES			
Durable Medical Equipment	20%	20%	
Home Health Care	20%	20%	
Hospice Care	No Charge	No Charge	
Nursing Facility – Skilled Care	20%	20%	
Physical and Occupational Therapy	20%; 120 days/CY	20%; 120 days/CY	
PRESCRIPTION DRUGS			
	Provided by Caremark		
Retail - 30 day supply	Participating Pharmacy	Non-Participating Pharmacy	
Generic	\$5 co-pay	\$5 co-pay + 20% of eligible charges	
Preferred Brand Name	\$15 co-pay	\$15 co-pay + 20% of eligible charges	
Other Brand Name	\$30 co-pay	\$30 co-pay + 20% of eligible charges	
Injectables & Specialty Drug	20% of eligible charges, up to \$250 maximum; \$2,000 out-of-pocket annual maximum; \$30 co-pay oral oncology specialty medications	Not a benefit	
Insulin -			

Preferred	\$5 co-pay	\$5 co-pay + 20% of eligible charges	
Other	\$15 co-pay	\$15 co-pay + 20% of eligible charges	
Diabetic Supplies -			
Preferred	No charge	No charge	
Other Supplies	\$15 co-pay	\$15 co-pay	
Mail Order and Retail- 90 Day Supply			
Generic	\$10 co-pay	Not a benefit	
Preferred Brand Name	\$35 co-pay	Not a benefit	
Other Brand Name	\$60 co-pay	Not a benefit	
Insulin -			
Preferred	\$10 co-pay	Not a benefit	
Other	\$35 co-pay	Not a benefit	
Diabetic Supplies -			
Preferred	No charge	Not a benefit	
Other Supplies	\$35 co-pay	Not a benefit	

NOTE: Prescriptions are currently provided under a separate contract.

**80/20 PPO Plan - Active EUTF - All Bargaining Units Except Bargaining Unit 12 and HSTA VB
Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)**

Complete the following table on a monthly, per capita tiered basis ONLY

HMSA 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Medical Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____ %	_____ %	_____ %
Total Medical Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
Prescription Drug Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____ %	_____ %	_____ %
Total Prescription Drug Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

Indicate adjustment to proposed rates if BU12 is included with the above _____ %

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

** If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

80/20 PPO Plan - Active EUTF - Bargaining Unit 12
Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)
Complete the following table on a monthly, per capita tiered basis ONLY

HMSA 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Medical Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____ %	_____ %	_____ %
Total Medical Premium (Including Administration and Retention)**			
Prescription Drug Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____ %	_____ %	_____ %
Total Prescription Drug Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

** If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

(1) The EUTF reserves the right to offer multiple options.

(2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

Self-Insured 80/20 PPO Plan ASO Fee – EUTF ACTIVE

Target Claims, Retention and Fees Tables (Self Insured)

Complete the following table based upon enrollment census and claims assumptions provided.

HMSA 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 2
PPO Leasing /Network Access Fees			
Claim Adjudication Fee			
Utilization Management Fees			
Disease Management			
Other*			
Total ASO Fees			
Total ASO Fees by Tier			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc.

Authorized Signature

Title

Name of Company

Date

**ACTIVE
HSTA VB - 80/20 PPO PLAN
TABLE AND PROPOSAL SHEETS #4**

TABLE 4 – ACTIVE			
PLAN DESIGN	HSTA VB 80/20 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network**	
Deductible Single/Family	None		
Out-of-pocket limit - Single/Family	\$2,500/\$7,500		
Lifetime Benefit Maximum	Unlimited		
Policy Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Primary Care Office Visit	20%	20%	
Specialist Office Visit	20%	20%	
Routine physical exams	No charge	No charge	
Screening Mammography	No Charge	No Charge	
Immunizations	20%	20%	
Well Baby Care Visits	No Charge	No Charge	
Maternity	20%	20%	
Second opinion – surgery	20%	20%	
Emergency Room (ER care)	20%	20%	
Ambulance	20%	20%	
INPATIENT HOSPITAL SERVICES			
Room and Board	20%	20%	
Ancillary Services	20%	20%	
Physician Services	20%	20%	
Surgery	20%	20%	
Anesthesia	20%	20%	

*** Out-of-Network benefits are limited to usual customary and reasonable charges.*

TABLE 4 – ACTIVE (continued)

PLAN DESIGN	HSTA VB 80/20 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network	
OUTPATIENT SERVICES			
Chemotherapy/Radiation Therapy	20%	20%	
Surgery	20%	20%	
Diagnostic Lab	No Charge	No Charge	
Diagnostic X-ray	20%	20%	
Anesthesia	20%	20%	
MENTAL HEALTH SERVICES			
Inpatient Care	20%	20%	
Outpatient Care	20%	20%	
OTHER SERVICES			
Durable Medical Equipment	20%	20%	
Home Health Care	No charge	No charge	
Hospice Care	No Charge	No Charge	
Nursing Facility – Skilled Care	20%	20%	
Physical and Occupational Therapy	20%; 120 days/CY	20%; 120 days/CY	
PRESCRIPTION DRUGS			
	Provided by Caremark		
Retail (30 days supply) -			
Generic and Insulin	\$5	\$5 + 30% of remaining eligible charge	
Brand Name	\$15	\$15 + 30% of remaining eligible charge	
Mail Order and Retail (90 day supply)			
Generic and Insulin	\$9	Not covered	
Brand Name	\$27	Not covered	

NOTE: Prescriptions are currently provided under a separate contract.

80/20 PPO Plan - Active HSTA VB
Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)
Complete the following table on a monthly, per capita tiered basis ONLY

HMSA 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Medical Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____%	_____%	_____%
Total Medical Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
Prescription Drug Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____%	_____%	_____%
Total Prescription Drug Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

** If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

**Proposal Sheet -
Proposal #4B**

SELF INSURED

**Self-Insured 80/20 PPO Plan ASO Fee – HSTA VB ACTIVE
Target Claims, Retention and Fees Tables (Self Insured)**

Complete the following table based upon enrollment census and claims assumptions provided.

HMSA 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
PPO Leasing /Network Access Fees			
Claim Adjudication Fee			
Utilization Management Fees			
Disease Management			
Other*			
Total ASO Fees			
Total ASO Fees by Tier			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc.

Authorized Signature

Title

Name of Company

Date

**ACTIVE
EUTF - HMO PLAN
TABLE AND PROPOSAL SHEETS #5**

TABLE 5 – ACTIVE		
PLAN DESIGN	EUTF HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
Carrier	HMSA	
General		
Deductible Single/Family	None/None	
Out-of-pocket limit - Single/Family	\$1,500/\$4,500	
Lifetime Benefit Maximum	None	
Policy Year Benefit Maximum	None	
PHYSICIAN SERVICES	MEMBER PAYS	
Primary Care Office Visit	\$15	
Specialist Office Visit	\$15	
Routine physical exams	\$15	
Screening Mammography	No Charge	
Immunizations	No Charge	
Well Baby Care Visits	No Charge	
Maternity	No Charge, Routine Pre/Post Natal Care & Delivery	
Second opinion – surgery	\$15	
Emergency Room (ER care)	\$25	
Ambulance	20%	
INPATIENT HOSPITAL SERVICES		
Room and Board	No Charge	
Ancillary Services	No Charge	
Physician Services	No Charge	
Surgery	No Charge	
Anesthesia	No Charge	

TABLE 5 – ACTIVE (continued)

PLAN DESIGN	EUTF HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	HMSA	
General		
OUTPATIENT SERVICES		
Chemotherapy/Radiation Therapy	\$15	
Surgery	\$15	
Diagnostic Lab	No Charge	
Diagnostic X-ray	\$15 per X-ray	
Anesthesia	\$15	
MENTAL HEALTH SERVICES		
Inpatient Care	No Charge	
Outpatient Care	No Charge	
OTHER SERVICES		
Durable Medical Equipment	20%	
Home Health Care	No Charge	
Hospice Care	No Charge	
Nursing Facility – Skilled Care	No Charge, 100 days/CY	
Physical and Occupational Therapy	\$15 (Outpatient)	
PRESCRIPTION DRUGS		
Provided by Caremark		
Retail - 30 day supply		
Generic	\$5 co-pay	
Preferred Brand Name	\$15 co-pay	
Other Brand Name	\$30 co-pay	
Injectables & Specialty Drug	20% of eligible charges; Up to \$250 maximum; \$2,000 out-of-pocket maximum per plan year; \$30 co-pay oral oncology specialty medications	
Insulin -		
Preferred	\$5 co-pay	
Other	\$15 co-pay	
Diabetic Supplies -		
Preferred	No charge	

TABLE 5 – ACTIVE (continued)

PLAN DESIGN	EUTF HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Other Supplies	\$15 co-pay	
MAIL ORDER and Retail- 90 DAY SUPPLY	Provided by Caremark	
Generic	\$10 co-pay	
Preferred Brand Name	\$35 co-pay	
Other Brand Name	\$60 co-pay	
Insulin -		
Preferred	\$10 co-pay	
Other	\$35 co-pay	
Diabetic Supplies -		
Preferred	No charge	
Other Supplies	\$35 co-pay	

NOTE: Prescriptions are currently provided under a separate contract

**HMO Plan - Active EUTF - All Bargaining Units Except Bargaining Unit 12 and HSTA VB
Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)**

Complete the following table on a monthly, per capita tiered basis ONLY

HMSA HMO PLAN	Contract Period 1	Contract Period 2	Contract Period 3
Medical Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____ %	_____ %	_____ %
Total Medical Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
Prescription Drug Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____ %	_____ %	_____ %
Total Prescription Drug Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

Indicate adjustment to proposed rates if BU12 is included with the above _____ %

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

** If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

HMO Plan - Active EUTF - Bargaining Unit 12
Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)
Complete the following table on a monthly, per capita tiered basis ONLY

HMSA HMO PLAN	Contract Period 1	Contract Period 2	Contract Period 3
Medical Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____%	_____%	_____%
Total Medical Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
Prescription Drug Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____%	_____%	_____%
Total Prescription Drug Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

** If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

Self-Insured HMO Plan ASO Fee – EUTF ACTIVE
Target Claims, Retention and Fees Tables (Self Insured)

Complete the following table based upon enrollment census and claims assumptions provided.

HMSA HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Leasing /Network Access Fees			
Capitation Fee			
Claim Adjudication Fee			
Disease Management			
Utilization Management Fees			
Other*			
Total ASO Fees			
Total ASO Fees by Tier			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc.

Authorized Signature

Title

Name of Company

Date

ACTIVE
EUTF - COMPREHENSIVE CLOSED PANEL HMO PLAN
TABLE AND PROPOSAL SHEETS #6

TABLE 6 – ACTIVE		
PLAN DESIGN	EUTF CLOSED PANEL COMPREHENSIVE HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
Carrier	Kaiser Comprehensive	
General		
Deductible Single/Family	None/None	
Out-of-pocket limit - Single/Family	\$2,000/\$6,000	
Lifetime Benefit Maximum	None	
Policy Year Benefit Maximum	None	
PHYSICIAN SERVICES	MEMBER PAYS	
Primary Care Office Visit	\$15	
Specialist Office Visit	\$15	
Routine physical exams	No Charge	
Screening Mammography	No Charge	
Immunizations	No Charge	
Well Baby Care Visits	No Charge	
Maternity	No charge for routine prenatal visits and one postpartum visit	
Second opinion – surgery	\$15	
Emergency Room (ER care)	\$50	
Ambulance	20%	
INPATIENT HOSPITAL SERVICES		
Room and Board	No Charge	
Ancillary Services	No Charge	
Physician Services	No Charge	
Surgery	No Charge	
Anesthesia	No Charge	

TABLE 6 – ACTIVE (continued)

PLAN DESIGN	EUTF HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	Kaiser Comprehensive	
General		
OUTPATIENT SERVICES		
Chemotherapy/Radiation Therapy	\$15	
Surgery	\$15	
Diagnostic Lab	\$15/department/day	
Diagnostic X-ray	\$15/department/day	
Anesthesia	No charge	
MENTAL HEALTH SERVICES		
Inpatient Care	No Charge	
Outpatient Care	\$15	
OTHER SERVICES		
Durable Medical Equipment	20%	
Home Health Care	No Charge	
Hospice Care	No Charge	
Nursing Facility – Skilled Care	No Charge, 100 days/CY	
Physical and Occupational Therapy	\$15	
PRESCRIPTION DRUGS		
	Provided by Kaiser	
Retail - 30 day supply	\$15 co-pay; includes injectables, specialty drugs, insulin and diabetic supplies	
Mail Order and Retail - 90 day supply	\$30 co-pay; includes injectables, specialty drugs and diabetic supplies	

**Closed Panel Comprehensive HMO Plan - Active EUTF - All Bargaining Units
Except Bargaining Unit 12 and HSTA VB
Premium Rate Table Fully Insured**

Complete the following table on a monthly, per capita tiered basis ONLY

Closed Panel Comprehensive HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Total Premium			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

Indicate any adjustment to the premium as a percent if BU 12 is included in the above ____%

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Closed Panel Comprehensive HMO Plan - Active EUTF - Bargaining Unit 12
Premium Rate Table Fully Insured

Complete the following table on a monthly, per capita tiered basis ONLY

Closed Panel Comprehensive HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Total Premium			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

(1) The EUTF reserves the right to offer multiple options.

(2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

ACTIVE
EUTF - CLOSED PANEL STANDARD HMO PLAN
TABLE AND PROPOSAL SHEETS #7

TABLE 7- ACTIVE		
PLAN DESIGN	EUTF HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	Kaiser Standard	
General		
Deductible Single/Family	None/None	
Out-of-pocket limit - Single/Family	\$2,000/\$7,500	
Lifetime Benefit Maximum	None	
Policy Year Benefit Maximum	None	
PHYSICIAN SERVICES	MEMBER PAYS	
Primary Care Office Visit	\$20	
Specialist Office Visit	\$20	
Routine physical exams	No Charge	
Screening Mammography	No Charge	
Immunizations	No Charge	
Well Baby Care Visits	No Charge	
Maternity	No charge for routine prenatal visits and one postpartum visit	
Second opinion – surgery	\$20	
Emergency Room (ER care)	\$100	
Ambulance	20%	
INPATIENT HOSPITAL SERVICES		
Room and Board	15%	
Ancillary Services	15%	
Physician Services	15%	
Surgery	15%	
Anesthesia	15%	

TABLE 7 – ACTIVE (continued)

PLAN DESIGN	EUTF HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	Kaiser Standard	
General		
OUTPATIENT SERVICES		
Chemotherapy/Radiation Therapy	20%	
Surgery	15%	
Diagnostic Lab	\$10/department/day for basic; 20% for specialty	
Diagnostic X-ray	\$10/department/day for basic; 20% for specialty	
Anesthesia	15%	
MENTAL HEALTH SERVICES		
Inpatient Care	15%	
Outpatient Care	\$20	
OTHER SERVICES		
Durable Medical Equipment	50%	
Home Health Care	No Charge	
Hospice Care	No Charge	
Nursing Facility – Skilled Care	15%; 60 days/CY	
Physical and Occupational Therapy	\$20	
PRESCRIPTION DRUGS		
Provided by Kaiser		
Retail - 30 day supply		
Generic	\$5 maintenance; \$10 other generic	
Preferred Brand Name	\$35	
Other Brand Name	\$35	
Injectables & Specialty Drug	\$5 maintenance / \$10 other generic / \$35 brand, if requires skilled administration by medical personnel - \$20 per dose	
Insulin -		
Preferred	\$35 brand insulin	
Other	\$10 generic insulin	
Diabetic Supplies -		

Preferred	50% of applicable charges	
Other Supplies	50% of applicable charges	
MAIL ORDER and RETAIL - 90 DAY SUPPLY		
Generic	\$10	
Preferred Brand Name	\$20	
Other Brand Name	\$70	
Insulin -		
Preferred	Not available through Mail Order	
Other	Not available through Mail Order	
Diabetic Supplies -		
Preferred	50% of applicable charges	
Other Supplies	50% of applicable charges	

**Closed Panel HMO Standard Plan - Active EUTF - All Bargaining Units
Except Bargaining Unit 12 and HSTA VB
Premium Rate Table Fully Insured**

Complete the following table on a monthly, per capita tiered basis ONLY

Closed Panel HMO Standard Plan	Contract Period 1	Contract Period 2	Contract Period 3
Total Premium			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

Indicate adjustment to proposed rates if BU12 is included with the above _____%

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Closed Panel HMO Standard Plan - Active EUTF - Bargaining Unit 12
Premium Rate Table Fully Insured

Complete the following table on a monthly, per capita tiered basis ONLY

Closed Panel Standard HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Total Premium			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

**Closed Panel HMO Standard Plan - Active Part-Time and Temporary Employees
Premium Rate Table Fully Insured**

Complete the following table on a monthly, per capita tiered basis ONLY

Closed Panel HMO Standard Plan	Contract Period 1 (1/1/15-6/30/16)		Contract Period 2		Contract Period 3	
	Employee and Dependent	Employee, Spouse and Dependent	Employee and Dependent	Employee, Spouse and Dependent	Employee and Dependent	Employee, Spouse and Dependent
Total Premium*						
Single						
Two-Party						
Family						
ACA Fees to be Added to the Above Rate, Per Employee, Per Month						
Patient-Centered Outcomes Research Institute (PCORI) Fee						
Reinsurer Fee						
Insurer Fee						

Indicate adjustment to proposed rates if plan begins 7/1/15 instead of 1/1/15 as a result of federal regulations _____%

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.
- * Offeror shall include all administrative services specified in Section IV of this RFP.

Authorized Signature

Title

Name of Company

Date

ACTIVE
HSTA VB – CLOSED PANEL HMO PLAN
TABLE AND PROPOSAL SHEETS #8

TABLE 8- ACTIVE		
PLAN DESIGN	HSTA VB HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	Kaiser	
General		
Deductible Single/Family	None/None	
Out-of-pocket limit - Single/Family	\$2,000/\$6,000	
Lifetime Benefit Maximum	None	
Policy Year Benefit Maximum	None	
PHYSICIAN SERVICES	MEMBER PAYS	
Primary Care Office Visit	\$15	
Specialist Office Visit	\$15	
Routine physical exams	No Charge	
Screening Mammography	No Charge	
Immunizations	No Charge	
Well Baby Care Visits	No Charge	
Maternity	No charge for routine prenatal visits and one postpartum visit	
Second opinion – surgery	\$15	
Emergency Room (ER care)	\$50	
Ambulance	20%	
INPATIENT HOSPITAL SERVICES		
Room and Board	No Charge	
Ancillary Services	No Charge	
Physician Services	No Charge	
Surgery	No Charge	
Anesthesia	No Charge	

TABLE 8 – ACTIVE (continued)

PLAN DESIGN	HSTA VB HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	Kaiser	
General		
OUTPATIENT SERVICES		
Chemotherapy/Radiation Therapy	\$15	
Surgery	\$15	
Diagnostic Lab	\$15/department/day	
Diagnostic X-ray	\$15/department/day	
Anesthesia	\$15	
MENTAL HEALTH SERVICES		
Inpatient Care	No Charge	
Outpatient Care	\$15	
OTHER SERVICES		
Durable Medical Equipment	20%	
Home Health Care	No Charge	
Hospice Care	No Charge	
Extended Care Facility	No Charge, 100 days/benefit period	
Physical and Occupational Therapy	\$15	
PRESCRIPTION DRUGS		
	Provided by Kaiser	
Retail - 30 day supply	\$10 co-pay	
Mail Order and Retail - 90 day supply	\$20 co-pay; Insulin not available through Mail Order	

**Closed Panel HMO Plan – Active HSTA VB
Premium Rate Table Fully Insured**

Complete the following table on a monthly, per capita tiered basis ONLY

Closed Panel HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Total Premium			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

**ACTIVE
EUTF - 75/25 PPO Plan
TABLE AND PROPOSAL SHEETS #9**

TABLE 9 – ACTIVE			
PLAN DESIGN	EUTF 75/25 PPO Plan		NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network**	
Annual Deductible Single/Family	\$300/\$900		
Annual Out-of-pocket limit - Single/Family	\$5,000/\$15,000		
Lifetime Benefit Maximum	None		
Policy Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Primary Care Office Visit	\$20*	\$20*	
Specialist Office Visit	\$20*	\$20*	
Routine physical exams	No Charge	No Charge	
Screening Mammography	No Charge	No Charge	
Immunizations	No Charge	No Charge	
Well Baby Care Visits	No Charge	No Charge	
Maternity	25%	25%	
Second opinion – surgery	\$20*	\$20*	
Emergency Room (ER care)	\$100	\$100	
Ambulance	25%	25%	
INPATIENT HOSPITAL SERVICES			
Room and Board	25%	25%	
Ancillary Services	25%	25%	
Physician Services	25%	25%	
Surgery	25%	25%	
Anesthesia	25%	25%	

*Deductible does not apply.

** Out-of-Network benefits are limited to usual customary and reasonable charges.

TABLE 9 – ACTIVE (continued)

PLAN DESIGN	EUTF 75/25 PPO Plan		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network	
OUTPATIENT SERVICES			
Chemotherapy/Radiation Therapy	25%	25%	
Surgery	25%	25%	
Diagnostic Lab	No Charge	No Charge	
Diagnostic X-ray	25%	25%	
Anesthesia	25%	25%	
MENTAL HEALTH SERVICES			
Inpatient Care	25%	25%	
Outpatient Care	25%	25%	
OTHER SERVICES			
Durable Medical Equipment	25%	25%	
Home Health Care	25%	25%	
Hospice Care	No Charge	No Charge	
Nursing Facility – Skilled Care	25%	25%	
Physical and Occupational Therapy	25%	25%	
PRESCRIPTION DRUGS			
	Provided by Caremark		
Retail - 30 day supply	Participating Pharmacy	Non-Participating Pharmacy	
1. Generic	\$5 co-pay	\$5 co-pay + 20% of eligible charges	
Preferred Brand Name	\$15 co-pay	\$15 co-pay + 20% of eligible charges	
Other Brand Name	\$30 co-pay	\$30 co-pay + 20% of eligible charges	
Injectables & Specialty Drug	20% of eligible charges, up to \$250 maximum; \$2,000 out-of-pocket annual maximum; \$30 co-pay oral oncology specialty medications	Not a benefit	
Insulin -			

Preferred	\$5 co-pay	\$5 co-pay + 20% of eligible charges	
Other	\$15 co-pay	\$15 co-pay + 20% of eligible charges	
Diabetic Supplies -			
Preferred	No charge	No charge	
Other Supplies	\$15 co-pay	\$15 co-pay	
Mail Order and Retail - 90 Day Supply			
Generic	\$10 co-pay	Not a benefit	
Preferred Brand Name	\$35 co-pay	Not a benefit	
Other Brand Name	\$60 co-pay	Not a benefit	
Insulin -			
Preferred	\$10 co-pay	Not a benefit	
Other	\$35 co-pay	Not a benefit	
Diabetic Supplies -			
Preferred	No charge	Not a benefit	
Other Supplies	\$35 co-pay	Not a benefit	

NOTE: Prescriptions are currently provided under a separate contract.

**75/25 PPO Plan - Active EUTF – All Bargaining Units Except Bargaining Unit 12 and HSTA VB
Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)**

Complete the following table on a monthly, per capita tiered basis ONLY

HMSA 75/25 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Medical Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____ %	_____ %	_____ %
Total Medical Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
Prescription Drug Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____ %	_____ %	_____ %
Total Prescription Drug Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

Indicate adjustment to proposed rates if BU12 is included with the above _____ %

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

** If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

75/25 PPO Plan - Active EUTF - Bargaining Unit 12
Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)
 Complete the following table on a monthly, per capita tiered basis ONLY

HMSA 75/25 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
Medical Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____%	_____%	_____%
Total Medical Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
Prescription Drug Benefit Costs*			
Single			
Two-Party			
Family			
Administration and Retention Expressed as a percent of claims*	_____%	_____%	_____%
Total Prescription Drug Premium (Including Administration and Retention)**			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

** If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

**75/25 PPO Plan - Active Part-Time and Temporary Employees
 Premium Rate Table (Community Rated, Non Experience Rated)
 Complete the following table on a monthly, per capita tiered basis ONLY**

HMSA 75/25 PPO Plan	Contract Period 1 (1/1/15-6/30/16)		Contract Period 2		Contract Period 3	
	Employee and Dependent	Employee, Spouse and Dependent	Employee and Dependent	Employee, Spouse and Dependent	Employee and Dependent	Employee, Spouse and Dependent
Medical Premium						
Single						
Two-Party						
Family						
Prescription Drug Premium						
Single						
Two-Party						
Family						
Total Premium* (Medical and Drug)						
Single						
Two-Party						
Family						
ACA Fees to be Added to the Above Rate, Per Employee, Per Month						
Patient-Centered Outcomes Research Institute (PCORI) Fee						
Reinsurer Fee						
Insurer Fee						

Indicate adjustment to proposed rates if plan begins 7/1/15 instead of 1/1/15 as a result of federal regulations _____%

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.
- * Offeror shall include all administrative services specified in Section IV of this RFP

Authorized Signature

Title

Name of Company

Date

**Self-Insured 75/25 PPO Plan ASO Fee – EUTF Active
Target Claims, Retention and Fees Tables (Self Insured)**

Complete the following table based upon enrollment census and claims assumptions provided.

HMSA 75/25 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
PPO Leasing /Network Access Fees			
Capitation Fee			
Claim Adjudication Fee			
Utilization Management Fees			
Disease Management			
Other*			
Total ASO Fees			
Total ASO Fees by Tier			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc.

Authorized Signature

Title

Name of Company

Date

**RETIREE
EUTF – 90/10 PPO PLAN
TABLE AND PROPOSAL SHEETS #10**

TABLE 10 – RETIREE			
PLAN DESIGN	EUTF 90/10 PPO Plan		NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network**	
Deductible Single/Family	\$100 per person; Maximum \$300 per family		
Out-of-pocket - Single/Family	\$2,500 per person; Maximum \$7,500 per family		
Lifetime Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Primary Care Office Visit	10% *	30%	
Specialist Office Visit	10% *	30%	
Routine physical exams	Not Covered	Not Covered	
Mammography	20% *	30% *	
Second opinion – surgery	10% *	30%	
Emergency Room (ER care)	10% *	10% *	
Ambulance	20%	30%	
INPATIENT HOSPITAL SERVICES			
Room and Board	10% *	30%	
Ancillary Services	10% *	30%	
Physician Services	10% *	30%	
Surgery	10% *	30%	
Anesthesia	10% *	30%	
OUTPATIENT SERVICES			
Chemotherapy	20%	30%	
Radiation Therapy	20% *	30%	
Surgery	10% * (Cutting)	30%	
Allergy Testing	20%	30%	
Other Diagnostic Lab, X-ray & Psych Testing	20% *	30%	
Anesthesia	10% *	30%	

*Deductible does not apply.

** Out-of-Network benefits are limited to usual customary and reasonable charges.

TABLE 10 – RETIREE (continued)

PLAN DESIGN	EUTF 90/10 PPO Plan		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network	
MENTAL HEALTH SERVICES			
Inpatient Care	10%*	30%	
Outpatient Care	10%*	30%	
OTHER SERVICES			
Durable Medical Equipment	20%	30%	
Home Health Care	No Charge	30%	
Hospice Care	No Charge	Not Covered	
Nursing Facility – Skilled Care	10%*, 120 days per year	30%, 120 days per year	
Physical and Occupational Therapy	20%	30%	
PRESCRIPTION DRUGS			
	Provided by Caremark		
Retail - 30 day supply	Participating Pharmacy	Non-Participating Pharmacy	
Generic	\$5 co-pay	\$5 co-pay + 20% of eligible charges	
Preferred Brand Name	\$15 co-pay	\$15 co-pay + 20% of eligible charges	
Other Brand Name	\$30 co-pay	\$30 co-pay + 20% of eligible charges	
Injectables & Specialty Drug -	20% of eligible charges, up to \$250 maximum; \$2,000 out-of-pocket annual maximum	Not a benefit	
Insulin -			
Preferred	\$5 co-pay	\$5 co-pay + 20% of eligible charges	
Other	\$15 co-pay	\$15 co-pay + 20% of eligible charges	

*Deductible does not apply

TABLE 10 – RETIREE (continued)

PLAN DESIGN	EUTF 90/10 PPO Plan		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
PRESCRIPTION DRUGS	Provided by Caremark		
Retail - 30 day supply	Participating Pharmacy	Non-Participating Pharmacy	
Diabetic Supplies -			
Preferred	No charge	No charge	
Other Supplies	\$15 co-pay	\$15 co-pay + 20% of eligible charges	
Mail Order and Retail- 90 Day Supply			
Generic	\$10 co-pay	Not a benefit	
Preferred Brand Name	\$35 co-pay	Not a benefit	
Other Brand Name	\$60 co-pay	Not a benefit	
Insulin -			
Preferred	\$10 co-pay	Not a benefit	
Other	\$35 co-pay	Not a benefit	
Diabetic Supplies -			
Preferred	No charge	Not a benefit	
Other Supplies	\$35 co-pay	Not a benefit	

Proposal Sheet - #10A Insured/Risk Sharing

90/10 PPO Plan – EUTF Retiree
Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)
Complete the following table on a monthly, per capita tiered basis ONLY

HMSA 90/10 PPO Plan	Contract Period 1		Contract Period 2		Contract Period 3	
	Under 65	Over 65	Under 65	Over 65	Under 65	Over 65
Medical Benefit Costs*						
Single						
Two-Party						
Family						
Administration and Retention Expressed as a percent of claims*	_____ %		_____ %		_____ %	
Total Medical Premium (Including Administration and Retention)**						
Single						
Two-Party						
Family						
Prescription Drug Benefit Costs*						
Single						
Two-Party						
Family						
Administration and Retention Expressed as a percent of claims*	_____ %		_____ %		_____ %	
Total Prescription Drug Premium (Including Administration and Retention)**						
Single						
Two-Party						
Family						
ACA Fees to be Added to the Above Rate, Per Employee, Per Month						
Patient-Centered Outcomes Research Institute (PCORI) Fee						
Reinsurer Fee						
Insurer Fee						

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

** If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

- (1) The EUTF reserves the right to offer multiple PPO options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

Self-Insured 90/10 Plan ASO Fee – Retiree EUTF

Target Claims, Retention and Fees Tables (Self Insured)

Complete the following table based upon enrollment census and claims assumptions provided.

HMSA 90/10Plan	Contract Period 1	Contract Period 2	Contract Period 3
PPO Leasing /Network Access Fees			
Claim Adjudication Fee			
Utilization Management Fees			
Disease Management			
Other*			
Total ASO Fees			
Total ASO Fees by Tier			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc.

Authorized Signature

Title

Name of Company

Date

RETIREE
HSTA VB – 90/10 PPO PLAN
TABLE AND PROPOSAL SHEETS #11

TABLE 11 – RETIREE			
PLAN DESIGN	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network**	
Deductible Single/Family	\$100 per person; \$300 per family		
Out-of-pocket limit - Single/Family	\$2,000/\$6,000		
Lifetime Benefit Maximum	\$2,000,000		
Policy Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Primary Care Office Visit	10% *	30%	
Specialist Office Visit	10% *	30%	
Routine physical exams	No Charge*; limited to combined CY dollar max depending on age scale	No Charge*; limited to combined CY dollar max depending on age scale	
Mammography	10% *	30%	
Second opinion – surgery	10% *	30%	
Emergency Room (ER care)	10% *	10% *	
Ambulance	10% *	30%	
INPATIENT HOSPITAL SERVICES			
Room and Board	10% *	30%	
Ancillary Services	10% *	30%	
Physician Services	10% *	30%	
Surgery	10% *	30%	
Anesthesia	10% *	30%	

*Deductible does not apply.

** Out-of-Network benefits are limited to usual customary and reasonable charges.

TABLE 11 – RETIREE (continued)

PLAN DESIGN	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network	
OUTPATIENT SERVICES			
Chemotherapy/Radiation Therapy	10%*	30%	
Surgery	10%*	30%	
Diagnostic Lab	10%*	30%	
Diagnostic X-ray	10%*	30%	
Anesthesia	10%*	30%	
MENTAL HEALTH SERVICES			
Inpatient Care	10%*	30%	
Outpatient Care	10%*	30%	
OTHER SERVICES			
Durable Medical Equipment	10%*	30%	
Home Health Care	No Charge*	30%	
Hospice Care	No Charge*	Not Covered	
Nursing Facility – Skilled Care	10%*, 120 days/CY	30%, 120 days/CY	
Physical and Occupational Therapy	10%*	30%	
PRESCRIPTION DRUGS (Non-Medicare)			
Provided by Caremark			
Retail (30 days supply)			
Generic and Insulin	\$5	\$5 + 30% of remaining eligible charge	
Brand Name	\$15	\$15 + 30% of remaining eligible charge	
Mail Order and Retail(90 day supply)			
Generic and Insulin	\$9	Not covered	
Brand Name	\$27	Not covered	

*Deductible does not apply.

90/10 PPO Plan – HSTA VB Retiree

Premium Rate Table (Insured With Risk Sharing-Dividend Eligible)

Complete the following table on a monthly, per capita tiered basis ONLY

HMSA 90/10 PPO Plan	Contract Period 1		Contract Period 2		Contract Period 3	
Medical Benefit Costs*	Under 65	Over 65	Under 65	Over 65	Under 65	Over 65
Single						
Two-Party						
Family						
Administration and Retention Expressed as a percent of claims*	_____%		_____%		_____%	
Total Medical Premium (Including Administration and Retention)**						
Single						
Two-Party						
Family						
Prescription Drug Benefit Costs* (Medicare eligible Retirees excluded from this proposal)	Under 65	Over 65	Under 65	Over 65	Under 65	Over 65
Single		N/A		N/A		N/A
Two-Party		N/A		N/A		N/A
Family		N/A		N/A		N/A
Administration and Retention Expressed as a percent of claims*	_____%		_____%		_____%	
Total Prescription Drug Premium (Including Administration and Retention)**						
Single						
Two-Party						
Family						
ACA Fees to be Added to the Above Rate, Per Employee, Per Month						
Patient-Centered Outcomes Research Institute (PCORI) Fee						
Reinsurer Fee						
Insurer Fee						

* The Medical and Retention components listed above must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

** If the total benefit paid is less than the proposed benefit cost, the excess amount will be refunded to the EUTF.

NOTES:

(1) The EUTF reserves the right to offer multiple options.

(2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

Self-Insured 90/10 Plan ASO Fee – Retiree HSTA VB

Target Claims, Retention and Fees Tables (Self Insured)

Complete the following table based upon enrollment census and claims assumptions provided.

HMSA 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3
PPO Leasing /Network Access Fees			
Claim Adjudication Fee			
Utilization Management Fees			
Disease Management			
Other*			
Total ASO Fees			
Total ASO Fees by Tier			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

* ID Cards, Wellness, Provider Directory, Booklets/SPDs, Data Reporting, Medical Info Line, Banking, Any Start-up Cost, etc.

Authorized Signature

Title

Name of Company

Date

**RETIREE
EUTF – CLOSED PANEL HMO PLAN
TABLE AND PROPOSAL SHEETS #12**

TABLE 12 – RETIREE

TABLE 12 – RETIREE		
PLAN DESIGN	EUTF HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	Kaiser	
General		
Deductible Single/Family	None/None	
Out-of-pocket limit - Single/Family	\$2,000/\$6,000	
Lifetime Benefit Maximum	None	
Policy Year Benefit Maximum	None	
PHYSICIAN SERVICES	MEMBER PAYS	
Primary Care Office Visit	\$15	
Specialist Office Visit	\$15	
Routine physical exams	No Charge	
Mammography	No Charge	
Second opinion – surgery	\$15	
Emergency Room (ER care)	\$50 in area / 20% out	
Ambulance	20%	
INPATIENT HOSPITAL SERVICES		
Room and Board	No Charge	
Ancillary Services	No Charge	
Physician Services	No Charge	
Surgery	No Charge	
Anesthesia	No Charge, office visit co-pay applies	

TABLE 12 – RETIREE(continued)

PLAN DESIGN	EUTF HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	Kaiser	
General		
OUTPATIENT SERVICES		
Chemotherapy/Radiation Therapy	\$15	
Surgery	\$15	
Allergy Testing	\$15	
Other Diagnostic Lab, X-ray & Psych Testing	\$15	
Anesthesia	\$15	
MENTAL HEALTH SERVICES		
Inpatient Care	No Charge	
Outpatient Care	\$15	
OTHER SERVICES		
Durable Medical Equipment	20%	
Home Health Care	No Charge	
Hospice Care	No Charge	
Nursing Facility – Skilled Care	No Charge, 100 days/year	
Physical and Occupational Therapy	\$15	
PRESCRIPTION DRUGS		
	Provided by Kaiser	
Retail - 30 day supply	\$15 co-pay; includes injectables, specialty drugs, insulin and diabetic supplies	
Mail Order and Retail- 90 day supply	\$30 co-pay; includes injectables, specialty drugs and diabetic supplies	

**Closed Panel HMO Plan – EUTF Retiree
Premium Rate Table (Fully Insured)**

Complete the following table on a monthly, per capita tiered basis ONLY

Closed Panel HMO Plan	Contract Period 1		Contract Period 2		Contract Period 3	
	Under 65	Over 65	Under 65	Over 65	Under 65	Over 65
Total Premium						
Single						
Two-Party						
Family						
ACA Fees to be Added to the Above Rate, Per Employee, Per Month						
Patient-Centered Outcomes Research Institute (PCORI) Fee						
Reinsurer Fee						
Insurer Fee						

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

**RETIREE
HSTA VB - CLOSED PANEL HMO
TABLE AND PROPOSAL SHEETS #13**

TABLE 13- RETIREE

TABLE 13- RETIREE		
PLAN DESIGN	HSTA VB HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	Kaiser	
General		
Deductible Single/Family	None/None	
Out-of-pocket limit - Single/Family	\$2,000/\$6,000	
Lifetime Benefit Maximum	None	
Policy Year Benefit Maximum	None	
PHYSICIAN SERVICES	MEMBER PAYS	
Primary Care Office Visit	\$15	
Specialist Office Visit	\$15	
Routine physical exams	No Charge	
Screening Mammography	No Charge	
Second opinion – surgery	\$15	
Emergency Room (ER care)	\$50 in area; 20% out-of-area	
Ambulance	20%	
INPATIENT HOSPITAL SERVICES		
Room and Board	No Charge	
Ancillary Services	No Charge	
Physician Services	No Charge	
Surgery	No Charge	
Anesthesia	No Charge	

TABLE 13 – RETIREE (continued)

PLAN DESIGN	HSTA HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	Kaiser	
General		
OUTPATIENT SERVICES		
Chemotherapy/Radiation Therapy	\$15	
Surgery	\$15	
Diagnostic Lab	\$15	
Diagnostic X-ray	\$15	
Anesthesia	No charge; \$15 Office visit copay applies	
MENTAL HEALTH SERVICES		
Inpatient Care	No Charge	
Outpatient Care	\$15	
OTHER SERVICES		
Durable Medical Equipment	20%	
Home Health Care	No Charge	
Hospice Care	No Charge	
Extended Care Facility	No Charge, 100 days/year	
Physical and Occupational Therapy	\$15	
PRESCRIPTION DRUGS		
	Provided by Kaiser	
Retail - 30 day supply	\$10 co-pay	
Mail Order and Retail- 90 day supply	\$20 co-pay; insulin not available through Mail Order	

Proposal Sheet - #13A INSURED

**Closed Panel HMO Plan – HSTA VB Retiree
Premium Rate Table (Fully Insured)**

Complete the following table on a monthly, per capita tiered basis ONLY

Closed Panel HMO Plan	Contract Period 1		Contract Period 2		Contract Period 3	
	Under 65	Over 65	Under 65	Over 65	Under 65	Over 65
Total Premium						
Single						
Two-Party						
Family						
ACA Fees to be Added to the Above Rate, Per Employee, Per Month						
Patient-Centered Outcomes Research Institute (PCORI) Fee						
Reinsurer Fee						
Insurer Fee						

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

**ACTIVE
EUTF - CHIROPRACTIC NETWORK BENEFIT
TABLE AND PROPOSAL SHEETS #14**

TABLE 14– EUTF ACTIVE

TABLE 14– EUTF ACTIVE		
PLAN DESIGN	Chiropractic Network Benefit	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	ROYAL STATE	
General		
Maximum Number of Office Visits per year	20 visits In-Network Only	
Copayment per visit	\$15	
Therapy Modalities	No charge	
Routine X-Ray	No Charge	
Lab	Not Covered	
Chiropractic Appliances	Not Covered	
Emergency/Urgent Care	Not Covered	
Out of Network Visits or treatments	Not Covered	
Alternative Medical Services	Not Covered	

* Therapy Modalities include: Ultrasound, ice packs, electrical muscle stimulation and other approved therapies

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

***Alternative Medical Services include: hypnotherapy, acupuncture, behavior training, sleep therapy, etc.

**EUTF Active Chiropractic Network Plan
Premium Rate Table (Fully Insured)**

Complete the following table on a monthly, per capita tiered basis ONLY

Chiropractic Network Plan	Contract Period 1	Contract Period 2	Contract Period 3
Total Premium			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

ACTIVE
HSTA VB - CHIROPRACTIC NETWORK BENEFIT
TABLE AND PROPOSAL SHEETS #15

TABLE 15– ACTIVE – HSTA VB Only		
PLAN DESIGN	Chiropractic Network Benefit	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Carrier	ROYAL STATE	
General		
Maximum Number of Office Visits per year	20 visits In-Network Only	
Copayment per visit	\$12	
Therapy Modalities	No charge	
Routine X-Ray	No Charge	
Lab	Not Covered	
Chiropractic Appliances	Not Covered	
Emergency/Urgent Care	Not Covered	
Out of Network Visits or treatments	Not Covered	
Alternative Medical Services	Not Covered	

Chiropractic services must be deemed therapeutically necessary.

* Therapy/Modalities include: Spinal manipulations, ultrasound, ice packs, electrical stimulation, and other approved therapies.

** Routine x-rays include: Two (2) views per body region, per plan year (must be performed in a provider's office).

**** Alternative Medical Services include, but not limited to: Hypnotherapy, acupuncture, behavior training, sleep therapy, etc.

Proposal Sheet - #15 INSURED

**Active Chiropractic Network Plan – HSTA VB Only
 Premium Rate Table (Fully Insured)
 Complete the following table on a monthly, per capita tiered basis ONLY**

Chiropractic Network Plan	Contract Period 1	Contract Period 2	Contract Period 3
Total Premium			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

RETIREE
HSTA VB Only - CHIROPRACTIC NETWORK BENEFIT
TABLE AND PROPOSAL SHEETS #16

TABLE 16– RETIREE – HSTA VB Only		
PLAN DESIGN	Chiropractic Network Benefit	NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
Carrier	ROYAL STATE	
General		
Maximum Number of Office Visits per year	20 visits In-Network Only	
Copayment per visit	\$12	
Therapy Modalities	No charge	
Routine X-Ray	No Charge	
Lab	Not Covered	
Chiropractic Appliances	Not Covered	
Emergency/Urgent Care	Not Covered	
Out of Network Visits or treatments	Not Covered	
Alternative Medical Services	Not Covered	

Chiropractic services must be deemed therapeutically necessary.

* Therapy/Modalities include: Spinal manipulations, ultrasound, ice packs, electrical stimulation, and other approved therapies.

** Routine x-rays include: Two (2) views per body region, per plan year (must be performed in a provider’s office).

*** Alternative Medical Services include, but not limited to: Hypnotherapy, acupuncture, behavior training, sleep therapy, etc.

Proposal Sheet - #16 INSURED

**RETIREE Chiropractic Network Plan – HSTA VB Only
Premium Rate Table (Fully Insured)**

Complete the following table on a monthly, per capita tiered basis ONLY

Chiropractic Network Plan	Contract Period 1	Contract Period 2	Contract Period 3
Total Premium			
Single			
Two-Party			
Family			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

EUTF - Medicare Advantage Plan

Proposal and Bid Sheet #17

TABLE 17 – RETIREE

PLAN DESIGN	EUTF 90/10 PPO Plan		NOTE YOUR COMPANY'S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network	
Deductible Single/Family	\$100 per person; Maximum \$300 per family		
Out-of-pocket - Single/Family	\$2,500 per person; Maximum \$7,500 per family		
Lifetime Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Primary Care Office Visit	10%*	30%	
Specialist Office Visit	10%*	30%	
Routine physical exams	Not Covered	Not Covered	
Mammography	20%*	30%*	
Second opinion – surgery	10%*	30%	
Emergency Room (ER care)	10%*	10%*	
Ambulance	20%	30%	
INPATIENT HOSPITAL SERVICES			
Room and Board	10%*	30%	
Ancillary Services	10%*	30%	
Physician Services	10%*	30%	
Surgery	10%*	30%	
Anesthesia	10%*	30%	
OUTPATIENT SERVICES			
Chemotherapy	20%	30%	
Radiation Therapy	20%*	30%	
Surgery	10%* (Cutting)	30%	
Allergy Testing	20%	30%	
Other Diagnostic Lab, X-ray & Psych Testing	20%*	30%	
Anesthesia	10%*	30%	

TABLE 17 – RETIREE (continued)

PLAN DESIGN	EUTF 90/10 PPO Plan		NOTE YOUR COMPANY'S PROPOSED BENEFITS
Carrier	HMSA		
General	In-Network	Out-of-Network	
MENTAL HEALTH SERVICES			
Inpatient Care	10%*	30%	
Outpatient Care	10%*	30%	
OTHER SERVICES			
Durable Medical Equipment	20%	30%	
Home Health Care	No Charge	30%	
Hospice Care	No Charge	Not Covered	
Nursing Facility – Skilled Care	10%*, 120 days per year	30%, 120 days per year	
Physical and Occupational Therapy	20%	30%	
PRESCRIPTION DRUGS			
	Provided by Caremark		
Retail - 30 day supply	Participating Pharmacy	Non- Participating Pharmacy	
Generic	\$5 co-pay	\$5 co-pay + 20% of eligible charges	
Preferred Brand Name	\$15 co-pay	\$15 co-pay + 20% of eligible charges	
Other Brand Name	\$30 co-pay	\$30 co-pay + 20% of eligible charges	
Injectables & Specialty Drug -	20% of eligible charges, up to \$250 maximum; \$2,000 out-of- pocket annual maximum	Not a benefit	
Insulin -			
Preferred	\$5 co-pay	\$5 co-pay + 20% of eligible charges	
Other	\$15 co-pay	\$15 co-pay + 20% of eligible charges	

*Deductible does not apply

TABLE 17 – RETIREE (continued)

PLAN DESIGN	EUTF 90/10 PPO Plan		NOTE YOUR COMPANY'S PROPOSED BENEFITS
PRESCRIPTION DRUGS	Provided by Caremark		
Retail - 30 day supply	Participating Pharmacy	Non-Participating Pharmacy	
Diabetic Supplies -			
Preferred	No charge	No charge	
Other Supplies	\$15 co-pay	\$15 co-pay + 20% of eligible charges	
Mail Order and Retail- 90 Day Supply			
Generic	\$10 co-pay	Not a benefit	
Preferred Brand Name	\$35 co-pay	Not a benefit	
Other Brand Name	\$60 co-pay	Not a benefit	
Insulin -			
Preferred	\$10 co-pay	Not a benefit	
Other	\$35 co-pay	Not a benefit	
Diabetic Supplies -			
Preferred	No charge	Not a benefit	
Other Supplies	\$35 co-pay	Not a benefit	

**EUTF Open Panel Medicare Advantage Plan
Premium Rate Table (Fully Insured)**

Complete the following table on a monthly, per capita tiered basis ONLY

Chiropractic Network Plan	Contract Period 1	Contract Period 2	Contract Period 3
Total Premium			
Single Retiree			
Single Retiree and Spouse both Medicare Eligible			
ACA Fees to be Added to the Above Rate, Per Employee, Per Month			
Patient-Centered Outcomes Research Institute (PCORI) Fee			
Reinsurer Fee			
Insurer Fee			

NOTES:

- (1) The EUTF reserves the right to offer multiple options.
- (2) No adjustments to the proposed rates based on actual initial enrollment or subsequent enrollment changes are acceptable.

Authorized Signature

Title

Name of Company

Date

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

Current Public Sector Client References					
Name	Contact Name	Phone Number, Email Address, and Location	Number of Employees covered	Number of Retirees covered	Contract Start Date

Recently Terminated Public Sector Clients					
Name	Contact Name	Phone Number, Email Address, and Location	Number of Employees covered	Number of Retirees covered	Termination Date & Reason

Questionnaire Instructions to OFFERORS:

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

- Please complete all appropriate sections of the questionnaire.
- **Provide answers to the questionnaires in Word format.**
- Provide an answer to each question even if the answer is “not applicable” or “unknown.”
- Answer the question as directly as possible.
 - If the questions asks “How many...” provide a number
 - If the question asks, “Do you...” indicate Yes or No followed by any additional brief narrative explanation to clarify.
- **IMPORTANT: Be concise in your response.** Use bullet points as appropriate. Reconsider how to word any response that exceeds 200 words in length so that the response contains the **most important points** you want displayed. Referring the reader to attachment for further information should be avoided or used on a limited basis. Any response that does not directly address the question, but only contains marketing information will be considered non-responsive.
- OFFEROR will be held accountable for accuracy/validity of all answers.
- Remember, RFP responses will become part of the contract between the winning OFFEROR and the EUTF.
- The submission of your proposal will be deemed a certification that you will comply with all requirements set forth in this RFP. If a multiple option plan is being requested, it will be assumed that all answers apply equally to all options. If this is not the case, separate answers should be provided for each option.

NOTE: Answers to the questions must be provided in hard copy and WORD format on CD

DO NOT PDF or otherwise protect the CD

QUESTIONNAIRE

GENERAL INFORMATION	
	OFFEROR RESPONSE
<p>1. Do you agree that if this proposal results in your company being awarded a contract and if, in the preparation of that contract, there are inconsistencies between what was proposed and accepted versus the contract language that has been generated and executed, that any controversy arising over such discrepancy will be resolved in favor of the language contained in the proposal or correspondence relating to your proposal? If NO, please list all exceptions in Attachment 5, <i>Exceptions</i>.</p>	
<p>2. Do you agree to perform all of the services contained in this RFP. If there are any exceptions to these requirements, please specify in Attachment 5 attach as a separate section to your proposal, a complete explanation of each exception, titled, <i>Exceptions</i>. Failure to perform the services required in this RFP may result in your proposal being deemed incomplete. If NO, Please list all exceptions in Attachment 5, <i>Exceptions</i></p>	
<p>3. Do you agree to all the terms and conditions in Section I of this RFP?</p> <p>IF NO, LIST ALL EXCEPTIONS TO THIS RFP in Attachment 5, <i>Exceptions</i>.</p>	
<p>4. Verify that all deviations from the requested plan design and coverage are included in the tables in Section V.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Is your organization currently or in the near future undertaking any mergers, acquisitions, sell-offs, change of ownership, etc? If yes, explain.</p>	
<p>6. The EUTF requires written notification of renewal actions 240 days preceding the expiration of the contract. Confirm your agreement to this requirement.</p>	
<p>7. What are the most recent ratings for your company by the following:</p>	<p><u>Rating</u> <u>Date</u></p>
Standard and Poor's	
Duff and Phelps	
A.M. Best	
Moody's	

GENERAL INFORMATION	
	OFFEROR RESPONSE
<p>Has there been any downgrade in your ratings in the last 2 years?</p> <p>If your firm is not rated, submit documentation of a similar nature which attests to your firm's financial stability.</p>	
<p>8. Confirm that you have completed the performance guarantees spreadsheet (Attachment 6).</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>9. Confirm that you will provide the following minimum reporting requirements:</p> <p>a) Monthly Enrollment Reports b) Monthly Claim Reports c) Quarterly Utilization Reports d) Semi-Annual Utilization Reports e) Annual Utilization Reports</p>	
<p>10. Does your company, including any affiliates, subsidiaries, or principals of the company, have any pending or has had any legal actions against the State of Hawaii, the EUTF Board, or any EUTF Trustee within the last five years? If yes, describe in detail.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>11. Will you agree to be bound by the terms of your proposal until a final contract is executed?</p>	
<p>12. a) Do you agree to allow the EUTF the right to audit the performance of the plan and services provided?</p>	
<p>b) Indicate what services, records and access will be made available to the EUTF at no additional charge.</p>	
<p>c) Indicate frequency and notice requirements that are part of the right to audit provision.</p>	
A. ORGANIZATIONAL EXPERIENCE AND STABILITY	
Network Ownership and Background	
<p>1. Name of Parent Company, if any:</p>	

GENERAL INFORMATION	
	OFFEROR RESPONSE
2. Identify service team: a) Day to day contact b) Underwriting c) Billing d) Local Overall account management e) Location of your local telephone service office and number of staff f) Location of your walk-in customer service office and number of staff	
3. Is your firm anticipating restructuring or reorganization in the next year? (Include any major staff relocations or office closings.)	<input type="checkbox"/> Yes, please explain <input type="checkbox"/> No
4. In the past 12 months has your organization: (Check all that apply).	<input type="checkbox"/> Closed any network services areas, If yes, please list the centers: _____ <input type="checkbox"/> Combined/consolidated member service or claims service centers. If yes, please list the centers: _____ <input type="checkbox"/> Closed/consolidated or relocated any claims offices. If yes, please list the offices: _____
5. Has your organization acquired, been acquired by, or merged with another organization in the past 24 months?	<input type="checkbox"/> Yes, please explain <input type="checkbox"/> No

Financial Condition Of Organization

Hawaii Membership Profile/Client Base

6. Please complete the following table:

Membership	2 Years Prior	1 Year Prior	Current
Annual PPO Membership-National			
Annual PPO Membership-Hawaii			
Annual HMO Membership-National			
Annual HMO Membership-Hawaii			

GENERAL INFORMATION			
	OFFEROR RESPONSE		
7. Please complete the following table on client retention rates (Group Accounts Only):			
	1 Year	2 Years	3 Years
Client Retention Rates	%	%	%
PPO			
HMO			
Self-Insured			
Termination Rates	%	%	%
PPO			
HMO			
Self-Insured			
B. ADMINISTRATIVE SERVICES			
Account Service			
1. Do you agree to notify the EUTF immediately if the network loses any accreditation, licenses, or liability insurance coverage or if there is a change in hospital network contracts?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
2. Are there any Special Conditions outlined in Section I that you cannot meet?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
3. Payment Options: EUTF to Vendor (Check only one)	<input type="checkbox"/> Electronic Fund Transfer <input type="checkbox"/> Manual Invoicing <input type="checkbox"/> Both options available		
4. Do customer service representatives have on-line access to real-time claim status information?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
5. Will you transfer enrollment cards, claim information, prior authorizations, quantity limits, TROOP balances and other administrative records to any carrier/TPA that would replace you in the event of termination of this contract and at no charge?	<input type="checkbox"/> Yes <input type="checkbox"/> No		

GENERAL INFORMATION		
OFFEROR RESPONSE		
6. What services do you offer with respect to the following:		
Services Available	Yes/No	Indicate any additional charges required
a) Reporting requirements under PPACA		
7. a) What on-line services/functions will be made available to the EUTF administrative staff via the Internet? (Check all that apply)		
<input type="checkbox"/> Claims Summary <input type="checkbox"/> Billing History <input type="checkbox"/> Premium Rates <input type="checkbox"/> Provider Directory <input type="checkbox"/> Eligibility Summary	<input type="checkbox"/> Enrollment Counts <input type="checkbox"/> Plan Details <input type="checkbox"/> Health Topics/Medical Information <input type="checkbox"/> Address Changes <input type="checkbox"/> Other	
b) What on-line services/functions will be made available to the EUTF members via the Internet? (Check all that apply)		
<input type="checkbox"/> Claims Summary <input type="checkbox"/> Billing History <input type="checkbox"/> Premium Rates <input type="checkbox"/> Provider Directory <input type="checkbox"/> Eligibility Summary	<input type="checkbox"/> Enrollment Counts <input type="checkbox"/> Plan Details <input type="checkbox"/> Health Topics/Medical Information <input type="checkbox"/> Address Changes <input type="checkbox"/> Other	
c) Provide name of web site and sample password, if applicable:		
8. For this question, complete the following table and check all that apply		
Forms	COST: INCLUDED IN FEE?	COST: ADDITIONAL
a) SPDs and SBC	Included in Basic Fee Not Available	Indicate additional cost _____
b) Claims Forms	Included in Basic Fee Not Available	Indicate additional cost _____
c) EOBs	Included in Basic Fee Not Available	Indicate additional cost _____
d) Network Directory	Included in Basic Fee Not Available	Indicate additional cost _____
e) Other, please describe:	Included in Basic Fee Not Available	Indicate additional cost _____

GENERAL INFORMATION																							
	OFFEROR RESPONSE																						
Member Service (i.e., Customer Service, Internet Access, etc.)																							
9. a) Confirm the cost of providing a toll-free number to be made available to participants to handle claims or other service issues is included in your quotation.	<input type="checkbox"/> Yes <input type="checkbox"/> No																						
10. Indicate the ways in which your organization is able to accommodate the special needs of enrollees. (Check all that apply)	<input type="checkbox"/> No special accommodations <input type="checkbox"/> Have a TDD (Telecommunications Device for the Deaf) or other voice capability for the hear impaired <input type="checkbox"/> We accommodate non-English special enrollees by contracting with an independent translation company <input type="checkbox"/> We maintain customer service staff with the ability to translate multiple languages, if so which languages? <input type="checkbox"/> We maintain customer service staff with the ability to translate the following languages:																						
11. Do you offer a 24 hour telephone Nurse Triage (nurse advice/demand management) telephone program for enrollees? (Check only one)	<input type="checkbox"/> Yes, staffed by live health professionals, at no additional charge <input type="checkbox"/> Yes, staffed by live health professionals, at additional charge of \$_____ <input type="checkbox"/> No, not offered <input type="checkbox"/> Other:																						
12. Do you agree to receive and timely and accurately process as indicated in this RFP all of the enrollment and eligibility information in the format as provided by EUTF, without the EUTF making changes to its file format? (See Exhibit G)	<input type="checkbox"/> Yes <input type="checkbox"/> No																						
13. Which of the following Member Functions do you provide? (Check all that apply)																							
<table border="1" style="margin-left: auto; margin-right: auto;"> <thead> <tr> <th style="width: 50%;">Functions</th> <th style="width: 50%;">By Website</th> </tr> </thead> <tbody> <tr><td>A. Provider Directory</td><td></td></tr> <tr><td>B. Provider Profiles</td><td></td></tr> <tr><td>C. Plan Details</td><td></td></tr> <tr><td>D. Health Information</td><td></td></tr> <tr><td>E. Claim Status</td><td></td></tr> <tr><td>F. Lab Results</td><td></td></tr> <tr><td>G. Submission of Referrals</td><td></td></tr> <tr><td>H. Request for Prior Authorization</td><td></td></tr> <tr><td>I. Submission of Rx</td><td></td></tr> <tr><td>J. Other (List)</td><td></td></tr> </tbody> </table>		Functions	By Website	A. Provider Directory		B. Provider Profiles		C. Plan Details		D. Health Information		E. Claim Status		F. Lab Results		G. Submission of Referrals		H. Request for Prior Authorization		I. Submission of Rx		J. Other (List)	
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14. Do your provider directories include the following:	<input type="checkbox"/> a. Physician office address and phone number																						

GENERAL INFORMATION	
	OFFEROR RESPONSE
<i>(Check all that apply)</i>	<input type="checkbox"/> b. Specialty designation (e.g., cardiology, pediatrics) <input type="checkbox"/> c. Office hours <input type="checkbox"/> d. Languages spoken in office <input type="checkbox"/> e. List of hospital with admitting privileges
15. Do you agree to notify members if a HMO network physician terminates their contract during the plan year, and at no additional cost? <i>(Check only one)</i>	<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No
C. UNDERWRITING ISSUES – FULLY INSURED PLANS	
1. a) Explain the methodology and data to be used for the renewal process. How will projected incurred claims be estimated for these plans?	
b) What experience period(s) will be used for the first renewal?	
c) What credibility will be given to each period of experience used?	
2. Explain your methodology for establishing Incurred But Not Reported reserve?	
3. Indicate the factors used to set the rates for the proposal.	Annual Trend Factor ____% of expected claims Reserve Factor ____% of expected claims Margin ____% of expected claims
4. Explain any other required reserves other than for IBNR. Indicate amounts, reason for reserve, is interest credited and whether reserves are refunded to the client upon policy termination.	
5. Detail any underwriting provisions if any (rules) you will impose on this EUTF.	
D. DISEASE MANAGEMENT (DM)	
1. Do you perform DM services? If yes, describe the DM services in detail that are covered by your basic fee.	
2. Do you have a minimum of three (3) years experience in performing disease management services?	
3. Are you currently providing DM services to a group of at least 10,000 covered employees/retirees (not counting dependents)?	
4. Do you have the ability and are you willing to customize your DM services to meet the needs/desires of the EUTF?	

GENERAL INFORMATION	
	OFFEROR RESPONSE
5. Do you agree to provide reports of DM activity at least monthly (within 15 days of the close of the month) and an annual ROI within 3 months of the close of the prior year?	
6. Do you agree (that after the award of this contract and during the implementation phase of your services) you will mine the client's medical claims and prescription drug data and identify those individuals appropriate for your DM services AND provide the EUTF (prior to the start date of the contract) with a short summary report/memo that outlines what you found in their data, including but not limited to the following elements:	
a. The total number of patients identified with chronic diseases you will manage in the initial data analysis, and	
b. The number of patients you identified in each of your risk classes/level; and	
c. The costs associated with the above groups; and	
d. the percent of clinical goals/objectives the population is NOT adhering to in the baseline data search.	
7. Which of your DM programs focus on helping patients identify and lessen the following risk factors:	
a. Obesity	
b. Smoking	
c. High cholesterol	
d. Lack of activity/exercise	
e. Stress Management	
f. Diabetes	
g. Asthma	
8. Are your DM services available to be used by participants who live in any of the 50 states?	
9. How do you recommend that a client communicate and encourage the use of DM services?	

GENERAL INFORMATION	
	OFFEROR RESPONSE
10. Indicate the most effective service you believe your DM staff provides to patients with chronic diseases?	
11. Explain how your staff introduces themselves to patients for the first time (e.g. phone call, letter)?	
12. Are you able to provide monthly summary reports regarding the type and number of patients involved in your DM services?	
13. What DM programs are available at an additional cost? Explain in detail and include the additional cost.	

E. WELLNESS PROGRAMS

1. Types of Wellness programs available:

Type of Program	# of Programs Implemented	Education Only	Worksite Program	Off-Worksite Program
Smoking Cessation/Control				
Nutrition				
Weight Control				
Blood Pressure				
Cholesterol				
Health Risk Appraisal				
Other (Describe)				

2. Describe how your wellness programs are offered.

3. For each service listed and/or requested, provide expected participation (based on a percent of total eligible members). What factors will improve participation? What factors will reduce participation?

4. Based on the demographics, list what programs you would expect to have the greatest impact on the following listed from highest to lowest impact:

- a. Reducing medical plan costs;
- b. Increase productivity
- c. Member satisfaction and acceptance

5. Based on your prior experience with wellness programs, for the programs listed above, provide the expected dollar savings per eligible member per year? Indicate expected savings by:

- a. Reduction in medical plan costs
- b. Reduction in lost workdays
- c. Increases in productivity
- d. Other factors you can identify

6. What is the method used in the derivation of savings estimate provided in #5 above.

7. For each program implemented what is the expected ratio of savings to program expenses in the first 12 months, 24 months and 36 months?

8. What is done to assess plan participant satisfaction with the program? Are management reports available? If so, please include a sample(s).

<p>9. Explain in detail each wellness program included in your quote. What wellness programs are available at an additional cost? Explain in detail and include additional cost.</p>	
<p>10. Provide a full explanation of how your company reimburses providers in order to control cost and manage utilization, other than fee for service arrangements</p>	
<p>11. Explain what programs you have implemented that address progress toward achieving patient centered outcome measurement and reimbursement to providers that improve these outcomes.</p>	
<p>12. Performance Improvement Projects (PIPs)</p> <p>A) Can your company undertake a Performance Improvement Project with providers that are to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The PIPs shall include the following:</p> <ul style="list-style-type: none"> • The use of objective, measurable, and clearly defined quality indicators to measure performance; • Valid sampling techniques; • Accurate and complete data collection; • The implementation of appropriate planned system interventions to achieve improvement in quality; • An evaluation of the effectiveness of the intervention, including sufficient data and barrier analysis; • An achievement of real improvement that is sustained; and • A plan and activities that shall increase or sustain improvement. <p>B) Are all of the services included in your base quote? If not, indicate the changes on a per capita basis.</p>	

F. FINANCIAL GUARANTEES - All Plans

Please note a “yes” answer to these questions will require the contract to include such language

1. Confirm that your proposed rates and fees are guaranteed for the contract periods contained in Section 1.4 .	
2. The EUTF requires written notification of renewal actions 120 days preceding the contract expiration date. Confirm your agreement to this requirement.	<input type="checkbox"/> Yes <input type="checkbox"/> No

G. CLAIM COSTS

Provider Reimbursement and Discount Worksheets

1. Indicate non-network equivalent Reasonable & Customary Percentile used for non-network reimbursement.	
2. Indicate source of non-network Reasonable & Customary Allowances (Ingenix, Medicare, ADP, Other).	
3. When you are the secondary payor in a COB situation, do you use your UCR profiles, reduced network fees, or those of the primary carrier in determining your level of reimbursement?	

Hospital and Outpatient Facility Charges

4. Describe how network hospitals are reimbursed. Your answer should be consistent with the fees provided on the proposal sheets provided. If reimbursement varies by geographic location, identify reimbursement arrangements by area for those relevant to the plan sponsor.	
5. Network Hospital and Outpatient Facility Profile - Complete the following table(s) for the network within the geographic areas requested.	

Island	Oahu	Maui	Hawaii	Kauai	Lanai	Molokai
List Number by Island						
Acute Hospitals						
Urgent Care Facilities						
Outpatient Surgical Centers						
Clinics						
General/Family Practice Physicians						
OBGYN Specialists						
Other Specialists						

GENERAL INFORMATION	
	OFFEROR RESPONSE
Hospital and Outpatient Facility Charges <i>continued</i>	
6. a) How are network outpatient facilities such as surgicenters, imaging centers and laboratories reimbursed (on a discounted fee arrangement, percent of Medicare APCs, pre-paid capitated arrangement)?	
b) If a scheduled fee arrangement is the basis for reimbursement, describe how the scheduled fees are derived.	
7. Do you have a contractual relationship with outpatient facilities? If so, provide the current network contractual charge for outpatient facilities services for the following procedures for the zip code(s) previously provided in this section (i.e. all Honolulu County Zip Codes). Include the cost for the use of the facility and any supplies and materials.	
8. Describe any other contractual relationships with any other providers such as pharmacies, physical therapists, orthotics suppliers, prosthetic suppliers, vision care and home health care providers.	
9. Do you have special arrangements with "Centers of Excellence" facilities?	
a) Describe the illnesses/conditions and services associated with your Centers of Excellence programs.	
b) Are services bundled with regard to reimbursement?	
c) Is the facility at risk for cost incurred in excess of the negotiated charge?	
d) Include the actual bundled charge for each condition, AND list the facilities by name and region.	
Claims Processing	
10. With regard to the claim offices that will be used, provide the following:	
a) Location: _____	
b) Average Claims/Processor/Day: _____	

GENERAL INFORMATION																			
		OFFEROR RESPONSE																	
c) Annual Claim Volume: _____																			
d) Staffing: <i>(Complete the following table)</i>																			
<table border="1" style="width:100%; border-collapse: collapse; margin-top: 10px;"> <thead> <tr> <th style="width: 20%; padding: 5px;">Position</th> <th style="width: 20%; padding: 5px;">A. # of Staff</th> <th style="width: 30%; padding: 5px;">B. Average Years of Claims Administration Experience</th> <th style="width: 30%; padding: 5px;">C. Annual Turnover (%)</th> </tr> </thead> <tbody> <tr> <td style="padding: 5px;">Processors</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Supervisors</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="padding: 5px;">Managers</td> <td></td> <td></td> <td></td> </tr> </tbody> </table>				Position	A. # of Staff	B. Average Years of Claims Administration Experience	C. Annual Turnover (%)	Processors				Supervisors				Managers			
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11. Describe the claims payment process from date of receipt to full adjudication of checks to providers or patients. If the process is different for network and non-network claims please discuss separately. For example, do you batch process checks to network providers? If so, explain.____																			
12. Based upon the latest 12 month period: <i>(Please answer all parts of this question)</i>		a. Average number of business days to process a claim from date received to date check/EOB issued:_____																	
		b. What percent of all claims submitted (regardless of information provided on claim) are processed (from date received to date check/EOB issued) within 10 business days? _____%																	
		c. What percent of all claims submitted (regardless of information provided on claim) are processed (from date received to date check/EOB issued) within 30 business days? _____%																	
13. Have you been penalized by any state for failing to meet state average claim turnaround requirements?		<input type="checkbox"/> a. Yes. List state where you were sanctioned in the last 12 months: _____ <input type="checkbox"/> b. No																	

GENERAL INFORMATION

OFFEROR RESPONSE

14. For the claim office proposed, please provide the following data:

Financial and Coding Accuracy	Latest 12 months
Financial accuracy as a percent of total claims dollars paid (include over/underpayments)	%
Coding accuracy (claims without error) as a percent of total claims submitted	%

15. a) What are your procedures for recovery of the overpayments or duplicate payments?

- b) Do you agree to return all recovered monies from overpayments or duplicate payments to client? (*Check only one*)
- a. Yes, 100% of recovery
 - b. Yes, less _____ recovery collection fee
 - c. No, do not agree

16. a) Explain your COB procedures.

- b) Do you pursue COB prospectively or retrospectively to payments?
- a. Prospectively
 - b. Retrospectively

c) How often are records updated for new information on other coverage?

d) Please complete the following table:

	Average COB savings as a percent of total plan cost	Will you guarantee COB Savings?
Active/Early Retiree		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No
Medicare Eligible		<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No

GENERAL INFORMATION	
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	OFFEROR RESPONSE
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17. Please complete the following table on fraud detection programs:

Task	Formal Written Program	If yes, provide total # of events per 1000 covered lives)	Describe Program
A. Ineligible Claimant	<input type="checkbox"/> Yes <input type="checkbox"/> No		
B. Assure that service billed is actually rendered	<input type="checkbox"/> Yes <input type="checkbox"/> No		
C. Over billings	<input type="checkbox"/> Yes <input type="checkbox"/> No		

18. a) Do you retain medical consultants for the review of any unusual claims or charges?	<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No
b) If yes, explain the method in which such consultants are used and describe their qualifications and any affiliations.	
19. a) How do you reimburse multiple surgical procedures being performed during one operation?	
b) Is a reduced scale used for the 1 st and subsequent procedures? <i>(Check only one)</i>	<input type="checkbox"/> a. Yes <input type="checkbox"/> b. No
20. What programs do you offer to address potential drug abuse?	

GENERAL NETWORK INFORMATION	
	OFFEROR RESPONSE
H. NETWORK MANAGEMENT	
Provider Relations Education	

1 A. For the City & County of Honolulu (Oahu) service area provide the number of Network Providers that have terminated their contract:					
Provider Type	Unknown	Total # of Terminations in the Past 12 Months	Terminations Equate to What % of Your Contracted Providers?	% of Terminations That Are Voluntary	Most Common Reasons For Termination (e.g. contract dispute, death, moved)
HMO					
Hospital					
Physicians					
PPO					
Hospital					
Physicians					

1 B. For the County of Hawaii service area provide the number of Network Providers that have terminated their contract:					
Provider Type	Unknown	Total # of Terminations in the Past 12 Months	Terminations Equate to What % of Your Contracted Providers?	% of Terminations That Are Voluntary	Most Common Reasons For Termination (e.g. contract dispute, death, moved)
HMO					
Hospital					
Physicians					
PPO					
Hospital					
Physicians					

1 C. For the County of Maui (including Kalaupapa) service area, provide the number of Network Providers that have terminated their contract:					
Provider Type	Unknown	Total # of Terminations in the Past 12 Months	Terminations Equate to What % of Your Contracted Providers?	% of Terminations That Are Voluntary	Most Common Reasons For Termination (e.g. contract dispute, death, moved)
HMO					
Hospital					
Physicians					
PPO					
Hospital					
Physicians					

1 D. For the County of Kauai service area provide the number of Network Providers that have terminated their contract:					
Provider Type	Unknown	Total # of Terminations in the Past 12 Months	Terminations Equate to What % of Your Contracted Providers?	% of Terminations That Are Voluntary	Most Common Reasons For Termination (e.g. contract dispute, death, moved)
HMO					
Hospital					
Physicians					
PPO					
Hospital					
Physicians					

GENERAL INFORMATION	
	OFFEROR RESPONSE
H. NETWORK MANAGEMENT (continued)	
Provider Profiling	
2. Do you have a mechanism for routinely investigating if a contracted provider has any disciplinary actions imposed by their State licensure medical board?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Do you compare individual network provider practice patterns against Best practices or averages on any of the following: (Check all that apply)	<input type="checkbox"/> Referral rates to specialists <input type="checkbox"/> Frequency and quality of prescription drug dispensing <input type="checkbox"/> Rates of Diagnostic Procedures ordered (Lab/Imaging) <input type="checkbox"/> Rates of surgical procedure relative to peers <input type="checkbox"/> Repeat Procedures within given timeframes <input type="checkbox"/> Hospital Readmission Rates <input type="checkbox"/> Unknown/Do Not Track
4. Other than provider directories and access to providers via your website, what quality or practice pattern data about your contracted providers do you make available to plan participants?	<input type="checkbox"/> We provide _____ <input type="checkbox"/> Nothing at this time
I. COVERAGE AND CONTRACT ISSUES	
General Contract Provisions	
1. Will you agree to include in your contract a hold harmless provision that indemnifies the EUTF against liability that arises as the result of negligent acts, errors, omissions, fraud and other criminal acts committed by your network providers, officers, employees, and agents of the organization?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Will you agree to be bound by the terms of your proposal until a final contract is executed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Termination Clauses	

GENERAL INFORMATION	
	OFFEROR RESPONSE
3. The EUTF requires that it maintain the right to terminate the contract at any time provided that it gives 60 days advance written notification to the contractor. Do you agree to this provision?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you agree to cover all eligible expenses incurred by a covered participant who is hospitalized on the date of termination until that person is discharged from the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No
J. HIPAA QUESTIONS	
1. a) Do you have a formal HIPAA compliance plan in place?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Attach a copy to your proposal.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. a) Do you have a website that details information about your policies and procedures for accepting and sending EDI transactions?	
b) Where does the copy of your Companion Guide for HIPAA EDI transactions reside?	
3. Will your organization be issuing Notices of Privacy Practices as required by HIPAA to each new plan enrollee? At what cost?	

K. NETWORK ANALYSIS

1. DISRUPTION ANALYSIS

As part of the proposal process Segal will also be conducting a network disruption analysis. Please provide us with electronic copies of your HMO and PPO physician and facility networks you are proposing for the EUTF Hawaii, Honolulu, Kauai and Maui and Kalaupapa counties.

Please send data that conforms to the following specifications - **deviations from these specifications may result in the removal of your network from our analysis:**

Acceptable Media Types

CD ROM

Acceptable File Format

Microsoft Access or Microsoft Excel

Required Fields (please include file layout) – NOTE combined first and last name fields as a substitute for the requested information will not be accepted. Name fields should not be combined

National Provider ID (MUST BE PROVIDED)

Provider TIN

Provider last name – MUST BE IN ITS OWN ISOLATED FIELD WITHOUT MEDICAL DESIGNATION

Provider first name – MUST BE IN ITS OWN FIELD WITHOUT TITLE AND NO MIDDLE INITIAL

5-digit zip code

Street address

Phone number

Indicator for PCP's who are accepting new patients

Specialty code

Primary Care: **001** (includes General Practice, Family Practice, Internal Medicine, OB/GYN and Pediatrician)

Specialists: **002** (all other physicians)

Inpatient Hospital: **003**

Ambulatory Facility: **004** (includes surgical centers and imaging centers)

You may also include any other fields (such as City or State) that are in your data files, but only the fields listed above are required.

Note: Be careful not to send us duplicate records **unless** a provider has two or more locations. Our experience dealing with electronic provider listings is that we very often receive two or more records for the same physician (e.g., "John Smith" and "John A. Smith" with the same provider ID/TIN).

2. SCOPE OF NETWORK

Include a list of all states where your PPO network exists.

- 3. GEO ACCESS – Provide a geo access report based upon the residential zip codes of the census file included with this RFP. List all providers within 8 miles of the residential zip code and list percent with a minimum of two primary care providers. For Acute Hospital Facilities in your network, list the percent within 15 miles.**

SECTION IX

ATTACHMENTS AND EXHIBITS

ATTACHMENT 1:	OFFER FORM OF-1
ATTACHMENT 2:	INTENT TO BID FORM
ATTACHMENT 3:	SEGAL CONFIDENTIALITY AGREEMENT
ATTACHMENT 4:	CONFIDENTIAL INFORMATION
ATTACHMENT 5:	EXCEPTIONS
ATTACHEMNT 6:	CURRENT PERFORMANCE GUARENTEES
EXHIBIT A:	CLAIMS EXPERIENCE
EXHIBIT B:	PREMIUM RATES
EXHIBIT C:	ADMINISTRATIVE RULES
EXHIBIT D:	CONTRACT FORM AND AG GENERAL CONDITIONS
EXHIBIT E:	EVIDENCE OF COVERAGE DOCUMENTS
EXHIBIT F:	BUSINESS ASSOCIATE AGREEMENT
EXHIBIT G:	SAMPLE 834 FILES FOR EUTF ELIGIBILITY TRANSACTIONS
EXHIBIT H:	ENROLLEMENT COUNTS
EXHIBIT I:	CENSUS DATA

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION IX

**ATTACHMENT 1
OFFER FORM OF-1**

Medical Benefits
STATE OF HAWAII
DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)
RFP-14-001

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

Dear Procurement Officer:

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

Offeror is:

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

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

Federal I.D. No. _____

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

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

Respectfully submitted:

Date: _____ (x) _____
Authorized (Original) Signature

Telephone No.: _____
Name and Title (Please Type or Print)

Fax No.: _____
** _____
Exact Legal Name of Company (Offeror)

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

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION IX

ATTACHMENT 2

INTENT TO BID FORM
RFP 14-001, Medical Benefits

Email or fax this registration form by **January 24, 2014** to:

Ms. Sandra Yahiro
Hawaii Employer Health Benefits Trust Fund
Telephone: (808) 586-7390
Fax: (808) 586-2320
Email: eutfadmin@hawaii.gov

Please be advised that we are in receipt of the above-referenced RFP. We also wish to advise that we will be submitting a proposal for the following service(s):

Plans	OFFEROR Proposing	Table and Proposal Sheet Number
<input type="checkbox"/> EUTF Active Employee 90/10 PPO Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	1
<input type="checkbox"/> HSTA VB Active Employee 90/10 PPO Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	2
<input type="checkbox"/> EUTF Active Employee 80/20 PPO Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	3
<input type="checkbox"/> HSTA VB Active Employee 80/20 PPO Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	4
<input type="checkbox"/> EUTF Active Employee HMO Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	5
<input type="checkbox"/> EUTF Active Employee Comprehensive Closed HMO Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	6
<input type="checkbox"/> EUTF Active Employee Closed Panel Standard HMO Plan, and Active Part-Time and Temporary Employees	<input type="checkbox"/> Yes <input type="checkbox"/> No	7
<input type="checkbox"/> HSTA VB Active Employee Closed Panel HMO Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	8
<input type="checkbox"/> EUTF Active Employee 75/25 PPO Plan, and Active Part-Time and Temporary Employees	<input type="checkbox"/> Yes <input type="checkbox"/> No	9
<input type="checkbox"/> EUTF Retiree 90/10 PPO Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	10
<input type="checkbox"/> HSTA VB Retiree 90/10 PPO Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	11
<input type="checkbox"/> EUTF Retiree Closed Panel HMO Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	12
<input type="checkbox"/> HSTA VB Retiree Closed Panel HMO Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	13
<input type="checkbox"/> EUTF Active Chiropractic Network Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	14
<input type="checkbox"/> HSTA VB Active Chiropractic Network Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	15

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION IX

<input type="checkbox"/> HSTA VB Retiree Chiropractic Network Benefit	<input type="checkbox"/> Yes <input type="checkbox"/> No	16
<input type="checkbox"/> EUTF Retiree Open Panel Medicare Advantage Plan	<input type="checkbox"/> Yes <input type="checkbox"/> No	17

Signed Confidentiality Agreement is attached.

Name of Company: _____

Primary Contact Name: _____

Primary Contact Phone: _____

Primary Contact Email: _____

Signature: _____

ATTACHMENT 3

Confidentiality Agreement
to be used by Entities Responding to RFPs

A signed confidentiality agreement is required before census data will be released. Any request for changes to this agreement will require Segal's review and concurrence, which will delay the release of the census information. If the OFFEROR already has a signed confidentiality agreement with Segal, please provide a copy of the agreement along with the Intent to Bid Form (Attachment 2). **An intent to Bid Form and signed Confidentiality Agreement is not required to submit a proposal.**

ATTACHMENT 3

SEGAL CONFIDENTIALITY AGREEMENT

Confidentiality Agreement
to be used by Entities Responding to RFPs

This confidentiality agreement is between The Segal Group, Inc., the parent of The Segal Company, on behalf of The Segal Company operating subsidiaries, (hereafter "Segal") and _____, on behalf of itself and all of its subsidiaries and affiliates, (hereafter "OFFEROR") and is executed in connection with various proposals that OFFEROR intends to submit to Segal in response to RFPs issued by Segal on behalf of its "Clients."

In order to prepare a responsive proposal, OFFEROR needs to receive certain Client health plan information and data, including individually identifiable health information pertaining to Client health plan participants and beneficiaries, as well as Segal Proprietary Information consisting of the RFP questionnaire/RFI specifications and any associated financial spreadsheets (collectively "Proprietary Information"). Segal and OFFEROR agree that the term "individually identifiable health information" refers to any health information that is not "de-identified," as defined in 45 C.F.R. Section 164.514(b)(2). Segal agrees to provide the necessary Proprietary Information in connection with this RFP, and OFFEROR agrees as follows:

1. OFFEROR will use this Proprietary Information only for the purpose of preparing OFFEROR's response to Segal's RFP.
2. OFFEROR agrees that only those individuals employed by OFFEROR who have a need to know this information to prepare a proposal and have been made aware of the terms of this Agreement and have agreed to a proposal by its terms will have access to the Proprietary Information provided by Segal ("OFFEROR's Representatives").
3. Neither OFFEROR nor any of its Representatives will disclose the Proprietary Information to any person or entity outside of OFFEROR, unless such a disclosure is: (a) necessary to prepare a proposal and the recipient first executes a confidentiality agreement with provisions equivalent to this one; or (b) required by law.
4. OFFEROR agrees to use commercially reasonable efforts to maintain the security of the Proprietary Information.
5. OFFEROR will return the Proprietary Information to Segal or destroy it upon completion of the proposal process if such return or destruction is feasible. If OFFEROR determines that return or destruction of some or all of the information is not feasible, OFFEROR agrees to: (a) inform Segal of the specific reason(s) that make return or destruction not feasible; (b) extend the protections of this Agreement to any retained information for as long as OFFEROR retains it; and (c) limit further uses or disclosures to those that make the return or destruction infeasible.
6. OFFEROR will report to Segal any use and/or disclosure of Proprietary Information that is not permitted by this Agreement.
7. OFFEROR shall regard and preserve as confidential all Proprietary Information that has been or may be obtained by OFFEROR in the course of any proposal, whether OFFEROR has such information in OFFEROR's memory, or in writing or in other physical form. OFFEROR shall not, without written authority from Segal, use any Proprietary Information for OFFEROR's benefit or OFFEROR's purposes, either during the proposal process or thereafter.
8. With respect to each RFP and the Proprietary Information disclosed in connection therewith, the obligations of OFFEROR assumed in this Agreement shall continue beyond the completion of the proposal process.
9. OFFEROR shall and does hereby indemnify, defend and hold harmless Segal and Segal's officers, directors, employees and shareholders from and against any and all claims, demands, losses, costs, expenses, obligations,

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION IX

liabilities, damages, recoveries, and deficiencies, including interest, penalties, and reasonable attorney fees and costs, that Segal may incur or suffer and that result from, or are related to, any breach or failure of OFFEROR and OFFEROR's Representatives to perform any of the representations, warranties and agreements contained in this Agreement that pertain to individually identifiable health information.

10. OFFEROR recognizes that any breach of the covenants contained in this Agreement would irreparably injure Segal. Accordingly, Segal may, in addition to pursuing its other remedies, obtain an injunction from any court having jurisdiction of the matter restraining any further violation and no bond or other security shall be required in connection with such injunction.
11. If any of the provisions herein become invalid or are declared invalid, such determination of invalidity as to the clause(s) shall not affect the other provisions of this Agreement. If any provision of this Agreement should be held invalid or unenforceable, the remaining provisions shall be unaffected by such a holding. If any provision is found inapplicable to any person or circumstance, it shall nevertheless remain applicable to all other persons and circumstances.
12. This Agreement shall be binding upon Segal and OFFEROR and their respective successors, assigns, heirs, executors and administrators.
13. This Agreement contains the entire understanding of the parties hereto and supersedes all previous communications, representations, or agreements, oral or written, with respect to the subject matter hereof. No failure to exercise nor any delays in exercising any right or remedy hereunder shall operate as a waiver thereof; nor shall any single or partial exercise of any right or remedy hereunder preclude any other or further exercise thereof or the exercise of any other right or remedy. Neither this Agreement nor any of its provisions may be amended, supplemented, changed, waived or rescinded except by a written instrument signed by the party against whom enforcement thereof is sought. No waiver of any right or remedy hereunder on any one occasion shall extend to any subsequent or other matter.
14. This Agreement shall be governed by and construed in accordance with the laws of the State of New York applicable to contracts made on and performed within the State of New York. Any action to enforce this Agreement shall be brought in State of New York, County of New York.

Intending to be legally bound, the Parties have executed this Agreement.

The Segal Group, Inc.

OFFEROR

Signed: _____

Signed: _____

Print Name: _____

Print Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

ATTACHMENT 4

CONFIDENTIAL INFORMATION

List all information believed to be confidential and not to be disclosed to the public. Identify the page numbers and sections in the proposal where the information is located.

ATTACHMENT 5

EXCEPTIONS

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

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION IX

ATTACHMENT 6

PERFORMANCE GUARANTEE – MEDICAL and INSURED PHARMACY

OFFEROR must agree to put “at risk” 50% of its administrative and retention fee toward all contracts for Active and Retiree Plans issued to the OFFEROR.

Performance under these guarantees will be self-measured, calculated and paid quarterly, subject to audit by EUTF, based on the combined performance under all contracts issued to the OFFEROR if more than one contract is issued to an OFFEROR.

	Penalty	Guarantee
Call Center Response	15% of Total (Divided equally among 3 sub-categories)	
		Answer 100% of calls within 20 seconds (not including calls answered by an automated voice response system)
		Resolve 99% of telephone inquiries/issues of all telephone inquiries/issues at the first point of contact (the number of telephone inquiries/issues completely resolved at the time of initial contact divided by the total number of calls)
		Maintain call abandonment rate below 3%
Claim Processing and Claim Service	15% of Total (Divided equally among 5 sub-categories)	
		Achieve a minimum of 99% financial accuracy on claim payment
		Achieve 95% of coding accuracy
		Process 99% of claims within 30 calendar days
		Resolve 98% of written inquires within 10 business days of receipt of inquiry
		Process 99% of appeals within 30 calendar days (first level)
Wellness and Total Health Management	25% of Total (Divided equally among 5 sub-categories)	
		Develop and present to the EUTF for adoption a proposed comprehensive wellness and disease management program within 6 months of commencement of contract.

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION IX

		Monitor compliance with and outcomes of wellness and total health management programs and report quarterly to EUTF administration and Board
		Provide web based wellness and participant education material and capability by beginning of first plan year.
		Provide web based health risk assessment facility for participants within 4 months of contact effective date
		Report to EUTF on results of health risk assessment results quarterly
EUTF Trustee and EUTF Administration Service	15% of Total (Divided equally among 4 sub-categories)	
		Resolve 95% of enrollee issues within 3 business days, any case that required the involvement of EUTF's staff due to incorrect or incomplete information being provided by the contractor.
		Respond to 95% of Trustee, Administrator and EUTF staff inquires within the same business day, or the next business day if the inquiry is made after 3:00 PM, HST.
		Provide required monthly reports within the prescribed time for Board meeting
		Maintain consistent, local primary account team throughout each contract term unless change requested by EUTF.
Plan Administration	15% of Total (Divided equally among 3 sub-categories)	
		Weekly 834 file loads not to exceed 24 hours after receipt and all transactions (enrollments, terminations, life event, other changes), including mailing of ID cards, processed within 48 hours
		Process eligibility, termination, life events, and other changes within 99% accuracy
		Maintain network turnover below 5%
Participant Service	15% of Total (Divided equally among 2 sub-categories)	
		Contractor agrees to conduct an enrollee satisfaction survey for each contract year and that the satisfaction rate must be 90% or greater.

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SECTION IX

		<p>“Enrollee Satisfaction Rate” means (i) the number of eligible persons responding to contractor’s annual standard patient satisfaction survey as being satisfied with the overall performance under the integrated program divided by (ii) the number of eligible persons responding to such annual patient satisfaction survey; EUTF must provide timely approvals and responses, and a minimum of 20% of surveys must be returned for the performance standard to be applicable.</p>
		<p>Provide accurate communication to participants 100% of the time, including ID cards. Letters pre-approved by EUTF prior to mailing.</p>

EXHIBIT A

CLAIMS EXPERIENCE

Claims data will be supplied upon completion of the Intent to Bid Form (Attachment 2).

EXHIBIT B

PREMIUM RATES

Premium rates are available at the EUTF Web Site:

<http://eutf.hawaii.gov/>

EXHIBIT C

ADMINISTRATIVE RULES

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND**ADMINISTRATIVE RULES****CONTENTS**

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1.00 GENERAL PROVISIONS

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- 1.13 Responsibilities of Employee-Beneficiaries and Public Employers; Enforcement Actions of the Fund

1.01 Purpose

Chapter 87A of the Hawaii Revised Statutes establishes a health trust fund known as the Hawaii Employer-Union Health Benefits Trust Fund. The Fund is to be used to provide eligible state and county employees, retirees, and their dependents with health and other benefit plans at a cost affordable to both the public employers and the public employees. The board is to administer and carry out the purposes of the Fund. These rules are adopted by the board pursuant to Section 87A-26 of the Hawaii Revised Statutes to implement the administration and purposes of the Fund.

1.02 Definitions

As used in these rules, unless otherwise indicated by the context, the following terms shall have the following meanings:

“Administrator” means the administrator of the Fund appointed by the board or the duly authorized representative of the administrator.

“Benefit plan” means a health benefit plan, a group life insurance plan that is subject to Section 79 of the Internal Revenue Code, or any other type of benefit plan except for a long-term care benefit plan.

“Board” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Carrier” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Child” means an employee’s, or where applicable, a domestic partner’s legally adopted child, a child placed for adoption, stepchild, foster child, or recognized natural child. Except for a recognized natural child of an employee or as otherwise provided by these rules, a child must live with the employee-beneficiary. A child has been placed for adoption when an adoptive parent has assumed custody of and the obligation to support a child in anticipation of adopting the child. A foster child is a child:

- (1) who lives with an employee in a regular parent-child relationship; and
- (2) for whom the employee has become the child’s guardian or has been awarded legal and physical custody of the child pursuant to a valid court order.

“Contributions” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“County” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Dependent-beneficiary” shall mean the persons described in Rule 3.01 of these rules as being eligible for coverage as dependent-beneficiaries in the health benefit plans offered or sponsored by the Fund.

“Dissolution of domestic partnership” shall occur when: (1) the employee-beneficiary no longer meets the requirements to qualify as a “domestic partner”; (2) one of the partners to the domestic partnership expressly informs the other of the end of their domestic partnership; (3) one of the partners to the domestic partnership takes actions inconsistent with the continued existence of the domestic partnership; or (4) the domestic partnership is otherwise terminated or dissolved.

“Domestic partner” shall mean a person in a spouse-like relationship with an employee-beneficiary who meets the following requirements: (1) the employee-beneficiary and the domestic partner intend to remain in a domestic partnership with each other indefinitely; (2) the employee-

beneficiary and the domestic partner have a common residence and intend to reside together indefinitely; (3) the employee-beneficiary and the domestic partner are and agree to be jointly and severally responsible for each other's basic living expenses incurred in the domestic partnership such as food, shelter and medical care; (4) neither the employee-beneficiary nor the domestic partner are married or a member of another domestic partnership; (5) the employee-beneficiary and the domestic partner are not related by blood in a way that would prevent them from being married to each other in the State of Hawaii; (6) the employee-beneficiary and the domestic partner are both at least 18 years of age and mentally competent to contract; (7) the consent of the employee-beneficiary or the domestic partner to the domestic partnership has not been obtained by force, duress or fraud; and (8) the employee-beneficiary and the domestic partner sign and file with the Fund a declaration of domestic partnership in such form as the board shall from time to time prescribe.

“Employee” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Employee-beneficiary” shall mean the persons described in Rule 3.01 of these rules as being eligible to enroll as employee-beneficiaries in the health benefit plans offered or sponsored by the Fund.

“Employer” or “public employer” shall have the meaning as set forth in Section 89-2 of the Hawaii Revised Statutes.

“Full-time student” means a student who is enrolled in an accredited school, college, or university for not less than the minimum number of credit hours required by such educational institution to have full-time student status.

“Fund” shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Fund benefit plan” means a benefit plan offered or sponsored by the Fund.

“Health benefit plan” shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Long-term care benefit plan” shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Non-Fund benefit plan” means a benefit plan offered or sponsored by a private employer or an entity other than the Fund.

“Part-time, temporary, and seasonal or casual employee” shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Periodic change” shall have the same meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Qualified beneficiary” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Qualified medical child support order” means any judgment, decree, or order issued by a court of competent jurisdiction that requires the provision of health benefits coverage to a child of a non-custodial parent.

“Retired member” or “retired employee” means a former employee, officer, appointed or elected official of the State or counties who is currently receiving a retirement or pension allowance from a State or county retirement system or an employee who retired prior to 1961.

“State or county retirement system” means the employees’ retirement system, the county pension system, or the police, fire, or bandsmen pension system of the State or any county.

“Trustee” shall have the meaning as set forth in Section 87A-1 of the Hawaii Revised Statutes.

“Trustee group” means the group composed of the five trustees representing public employers or the group composed of the five trustees representing employee-beneficiaries as described in Section 87A-5 of the Hawaii Revised Statutes.

1.03 Public Information

To the extent permitted by applicable federal or state law, the public records of the Fund shall be available for inspection at the Fund's office during regular business hours. All requests for inspection of public records shall be in writing and addressed to the administrator or any other person designated by the board to receive such requests. Copies of public records shall be provided upon the payment of the reasonable costs of reproduction and any fees for searching, reviewing and segregating such records. The board shall establish such costs and fees in accordance with applicable federal and state law.

Protected health information about employee-beneficiaries and dependent-beneficiaries are not public records. Employee-beneficiaries, dependent-beneficiaries, and others may have access to such information only in conformance with the Health Insurance Portability and Accountability Act of 1996 and the rules passed under that Act ("HIPAA"), and the Fund's HIPAA Privacy Policies and Procedures.

1.04 Computation of Time

Whenever a period of time is stated in these rules as a number of days from or after an event: (a) the period shall be computed in calendar days; (b) the day of the event shall not be included in the calculation; and (c) the last day of the period shall be included in the calculation.

1.05 Officers of the Board

- (a) The board shall elect a chairperson, vice-chairperson, and secretary-treasurer.
- (b) Both the chairperson and vice-chairperson shall be elected from the same trustee group. The secretary-treasurer shall be elected from the other trustee group.
- (c) Officer terms shall be for one year beginning July 1, 2002, and shall rotate between the trustee groups annually. The terms of all elected officers shall terminate on June 30 of each succeeding year and such officers shall vacate their offices at that time.

- (d) Except as otherwise provided by law or by rules or policies adopted by the board, the duties of the officers shall be as provided in the 10th Edition of *Robert's Rules of Order, Newly Revised*.
- (e) The chairperson or vice-chairperson and secretary-treasurer shall coordinate assignments to the administrator and other Fund staff, requests for information, and other matters concerning the administration and operation of the board.

1.06 Committees of the Board

- (a) Standing committees shall be established by the board to address critical issues in the major functional areas of the Fund:
 - (1) The Administrative Committee will have combined administrative and finance committee functions;
 - (2) The Benefits Committee will have benefits, communication, and appeals committee functions.
- (b) The board may establish other committees to address matters related to the operation or administration of the Fund or to investigate issues that impact the Fund.
- (c) Committees shall operate informally and shall make recommendations to the full board. Meetings of all standing committees will comply with Part I of Chapter 92 of the Hawaii Revised Statutes.
- (d) A minimum of four trustees (two trustees from each trustee group) shall be assigned to a committee. The assigned number of trustees may be larger for certain committees provided that an equal number of trustees are assigned from each trustee group.
- (e) Attendance of at least one trustee from each trustee group shall be necessary to convene a committee meeting.
- (f) Committees may select a chairperson and any other officers as deemed necessary by the board.
- (g) Committee chairpersons shall coordinate assignments to the administrator and other Fund staff for their respective committees.

- (h) Trustees in attendance shall agree within their working committees on recommendations made to the full board. When there is no agreement by the trustees in attendance, the committee shall present a summary of the disagreement(s) to the full board.

1.07 Meetings of the Board

- (a) To the extent permitted by applicable federal or state law, the meetings of the board shall be open to the public. Without limiting the foregoing, board meetings shall comply with Part I of Chapter 92 of the Hawaii Revised Statutes, including the provisions therein requiring: (1) written and electronic notice of board meetings at least six calendar days prior to each meeting; and (2) written minutes.
- (b) The board shall designate the administrator or some other member of the Fund's staff to be responsible for preparing agendas for future board meetings. Any trustee may place a question or subject on the agenda of a future board meeting by notifying the administrator or other designated staff person by 12:00 noon, seven days prior to the board meeting. All board meeting agendas shall be transmitted to the chairperson for review prior to public notice.
- (c) Unless otherwise required by the board or applicable law, the parliamentary procedure to be used by the board in the conduct of its meetings shall be in accordance with the 10th Edition of *Roberts Rules of Order, Newly Revised*.
- (d) Voting procedures for board meetings and the criteria for a quorum are established in Section 87A-11 of the Hawaii Revised Statutes. In addition, the following voting procedures shall apply:
 - (1) After a motion is made and seconded, the presiding officer shall read the motion and open the question to discussion and debate by the trustees. When ready to put the motion to a vote, the presiding officer shall call for the public employer and employee-beneficiary trustee votes to determine whether there are three votes from each trustee group in favor of the motion. If so, the motion shall be recorded as having been approved by one vote from the public employer trustees and one vote from the employee-beneficiary trustees.

- (2) For routine or procedural matters, the presiding officer may ask if there is any opposition to a motion after it has been made, and to the extent required, seconded and debated. If no opposition is voiced, the motion shall be recorded as having been unanimously approved by one vote by the public employer trustees and one vote from the employee-beneficiary trustees.
- (3) If the voting is not unanimous by each side, the names of the trustees who voted in favor of the motion, voted against the motion, or abstained from voting shall be recorded in the minutes.
- (4) In the event of a deadlock in a vote of the board on the same question or resolution at two successive meetings of the board, the board shall vote on whether or not to engage in dispute resolution. If six trustees of the board vote to engage in dispute resolution, the two trustee groups shall enter into mediation to attempt to resolve the question or resolution upon which the board has deadlocked.

The mediation shall be handled by a mediator appointed by the Federal Mediation and Conciliation Service. If the Federal Mediation and Conciliation Service fails or refuses to appoint a mediator within ten days of the date on which the six trustees voted to engage in dispute resolution, the mediation shall be handled by a mediator mutually agreeable to the two trustee groups. If the two trustee groups do not agree on a mediator within twenty days of the date on which the six trustees voted to engage in dispute resolution, either trustee group may petition the Administrative Judge of the First Circuit, Circuit Courts of the State of Hawaii, to appoint a mediator. Upon the appointment of a mediator, the two trustee groups shall in good faith enter into mediation on the question or resolution upon which the board has deadlocked. Nothing in this rule is meant to preclude the board from voting to engage in other forms of alternate dispute resolution to resolve a question or resolution upon which it has deadlocked.

- (5) Whenever any statute or other law requires a vote of a majority, two-thirds or other percentage or fraction of the trustees or members to which the board is entitled, the motion or other action shall be approved if it receives two votes in favor of the motion or

action as provided in subsection (d)(1), regardless of the total number of votes in favor of the motion or action.

For example, if a statute or other law requires a two-thirds vote of the members to which the board is entitled, the motion or other action will be approved if three trustees from each trustee group vote in favor of the motion or other action, even if the remaining four trustees vote against the motion or other action.

1.08 Appearances Before the Board

- (a) All persons shall comply with this rule when appearing before the board. Unless otherwise required by applicable federal or state law, the board shall have the discretion to prescribe additional standards and procedures for all appearances and proceedings before the board. The board may waive or suspend the provisions of this rule with respect to any particular appearance or proceeding before it.
- (b) Any person appearing before the board may appear in person, by an officer, partner or regular employee of the party, or be represented by an authorized representative. The board may at any time require any person transacting business with the board in a representative capacity to prove or authenticate the person's authority and qualification to act in such capacity.
- (c) The board shall afford all interested persons an opportunity to present oral testimony or submit data, views, or arguments, in writing, on any agenda item.
 - (1) Persons providing written testimony shall provide thirty copies of their testimony of which twenty copies shall be made available to the public. Twenty copies of materials provided to the board for or during a meeting that are determined to be disclosable shall be made available for distribution to the public.
 - (2) The board shall hear oral testimony on an agenda item after it has completed discussion of that item. At that time, the presiding officer shall invite members of the public to ask questions or provide comments on the agenda item prior to any action by the board. After the public has had an opportunity to provide input on

the agenda item, the board may discuss the agenda item further and act on the item or move on to the next agenda item.

- (3) A person may speak at a board meeting only when recognized to do so by the presiding officer. Comments are limited to three minutes per speaker. Time limitations may be adjusted at the discretion of the presiding officer or at the request of any three trustees. A person may not speak a second time on the same question unless authorized by the presiding officer to do so.
 - (4) The board may refuse to hear any testimony that is irrelevant, immaterial, or unduly repetitious and may from time to time impose additional conditions as are necessary or desirable for the orderly, efficient, and convenient presentation of oral testimony to the board. The board may request that the person providing oral testimony submit the testimony in writing to the board.
- (d) Nothing herein shall require the board to hear or receive any oral testimony or documentary evidence from a person on any matter which is the subject of another proceeding pending before the board.

1.09 Delegation of Authority

To the extent permitted by law, the board may delegate authority to act on its behalf in accordance with board policies and standards to a committee of the board, an administrator, a carrier, a third party administrator, or to such other persons and entities as it deems necessary or reasonable for the effective and efficient administration of the Fund and the provisions of Chapter 87A of the Hawaii Revised Statutes; provided, however, that nothing in this rule shall permit the board to delegate its power to adopt, amend or repeal any rules.

1.10 State Ethics Code

All trustees and employees of the Fund shall comply with Chapter 84 of the Hawaii Revised Statutes.

1.11 Controlling Law

To the extent that federal or state law governs any matter covered by these rules, the Fund and the board shall comply with and follow such federal or state law. To the extent that any matter is not completely governed by federal or state

law, the Fund and the board shall apply these rules to the extent reasonable and practicable.

1.12 Authority of the Board to Waive Rule Provisions

Subject to statutory requirements and limitations, the Board may waive an employee-beneficiary's compliance with any provision of the Fund's rules when the Board determines that: (a) good cause exists for such a waiver; (b) strict enforcement of such provision would impose a manifest injustice upon an employee-beneficiary who has substantially complied with the Fund's rules in good faith; and (c) such waiver does not involve any increase in the obligations or liabilities of the Fund beyond that which would have been involved if the employee-beneficiary had fully complied with the Fund's rules. Each waiver by the Board must be in writing and supported by documentation of the pertinent facts and grounds.

1.13 Responsibilities of Employee-Beneficiaries and Public Employers; Enforcement Actions of the Fund

- (a) Employee-beneficiaries are responsible for:
- (1) Providing current and accurate personal information as per Rules 4.06 and 4.07;
 - (2) Paying the employee's premium contributions in the amount or amounts provided by statute, an applicable bargaining unit agreement, or by the applicable Fund benefit plan;
 - (3) Paying the employee's premium contributions at the times and in the manner designated by the board; and
 - (4) Complying with the Fund's rules.
- (b) Any public employer whose current or former employees participate in Fund benefit plans is responsible for:
- (1) Providing information as requested by the Fund under section 87A-24(9) of the Hawaii Revised Statutes;
 - (2) 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;

- (3) Assisting the Fund in distributing information to and collecting information from the employee-beneficiaries; and
 - (4) Complying with the Fund's rules.
- (c) The Fund shall have the right and authority to file actions in any court, including but not limited to the courts of the State of Hawaii and the United States of America, to enforce the foregoing obligations and to collect premium contributions. Nothing in this rule is intended to limit or restrict the rights or remedies otherwise available to the Fund.

2.00 ADMINISTRATIVE PROCEDURES

- 2.01 Adoption, Amendment or Repeal of Rules
- 2.02 Policies, Standards, and Procedures
- 2.03 Declaratory Rulings
- 2.04 Administrative Appeals
- 2.05 Emergency Appeals

2.01 Adoption, Amendment or Repeal of Rules

- (a) The board may adopt, amend or repeal any rule of the Fund upon a motion of any trustee or upon the petition of an interested person or organization.
- (b) In the case of an interested person or organization, the petition shall be in writing and shall be submitted in duplicate to the board. The petition need not be in any particular form but shall contain:
 - (1) The petitioner's name, address, and telephone number;
 - (2) A statement of the nature of the petitioner's interest;
 - (3) A statement of the reasons for the proposed rule, amendment or repeal;
 - (4) A draft of the proposed rule, amendment or repeal; and
 - (5) The signature of the petitioner.

The board may reject any petition that does not contain the foregoing information.

- (c) The board shall determine whether to deny or proceed with a petition within ninety days. If the petition is denied, the board shall notify the interested person or organization in writing of the denial.
- (d) If the board decides to proceed with any proposed rule change, whether by a trustee or interested person or organization, it shall consult with public employers and affected employee organizations with regard to the proposed rule change as follows. First, it shall transmit the proposed rule change to the public employers, exclusive employee organizations, exclusive representatives, retiree organizations, and all other employee organizations registered with the board for consultation prior to adoption. Second, it shall provide the employers, representatives and organizations a

reasonable amount of time for review and comment on the proposed change prior to final action by the board.

- (e) After the consultation provided for in subsection (d), the proposed rule change shall be considered for adoption at an open meeting of the board that permits the attendance of interested persons.
- (f) All proposed rule changes shall be adopted by the board in accordance with the provisions of section 87A- 26 of the Hawaii Revised Statutes.
- (g) New rules, amendments or repeals of rules that are adopted by the board shall be submitted to the governor for approval and filed with the lieutenant governor's office.
- (h) Unless some other date is expressly selected by the board, a new rule, amendment of a rule, or repeal of a rule shall be effective the first day after the rule, amendment, or repeal is filed with the lieutenant governor's office.

2.02 Policies, Standards, and Procedures

Policies, standards and procedures to be adopted amended or repealed may, at the discretion of the board, be transmitted to public employers and affected employee organizations for consultation purposes. Nothing herein shall require the board to consult with public employers or affected employee organizations concerning the board's adoption, amendment or repeal of policies, standards and procedures or to transmit any such policies, standards or procedures to public employers or affected employee organizations for consultation purposes.

2.03 Declaratory Rulings

- (a) Any interested person may petition the board for a declaratory ruling as to the applicability of any statutory provision administered by the board or of any rule or order of the Fund.
- (b) Every petition shall be in writing and shall be submitted in duplicate to the board. The petition need not be in any particular form but shall contain the following:
 - (1) The petitioner's name, address, and telephone number;
 - (2) A designation of the specific statute, rule or order in question;

- (3) A statement of the nature of the petitioner's interest, including the reasons for the submittal of the petition;
- (4) A complete statement of the relevant and material facts;
- (5) A statement of the position or contentions of the petitioner; and
- (6) A full discussion of the reasons, including any legal authorities, in support of the petitioner's position or contention.

The board may reject any petition that does not contain the foregoing information.

- (c) Petitions to intervene and become a party to a declaratory ruling proceeding may be submitted in writing to the board. Such petitions shall contain the same information as required under subsection (b) and the grounds and reasons on which intervention is sought. The Board may deny intervention where the petition to intervene raises issues not reasonably pertinent to the issues already presented or the petition raises issues that would broaden the issues to be decided. If intervention is granted, the petitioner shall become a party to the proceeding to the degree permitted by the order granting intervention.
- (d) The board may dismiss any petition for a declaratory ruling for good cause. Without limiting the generality of good cause, the board may dismiss a petition if:
 - (1) The question raised is purely speculative or hypothetical;
 - (2) The petitioner's interest is not of the type or nature that would give the petitioner standing to maintain an action if the petitioner were to seek judicial relief;
 - (3) The issuance of a declaratory ruling may adversely affect the interests of the employer, the board, any of the trustees, the Fund, or any of the Fund's officers or employees in litigation which is pending or reasonably expected to arise in the future; or
 - (4) The matter is not within the jurisdiction of the board.
- (e) Subject to applicable federal and state law, the board at its discretion shall:
 - (1) Render a decision on the petition for a declaratory ruling without a hearing; or
 - (2) Hold a hearing and thereafter render its decision on the petition; or
 - (3) Refer the petition for consideration or hearing to the administrator, a special or standing committee of the board or any other person or

entity duly designated by the board. After considering the recommendation of the administrator, committee or designated person or entity, the board shall render its decision on the petition.

Where any question of law is involved, the board may seek the assistance of the state attorney general in reviewing the matter. The board may also seek the assistance of other government agencies when necessary or desirable.

Any petitioner who desires a hearing shall submit a written request for a hearing together with the petition for a declaratory ruling. The written request shall set forth in detail the reasons why the matters alleged in the petition, together with supporting affidavits or other written evidence and briefs or memoranda of legal authorities, will not permit the fair and expeditious disposition of the petition and, to the extent that the request for a hearing is dependent upon factual assertions, shall submit affidavits or certificates establishing those facts.

- (f) The petition for a declaratory ruling shall either be rejected in accordance with subsection (d) or acted upon by issuance of an order within ninety days. Upon the disposition of the petition, the board shall promptly notify the petitioner.
- (g) Orders disposing of petitions for a declaratory ruling will have the same status as other agency orders. An order shall be applicable only to the fact situation alleged in the petition or as set forth in the order. An order shall not be applicable to different fact situations or where additional facts exist that were not considered in the order.

2.04 Administrative Appeals

- (a) A person aggrieved by one of the following decisions by the Fund may appeal to the board for relief from that decision:
 - (1) A determination that the person is not an employee-beneficiary, dependent-beneficiary or qualified beneficiary, or that the person is not eligible to enroll in or be covered by a benefit plan offered or sponsored by the Fund;

- (2) A determination that the person cannot make a change in enrollment, a change in coverage, or a change in plans;
 - (3) A cancellation or termination of the person's enrollment in or coverage by a benefit plan, including long term care, offered or sponsored by the Fund; 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 Fund.
- (b) The first step in the appeal process is an appeal to the administrator. In order to appeal to the administrator for relief, an aggrieved person must file a written appeal in the Fund's office within 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.
- (c) If the aggrieved person is dissatisfied with the administrator's action or if no action is taken by the administrator on the aggrieved person's written appeal within ninety days of its being filed in the Fund's office, the second step in the appeal process is for the aggrieved person to file a written appeal to the board. A written appeal to the board must be filed in duplicate in the Fund's office. The written appeal need not be in any particular form but shall contain the following information:
- (1) The aggrieved person's name, address and telephone number;
 - (2) A statement of the nature of the aggrieved person's interest, e.g., employee-beneficiary or dependent-beneficiary;

- (3) A description of the decision with respect to which relief is requested, including, the date of the decision;
- (4) A complete statement of the relevant and material facts;
- (5) A statement of why the aggrieved person is appealing the decision, including a complete statement of the position or contentions of the aggrieved party; and
- (6) A full discussion of the reasons, including any legal authorities, in support of the aggrieved party's position or contentions.

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

- (d) The board at any time may request the aggrieved person or any other party to the proceeding to submit a statement of additional facts or a memorandum, the purpose of which is to clarify the party's position or a specific factual or legal issue.
- (e) The board shall grant or deny the appeal within 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.
- (f) At any time, an aggrieved person may voluntarily waive his or her rights to the administrative appeal provided by the Rule by submitting such a waiver in writing to the Fund's office. The board may require the aggrieved person to make such a waiver by signing a form prescribed by it.

2.05 Emergency Appeals

- (a) An employee-beneficiary ("appellant") who is aggrieved by a plan administrator's decision denying or limiting benefits provided under a plan offered by the Fund to the employee-beneficiary or a dependent-beneficiary enrolled by the employee beneficiary may make an emergency

appeal directly to the Board where a delay in following the Fund's normal appeal process could:

- (1) Seriously jeopardize the life or health of the employee-beneficiary or dependent-beneficiary;
 - (2) Seriously jeopardize the employee-beneficiary's or dependent-beneficiary's ability to regain maximum functioning; or
 - (3) In the opinion of a physician with knowledge of the medical condition of the employee-beneficiary or dependent-beneficiary, subject the employee-beneficiary or dependent-beneficiary to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.
- (b) Any appellant desiring to make an emergency appeal under this Rule shall file a written request with the Fund administrator that contains the following information:
- (1) The name, address, and telephone number of the appellant;
 - (2) A description of the decision with respect to which relief is requested;
 - (3) A statement of the relevant and material facts;
 - (4) A statement as to why the appellant is appealing the decision, including all arguments and reasons that support the appellant's position or contentions;
 - (5) A statement as to why the appellant's appeal qualifies as an emergency appeal, i.e., why the appeal meets one or more of the conditions stated in subsection (a) above;
 - (6) A statement as to exactly what relief the appellant is seeking;
 - (7) Any documents and records that support the appellant's appeal, including, but not limited to, any opinions from physicians that show that the appeal should be handled as an emergency appeal; and
 - (8) If the appellant is going to be represented by a third person on the appeal: (i) a signed authorization by the appellant designating the third person to represent him or her on the appeal; or (ii) other documentation establishing the right of the third person to represent the appellant. Such documentation may include letters of guardianship, a power of attorney, or any other document establishing that the third person may represent the appellant. Appropriate representatives may include, but are not limited to, the parent, child, spouse or domestic partner of the appellant.

Notwithstanding the foregoing, the Fund administrator may waive the foregoing requirements if the Fund administrator finds that the criteria for making an emergency appeal are present and circumstances prevent the appellant from filing a written request for an appeal.

- (c) Within two business days of receipt of a request for emergency appeal, the Fund administrator shall determine whether the request for emergency appeal qualifies as an emergency appeal under the criteria stated in this Rule. If the Fund administrator determines that the request for emergency appeal does not qualify as an emergency appeal, the appellant's appeal shall be handled as a normal appeal. Appellant may appeal the Fund administrator's denial of a request for emergency appeal by filing a written request with the Fund Administrator. No particular form is required for such a written request so long as it can be understood that the appellant is seeking to appeal the Fund administrator's decision to the Board.
- (d) Upon determining that an appeal qualifies as an emergency appeal or upon receipt of an appeal of the Fund administrator's denial of a request for emergency appeal, the Fund administrator shall take the following actions:
 - (1) Set a time and date of a hearing when a quorum of the Board can be present. Subject to quorum requirements, the hearing shall be set within five business days of: (i) the date of the Fund administrator's determination that the appeal qualifies as an emergency appeal, or (ii) the date of receipt of an appeal of the Fund administrator's denial of a request for emergency appeal;
 - (2) Notify the appellant and his or her representative, if any, of the time and date of the hearing;
 - (3) Notify the plan administrator of the time and date of the hearing, provide the plan administrator with a copy of the written request for an emergency appeal filed by the appellant, and invite the plan administrator to submit a written statement of the plan administrator's position regarding the emergency appeal. If the plan administrator submits such a written statement, a copy shall be provided by the Fund administrator to the appellant;
 - (4) In the notices to the appellant and plan administrator, the Fund administrator shall request the parties to provide the Fund administrator with copies of any documents, records, written

- testimony, or other written evidence that they wish the Board to consider at the hearing. To facilitate the hearing, the Fund administrator may request that the parties stipulate to the admission of all or any of such documents, records, written testimony, or other written evidence; and
- (5) Prior to the hearing, the Fund administrator shall provide each member of the Board that will attend the hearing with copies of the written request for an emergency appeal and any written statement of position by the plan administrator.
- (e) Unless the appellant expressly requests a public hearing, any hearing under this Rule shall be closed to the public. At the hearing, the following procedures shall apply:
- (1) The hearing shall be chaired by the EUTF chair, vice-chair, or secretary-treasurer. If none of these officers is present, the Board shall elect one of their members to chair the hearing;
 - (2) The chair shall be in charge of regulating the course and conduct of the hearing;
 - (3) The chair shall make all rulings on the admission, exclusion, or limitation of testimony and evidence. The admissibility of testimony and evidence shall not be governed by the laws of evidence. All relevant oral or documentary evidence shall be admitted if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs. Irrelevant, immaterial, or unduly repetitious material shall not be admitted into evidence. The chair shall give effect to the privileges recognized by law;
 - (4) At the outset of the hearing, the chair shall provide a brief overview of the procedures that will apply to the hearing. Following this, the Fund administrator or other representative of the Fund staff shall state the nature and background of the proceeding, including the name of the appellant, the decision being appealed, and the relief being requested;
 - (5) After the presentation by the Fund administrator or staff, the appellant shall present his or her testimony, evidence, and arguments in support of the appeal. Following the appellant, the plan administrator shall present its testimony, evidence, and argument, if any, in support of the decision being appealed. At any time during the hearing, the Board may ask questions to the appellant, plan administrator, Fund staff, and any witnesses who

- testify at the hearing. At the conclusion of the hearing, both the appellant and plan administrator may present final arguments in support of their positions;
- (6) At any time during the hearing, the Board may enter executive session to consult counsel regarding any legal issues involved in the appeal; and
 - (7) Prior to the conclusion of the hearing, the Board shall announce its decision on the appeal to the appellant and plan administrator. The Board shall subsequently issue the Board's decision in writing. A certified copy of the written decision shall be sent by certified mail, return receipt requested, to the appellant and plan administrator within a reasonable time after the hearing.
- (f) The Fund administrator may designate one or more EUTF staff members to perform any or all of the Fund administrator's duties under this Rule when the Fund administrator is unavailable or otherwise unable to perform such duties.

3.00 ELIGIBILITY FOR ENROLLMENT

- 3.01 Health Benefits
- 3.02 Long-Term Care
- 3.03 Group Life Insurance

3.01 Health Benefits

- (a) Employee-beneficiaries. The following persons shall be eligible to enroll as employee-beneficiaries in the benefit plans offered or sponsored by the Fund:
- (1) An employee;
 - (2) A retired employee;
 - (3) The surviving spouse or domestic partner of an employee who is killed in the performance of the employee's duty, provided the surviving spouse or domestic partner does not remarry or enter into a domestic partnership;
 - (4) The unmarried child of an employee who is killed in the performance of the employee's duty, provided the child is under the age of nineteen and does not have a surviving parent who is eligible to be an employee-beneficiary;
 - (5) The surviving spouse or domestic partner of a deceased retired employee, provided the surviving spouse or domestic partner does not remarry or enter into a domestic partnership; and
 - (6) The unmarried child of a deceased retired employee, provided the child is under the age of nineteen and does not have a surviving parent who is eligible to be an employee-beneficiary.

With respect to subsections (3) and (5), a surviving spouse or domestic partner ceases to be an eligible employee-beneficiary once the spouse or domestic partner remarries or enters into a domestic partnership even though the spouse or domestic partner may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of domestic partnership, or death. A surviving domestic partner shall not cease to be eligible under subsections (3) or (5) because the death of the employee or retired employee prevents him or her from further meeting the requirements of parts (1), (2), (3), (6), and (8) of the definition of "domestic partner" in Rule 1.02. With respect to subsections (4) and (6),

an unmarried child ceases to be eligible as of midnight of the child's nineteenth birthday.

Notwithstanding any other provision in these rules to the contrary, an employee-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan shall not be eligible for coverage under any benefit plan offered or sponsored by the Fund until the employee-beneficiary enrolls in the Medicare Part B medical insurance plan.

- (b) Dependent-beneficiaries. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund:
- (1) An employee-beneficiary's spouse or domestic partner;
 - (2) An employee-beneficiary's or domestic partner's unmarried child, provided the child is either under the age of nineteen or a full-time student and under the age of twenty-four;
 - (3) An employee-beneficiary's or domestic partner's unmarried child, regardless of age, who is incapable of self-support because of a mental or physical incapacity that existed prior to the child reaching the age of nineteen; and
 - (4) A child for whom an employee-beneficiary must provide health benefit coverage under the terms of a qualified medical child support order.

With respect to subsection (2), an unmarried child ceases to be eligible as of midnight of the child's nineteenth or twenty-fourth birthday, as applicable. With respect to subsections (2) and (3), the child of a domestic partner ceases to be eligible upon the dissolution of the domestic partnership. In addition, as a condition of eligibility for any child over the age of nineteen, the employee-beneficiary shall provide the Fund with written proof reasonably satisfactory to the Fund of the full-time student status of such child. Such written proof shall be provided at such times and in such form as the Fund may from time to time direct.

Notwithstanding any other provisions in these rules to the contrary, a dependent-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan shall not be eligible for coverage under any retiree benefit plan offered or sponsored by the Fund until the dependent-beneficiary has enrolled in the Medicare Part B medical insurance plan.

3.02 Long-Term Care

The following persons shall be eligible for any long-term care benefit plans offered or sponsored by the Fund, provided that they comply with the age, enrollment, medical underwriting and contribution requirements of such plans:

- (1) Employee-beneficiaries and their spouses, parents, and grandparents;
- (2) Employee-beneficiaries' in-law parents and grandparents; and
- (3) Qualified-beneficiaries who enroll between the ages of twenty and eighty-five.

3.03 Group Life Insurance

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

4.00 ENROLLMENT PROCEDURES

- 4.01 Application for Enrollment
- 4.02 Rejection of an Enrollment Application
- 4.03 Dual or Multiple Enrollment
- 4.04 Date of Filing
- 4.05 Failure to File Properly Completed Enrollment Application Within the Prescribed Time; Effect on Coverage Dates
- 4.06 Notification of Changes in Personal Information
- 4.07 Verification of Eligibility
- 4.08 Exceptions to the Timely Filing of an Enrollment Application
- 4.09 Open and Special Enrollment Periods
- 4.10 Continuation of Coverage
- 4.11 Contribution Shortage
- 4.12 Cancellation of Enrollment; Effective Dates of Cancellation
- 4.13 Termination of Enrollment; Effective Dates of Termination
- 4.14 Reinstatement of Enrollment

4.01 Application for Enrollment

- (a) An employee-beneficiary shall file an enrollment application, in the form prescribed by the board or by the board's policy, to enroll, change or cancel an enrollment in any benefit plan, including long term care, offered or sponsored by the Fund. Unless otherwise provided by the board or by the board's policy, all enrollment applications shall be filed by the employee-beneficiary with: (1) in the case of an employee, the employee's employer; and (2) in all other cases, the Fund. Notwithstanding the foregoing, upon retirement, an employee-beneficiary shall file an enrollment application to enroll or change enrollment in the benefit plans offered or sponsored by the Fund with the entity that pays his or her retirement or pension allowance. Thereafter, the retired employee-beneficiary shall file any and all enrollment applications directly with the Fund.
- (b) With due consideration of appropriate federal or state laws, the board shall set the standards and procedures for filing such enrollment applications, including, but not limited to, the form of such enrollment applications, the information required to be provided by the employee-beneficiary on such enrollment applications, and the method for filing such enrollment

applications. Enrollment applications shall include the employee-beneficiary's authorization to the state comptroller or the appropriate county director of finance to assign sufficient compensation to the Fund in payment of all contributions due from such employee-beneficiary for enrollment or coverage in any and all Fund benefit plans.

- (c) A representative of an employee-beneficiary may file an enrollment application for the employee-beneficiary if:
 - (1) The representative has a written authorization signed by the employee-beneficiary that authorizes the representative to file such enrollment applications; or
 - (2) A valid court order authorizes the representative to file such enrollment applications.

4.02 Rejection of an Enrollment Application

- (a) Any enrollment application may be rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.
- (b) An enrollment application shall be rejected if:
 - (1) The application seeks to enroll a person who is not eligible to enroll in the benefit plan for which enrollment is requested;
 - (2) The application is not filed within the time limitations prescribed by these rules;
 - (3) The application contains an intentional misstatement or misrepresentation of a material fact or contains other information of a fraudulent nature;
 - (4) The employee-beneficiary owes past due contributions or other amounts to the Fund; or
 - (5) Acceptance of the application would violate applicable federal or state law or any other provision of these rules.
- (c) Notification shall be provided to the employee-beneficiary of the rejection of any enrollment application.

4.03 Dual or Multiple Enrollment

- (a) No person may be enrolled simultaneously in any benefit plan offered or sponsored by the Fund as both an employee-beneficiary and a dependent-beneficiary, nor may unmarried children be enrolled by more than one employee-beneficiary. The Fund shall cancel such dual coverage enrollments.
- (b) Where an employee-beneficiary files more than one enrollment application, the enrollment application bearing the latest filing date shall be the one used by the Fund to process the employee-beneficiary's enrollment, provided the employee-beneficiary is eligible for such enrollment.

4.04 Date of Filing

An employee-beneficiary's enrollment application, beneficiary designation, or any other form required to be filed with the Fund shall be deemed to have been filed with the Fund on the date that the following entities, as applicable, actually receive such forms: (1) the employee-beneficiary's employer; (2) the entity that pays the employee-beneficiary's retirement or pension allowance; or (3) the Fund. However, if filed before the time or times prescribed in these rules, an enrollment application, beneficiary designation, or other form shall be deemed to have been filed on the date that the person would have been first eligible to file that document.

4.05 Failure to File Properly Completed Enrollment Application Within the Prescribed Time; Effect on Coverage Dates

Except as otherwise provided in these rules or by applicable federal or state law, the following shall apply to all applications to enroll in the benefit plans offered or sponsored by the Fund, to add or delete dependent-beneficiaries, or to change enrollments or coverages:

- (a) No enrollment of an employee-beneficiary, addition or deletion of a dependent-beneficiary, or change in an enrollment or coverage shall be effective without the filing of a properly completed enrollment application.
- (b) The effective dates of coverage, deletions of coverage, and changes in coverage shall be dependent on the filing of a properly completed

enrollment application within thirty days of the specified event that allows the filing of the application.

- (c) An employee-beneficiary who fails to file an enrollment application within the time prescribed by subsection (b) or any otherwise applicable rule shall not be permitted to file that application until the next open or special enrollment period.

4.06 Notification of Changes in Personal Information

Each employee-beneficiary shall immediately notify the Fund in writing of any changes in the employee-beneficiary's name or address or marital or domestic partnership status, of the birth or adoption of a child or any other changes in the family status of the employee-beneficiary, and any other material changes in the information previously filed by the employee-beneficiary as part of an enrollment application. Each notice to the Fund shall be submitted through the employee-beneficiary's employer or, if none, shall be submitted directly to the Fund.

4.07 Verification of Eligibility

The board may require periodic verification of eligibility for employee-beneficiaries and dependent-beneficiaries enrolled by an employee-beneficiary in Fund benefit plans. The board may set standards and procedures for the required verification. If verification is not provided in accordance with the standards and procedures established by the board, the dependent-beneficiary's enrollment shall be cancelled as set forth in Rule 4.12(d).

4.08 Exceptions to the Timely Filing of an Enrollment Application

- (a) Rule 4.05 and the times for filing enrollment applications prescribed in these rules shall not apply to the following persons:
 - (1) Retired members who are currently enrolled in a benefit plan offered or sponsored by the Fund;
 - (2) The surviving spouse, domestic partner, or any unmarried child under the age of nineteen of a deceased retired member who is eligible as an employee-beneficiary under Rule 3.01(a); and

- (3) The surviving spouse, domestic partner, or any unmarried child under the age of nineteen of any employee who is killed in the performance of duty who is eligible as an employee-beneficiary under Rule 3.01(a).
- (b) Coverage for the persons covered by subsection (a) shall become effective on the later of:
 - (1) The date of the event that makes the person eligible for enrollment when a properly completed enrollment application is filed within thirty days of the event; or
 - (2) The first day of the month following the date the person files a properly completed enrollment application.
- (c) Nothing in this rule shall permit an employee-beneficiary or dependent-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan to be covered under any benefit plan offered or sponsored by the Fund until enrolled in the Medicare Part B medical insurance plan. Further, nothing in this rule is meant to permit the enrollment of any person who is not otherwise eligible for enrollment in the benefit plan offered or sponsored by the Fund.

4.09 Open and Special Enrollment Periods

Except as otherwise provided by these rules, an employee-beneficiary may file an enrollment application during an open or special enrollment period to make any one or a combination of specific enrollment changes that have been approved by the board for that open or special enrollment period. The changes that the board may approve include, but are not limited to, changes from non-enrolled to enrolled status, changes between plans, changes in levels of coverage, and cancellations. All changes made shall become effective on the date approved by the board for the open or special enrollment period.

4.10 Continuation of Coverage

Subject to applicable federal and state law, coverage under the benefit plans offered or sponsored by the Fund shall continue:

- (a) Provided the employee-beneficiary meets the eligibility provisions of Rule 3.01 and pays the employee's premium contribution as provided by

statute, the employer's administrative rules, or an applicable bargaining unit agreement;

- (b) While the employee-beneficiary participates in an employee strike authorized by chapter 89, Hawaii Revised Statutes, provided that nothing in this rule shall limit the right or ability of the Fund to collect premium contributions from any public employer or employee-beneficiaries or the remedies available to the Fund to collect such premium contributions.
- (c) When an employee terminates employment and is rehired by a public employer within the same pay period or the next consecutive pay period, the employee shall be considered as having transferred employment. The employee shall be treated as if continuously enrolled in the Fund benefit plans in which the employee was enrolled at the time of termination and shall be required to pay the full cost of coverage to the extent that such is not paid by the employee's public employer. The employee shall not be allowed to change between plans unless the employee's current Fund benefit plan is unavailable at the employee's new employment location.

4.11 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 Fund. The notice shall be sent within thirty days of the date on which the required semi-monthly contribution payment was due. Cancellation of the employee-beneficiary's enrollment due to any contribution shortage shall be as per Rule 4.12(c), and reinstatement of the employee-beneficiary's enrollment after any such cancellation shall be as per Rule 4.14(b).

4.12 Cancellation of Enrollment; Effective Dates of Cancellation

- (a) Voluntary Cancellation Requested by the Employee-Beneficiary. An employee-beneficiary may voluntarily cancel enrollment in a Fund benefit plan at any time by filing an enrollment application requesting cancellation with the employee-beneficiary's employer or, if none, directly with the Fund. The effective date of cancellation shall be the first day of the pay period following the requested cancellation date or, if no date is specified, the effective date of cancellation shall be the first day of the pay

period after which the Fund receives the employee-beneficiary's request for cancellation.

- (b) Cancellation Due to Ineligibility. The enrollment of any ineligible person who was enrolled in error or is ineligible to enroll in or be covered in a benefit plan offered or sponsored by the Fund shall be canceled:
- (1) When the person is notified of the error or ineligibility prior to the effective date of the enrollment, the person shall be treated as if the enrollment application was not submitted.
 - (2) When the person is notified after the effective date of the enrollment, the enrollment shall be canceled on the first day of the second pay period that follows the date of the Fund's notice of cancellation to the ineligible person or employee-beneficiary.
- (c) Cancellation Due to Failure to Pay Contribution Shortage. If any portion of an employee-beneficiary's required semi-monthly or monthly contributions is not paid or is not withheld from the employee-beneficiary's earnings and transmitted to the Fund within 30 days of the date of the notice of contribution shortage, the employee-beneficiary's enrollment and all coverages for dependent-beneficiaries under that enrollment shall be cancelled as of the first day following the last period for which full payment of the employee-beneficiary's required semi-monthly or monthly contributions were paid and transmitted to the Fund. However, the enrollment of the employee-beneficiary and his or her dependent-beneficiaries may be reinstated as provided in Rule 4.14(b). Cancellation of an employee-beneficiary's enrollment pursuant to this rule shall not affect the Fund's right to collect any and all contribution shortages from the employee-beneficiary.
- (d) Cancellation Due to Failure to Comply with Rules. If an employee-beneficiary materially fails to comply with any of the Fund's rules, the employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment may be canceled after notice of such has been provided to the employee-beneficiary. The board may set standards and procedures for providing notice to employee-beneficiaries under this rule. The notice shall at a minimum specify how the employee-beneficiary has failed to comply with the Fund's rules, and a date by which the employee-beneficiary must comply with the Fund's rules in order to avoid

cancellation. The effective date of the cancellation shall be the date set forth in the notice as to when the employee-beneficiary must comply with the Fund's rules in order to avoid cancellation.

4.13 Termination of Enrollment; Effective Dates of Termination

- (a) Termination Due to Change in Employment Status. An employee-beneficiary's enrollment in all benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be terminated upon the employee-beneficiary's loss of eligibility to participate in such plans due to a change in employment status. The effective date of the termination shall be the first day of the pay period following the effective date of the change in employment status.

- (b) Termination Due to Filing of Fraudulent Claims. An employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment may be terminated if the employee-beneficiary files fraudulent claims for benefit. A dependent-beneficiary's coverage in all of the benefit plans offered or sponsored by the Fund may be terminated if the dependent-beneficiary files fraudulent claims for coverage and/or benefits. The effective date of the termination shall be the date that the Fund determines that the employee-beneficiary or dependent-beneficiary, as applicable, has filed fraudulent claims.

- (c) Notice to the Fund; Recovery of Benefits. If an event occurs that makes a person ineligible for continued enrollment or coverage in the benefit plans offered or sponsored by the Fund, that person or employee-beneficiary shall notify the Fund of the event as soon as reasonably practicable. All such notices shall be in writing and shall be sent to the Fund. The Fund shall be entitled to seek recovery of any benefits that were provided to any person after an event that terminated the person's enrollment or that otherwise made that person ineligible for continued enrollment in or coverage by the benefit plans offered or sponsored by the Fund. In seeking to recover benefits under this rule, the Fund shall have the rights of offset and set-off, including without limitation, the right to recover amounts from and out of any and all future benefits payable to the person whose enrollment was terminated or who otherwise ceased to be eligible for continued enrollment or coverage in the Fund's benefit plans.

4.14 Reinstatement of Enrollment

- (a) General Rule. Unless another rule of the Fund expressly applies, an employee-beneficiary whose enrollment in any of the Fund's benefit plans has been cancelled or terminated may not apply for reinstatement in those benefit plans. The employee-beneficiary may only apply for a new enrollment during the Fund's next open enrollment period. Any such new enrollment may be conditioned upon the employee-beneficiary meeting all the Fund's rules for eligibility and enrollment, curing any past deficiencies or failures that led to the employee-beneficiary's cancellation or termination, and providing adequate assurance that the employee-beneficiary will not further engage in the conduct that previously led to the employee-beneficiary's cancellation or termination. Nothing in this Rule shall be deemed to require the Fund to re-enroll any employee-beneficiary whose enrollment has been previously cancelled or terminated.
- (b) Contribution Shortage Cancellation. If an employee-beneficiary's enrollment in the Fund's benefit plan or plans has been cancelled under Rule 4.12 (c), the employee-beneficiary's enrollment in such benefit plan or plans may be reinstated if the employee-beneficiary makes full payment of all contributions due from the employee-beneficiary by the date specified in the contribution shortage notice provided for in Rule 4.11. The reinstatement shall be made so that the employee-beneficiary and his or her dependent-beneficiaries shall suffer no break in coverage. However, if the employee-beneficiary fails to pay all contribution shortages by the date specified in the contribution shortage notice provided for in Rule 4.11, the employee-beneficiary will suffer a break in coverage and may only apply for a new enrollment at the next open enrollment as per Rule 4.14 (a).

5.00 HEALTH AND OTHER BENEFIT PLANS

- 5.01 Enrollment; Effective Dates of Coverage
- 5.02 Changes in Enrollment; Effective Dates of Coverage
- 5.03 Mandatory Change to Medicare Supplemental Plan for Retired Employees
- 5.04 Cancellation Due to Failure to Enroll in Medicare; Effective Date of Cancellation
- 5.05 Termination of Enrollment; Effective Dates of Termination
- 5.06 Reinstatement of Enrollment; Effective Dates of Reinstatement

5.01 Enrollment; Effective Dates of Coverage

- (a) New Employee. An employee-beneficiary may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when the employee-beneficiary is first hired as an employee. At the option of the employee-beneficiary, the effective date of coverage shall be one of the following dates: (1) the date the employee beneficiary is first hired; (2) the first day of the first pay period following the date the employee-beneficiary is first hired; or (3) the first day of the second pay period following the date the employee-beneficiary is first hired. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within thirty (30) days of the date that the employee-beneficiary is first hired. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date the employee-beneficiary is first hired.
- (b) Newly Eligible Employee. An employee-beneficiary, other than a retired member, may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when the employee-beneficiary first becomes an employee due to a change in employment status. At the option of the employee-beneficiary, the effective date of coverage shall be one of the following dates: (1) the date the change in employment status occurs; (2) the first day of the first pay period following the date the change in employment status occurs; or (3) the first day of the second pay period following the date the change in employment status occurs. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within (30) days of the date the change in employment status occurs. If the employee-

beneficiary fails to make a selection, the effective date of coverage shall be the date the change in employment status occurs.

- (c) Loss of Coverage in a Benefit Plan Offered by the Fund. An employee-beneficiary may enroll in the health benefit plans offered or sponsored by the Fund and obtain coverage for dependent-beneficiaries when the employee-beneficiary loses coverage under the benefit plans offered or sponsored by the Fund because the employee-beneficiary's covering enrollment was terminated or the employee-beneficiary ceased to be eligible as a dependent-beneficiary. The effective date of coverage shall be the date of the employee-beneficiary's loss of coverage.
- (d) Loss of Coverage in a Non-Fund Health Benefit Plan. An employee-beneficiary who is eligible but not enrolled, may enroll in the health benefit plans offered or sponsored by the Fund, and obtain coverage for eligible dependent-beneficiaries, when the employee-beneficiary meets the conditions required for a special enrollment under 26 U.S.C. §9801(f) and the federal regulations enacted under or pursuant to that statute. These conditions are:
- (1) At the time that coverage under the Fund's health benefit plans were offered to the employee-beneficiary, the employee-beneficiary was covered by a Non-Fund health benefit plan or a COBRA continuation provision; and
 - (2) The employee-beneficiary declined coverage under the Fund's health benefit plans because of the employee-beneficiary's coverage under the Non-Fund health benefit plan or a COBRA continuation provision; and
 - (3) The employee-beneficiary's coverage under the Non-Fund health benefit plan was terminated as a result of loss of eligibility for that coverage (including as a result of legal separation, divorce, death, termination of employment or reduction of hours of employment) or because employer contributions towards such coverage was terminated; or
 - (4) The employee-beneficiary's coverage under the COBRA continuation provision was exhausted.

The effective date of the coverage under Rule 5.01(d) shall be as follows: If a properly completed enrollment application is filed within thirty (30) days of the date that the employee-beneficiary loses coverage or the date that the employee-beneficiary's COBRA continuation coverage is

exhausted, whichever event is applicable, the effective date of coverage will be the date of that event. If a properly completed enrollment application is filed more than thirty (30) days after the event, the effective date of coverage will be the first day of the pay period after the enrollment application is received.

- (e) Enrollment Due to Changes in Marital, Domestic Partnership or Family Status. An employee-beneficiary who has previously declined coverage in the health benefit plans offered or sponsored by the Fund may enroll in the Fund benefit plans when the employee-beneficiary gains a dependent through a change in marital, domestic partnership or family status, e.g., marriage, entry into domestic partnership, birth, adoption, or issuance of a qualified medical child support order. At the option of the employee-beneficiary, the effective date of enrollment shall be:
- (1) With respect to a change in marital or domestic partnership status, any of the following: (i) The date the Fund receives proper notification of the change in marital or domestic partnership status, (ii) the first day of the first pay period following the date the Fund receives such notification, or (iii) the first day of the second pay period following the date the Fund receives such notification;
 - (2) With respect to the birth, adoption, or placement for adoption of a child, any of the following: (i) the date of the child's birth, adoption, or placement for adoption; (ii) the first day of the first pay period following the date of the child's birth, adoption, or placement for adoption; or (iii) the first day of the second pay period following the date of the child's birth, adoption, or placement for adoption; and
 - (3) With respect to the issuance of a qualified medical child support order, the date specified in the order, or if no date is specified, the date that the order is issued.

The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within thirty (30) days of the date of the event described in Rule 5.01(e)(1)(i) or Rule 5.01(e)(2)(i), as applicable. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date of the event described in Rule 5.01(e)(1)(i) or Rule 5.01(e)(2)(i), as applicable.

- (f) Enrollment or Changes in Enrollment Upon Retirement. An employee-beneficiary may enroll or change coverages in the health benefit plans

offered or sponsored by the Fund and obtain coverage for eligible dependent-beneficiaries when that person begins to receive a retirement allowance from a state or county retirement system. The effective date of the coverage shall be the employee-beneficiary's date of retirement.

- (g) Surviving Spouse, Domestic Partner, or Child of a Deceased Retiree or an Employee Who was Killed in the Performance of Duty. A surviving spouse, domestic partner or unmarried child who is eligible as an employee-beneficiary under Rule 3.01(a) may enroll in the health benefit plans offered or sponsored by the Fund. The effective date of coverage shall be determined under Rule 4.08, the date of the event that permits enrollment being the date that the retiree deceases or the date that the employee is killed in the performance of duty, whichever is applicable.
- (h) The public employer's premium contributions and employee-beneficiary's premium contributions, if any, shall begin as of the first day of the pay period during which the employee-beneficiary's effective date of coverage occurs. The contributions shall not be prorated based on when the employee-beneficiary's coverage begins during the pay period. For example, if an employee-beneficiary's effective date of coverage occurs on any date during the first pay period of a month (first half of a month), the public employer and employee-beneficiary shall make contributions as if the employee-beneficiary had been enrolled in the applicable health benefit plans as of the first day of that first pay period. Similarly, if there is a change in contributions due to an employee-beneficiary's change in enrollment or coverage, the change in contributions shall begin as of the first day of the pay period during which the change in enrollment or coverage occurs. For example, if an employee-beneficiary changes enrollment or coverage during any date during the second pay period of a month (second half of a month), the public employer and employee-beneficiary shall make contributions as if the change in enrollment or coverage had occurred as of the first day of that second pay period.

5.02 Changes in Enrollment; Effective Dates of Coverage

- (a) Additions of Dependents Due to Changes in Marital, Domestic Partnership or Family Status. An employee-beneficiary may change his or her enrollment to add coverage for dependent-beneficiaries in the Fund health benefit plans in which the employee-beneficiary is currently enrolled upon the occurrence of any of the following events: marriage, entry into domestic partnership, birth of a child, adoption of a child, addition of a

foster child, or the issuance of a qualified medical support order. At the option of the employee-beneficiary, the effective date of the change in enrollment shall be:

- (1) With respect to the addition of a spouse, foster child, or other dependent-eligible, any of the following dates: (i) the date that the Fund receives proper notification of the addition of the spouse, foster child, or other dependent-eligible, (ii) the first day of the first pay period following the date that the Fund receives such notification, or (iii) the first day of the second pay period following the date that the Fund receives such notification; or
- (2) With respect to the birth of a child, any of the following dates: (i) the date of the child's birth, (ii) the first day of the first pay period following the date of the child's birth, or (iii) the first day of the second pay period following the date of the child's birth; or
- (3) With respect to the adoption of a child at birth, any of the following dates: (i) the date of the child's birth, provided that the employee-beneficiary provides the Trust Fund with a written certification of intent to adopt the child (in form and content satisfactory to the Fund) and an enrollment application for the child prior to the child's birth or within thirty days thereafter, (ii) the first day of the first pay period following the date of the child's birth, subject to the same conditions set forth above, or (iii) the second day of the second pay period following the date of the child's birth, subject to the same conditions set forth above; or
- (4) With respect to the adoption of a child after birth, any of the following dates: (i) the date of the adoption, provided that the employee-beneficiary provides the Fund with satisfactory documents evidencing the adoption and an enrollment application for the child within thirty days of the date of adoption, (ii) the first day of the first pay period following the date of the adoption, subject to the same conditions set forth above, or (iii) the first day of the second pay period following the date of adoption, subject to the same conditions set forth above; or
- (5) With respect to a child placed for adoption, any of the following dates: (i) the date that the employee-beneficiary assumes custody of and an obligation to support the child in anticipation of adopting the child, provided that the employee-beneficiary provides the Fund with a written certification of intent to adopt the child (in form and content satisfactory to the Fund) and an enrollment application for the child within thirty days of the date that the

- employee-beneficiary assumes custody of and an obligation to support the child, (ii) the first day of the first pay period following the date that the employee-beneficiary assumes custody of and an obligation to support the child in anticipation of adopting the child, subject to the same conditions set forth above, or (iii) the first day of the second pay period following the date that the employee-beneficiary assumes custody of and an obligation to support the child in anticipation of adopting the child, subject to the same conditions set forth above; or
- (6) With respect to a qualified medical child support order, the date specified in the order, or if no date is specified, the date that the order is issued.

Notwithstanding Rule 5.02(a) (5), the effective date of coverage for a child placed for adoption may be any other date that is specified: in an applicable court order, by a government agency placing the child, or by a licensed child placing organization placing the child. Except as otherwise required by law or these rules, Rule 4.05 shall apply to changes of enrollment under this Rule and the employee-beneficiary shall select the effective date of coverage in an enrollment application filed within thirty (30) days of the event described in Rule 5.02(a)(1)(i), 5.02(a)(2)(i), 5.02(a)(3)(i), 5.02(a)(4)(i), or 5.02(a)(5)(i), as applicable. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date of the event described in Rule 5.02(a)(1)(i), 5.02(a)(2)(i), 5.02(a)(3)(i), 5.02(a)(4)(i), or 5.02(a)(5)(i), as applicable.

- (b) Deletions of Dependents Due to Changes in Marital, Domestic Partner or Family Status. An employee-beneficiary shall change his or her enrollment to terminate coverage of dependent-beneficiaries who cease to be eligible for continued enrollment in the Fund health benefit plans upon the occurrence of any of the following events: divorce or dissolution; annulment; legal separation; dissolution or other act ending domestic partnership; death of a spouse, domestic partner or child; failure to complete the adoption of a child; the end of any required coverage of a child under a qualified medical support order; or a child ceases to be eligible for coverage as a dependent-beneficiary under Rule 3.01(b). The effective date of change in coverage shall be the first day of the first pay period following the occurrence of the event. Employee-beneficiaries and dependent-beneficiaries are required to provide the Fund with written notice of the occurrence of these events as soon as reasonably practicable pursuant to Rule 4.06 and Rule 4.13(c).

- (c) Loss of Spouse's or Domestic Partner's Coverage. An employee-beneficiary may change enrollment to add a spouse or domestic partner as a dependent-beneficiary in the Fund health benefit plans in which the employee-beneficiary is currently enrolled when the employee-beneficiary's spouse or domestic partner has lost coverage in any health benefit plan due to an employment termination or other loss of eligibility. The effective date of the change in enrollment shall be the date that the employee-beneficiary's spouse or domestic partner lost coverage in the spouse's or domestic partner's health benefit plan.
- (d) Last Child Becomes Ineligible. An employee-beneficiary may change his or her enrollment in the Fund health benefit plans in which the employee-beneficiary is currently enrolled when the last of the employee-beneficiary's children becomes ineligible for coverage as a dependent-beneficiary under the health benefit plans offered or sponsored by the Fund, e.g., when the child marries, becomes nineteen years of age and is not a full-time student, is between nineteen and twenty-four years of age and ceases to be a full-time student, or becomes twenty-four years of age. The effective date of the change in enrollment shall be the date on which the child lost eligibility.

Notwithstanding Rule 4.06, if the employee-beneficiary fails to give the appropriate notice to the Fund within thirty days of the event, the effective date of the change in coverage shall be the date on which notice was received by the Fund.

- (e) Changes Between Plans. An employee-beneficiary may change between health benefit plans offered or sponsored by the Fund when:
- (1) The employee-beneficiary moves to a residence outside of the geographic areas covered by the employee-beneficiary's present benefit plan. The effective date of the change shall be the date of the employee-beneficiary's relocation.
 - (2) The employee-beneficiary is enrolled in a supplemental health benefits plan offered or sponsored by the Fund and loses primary coverage in a Non-Fund health benefits plan. The effective date of the change shall be the date that the employee-beneficiary loses coverage in the Non-Fund health benefits plan.

- (f) Any change in the public employer's premium contributions and the employee-beneficiary's premium contributions, if any resulting from a change in enrollment or coverage shall begin as of the first day of the pay period in which the effective date of the employee-beneficiary's change in enrollment or coverage occurs. As in Rule 5.01(h), contributions shall not be prorated based on when the employee-beneficiary's change in enrollment or coverage occurs during the pay period.

5.03 Mandatory Enrollment in Medicare Part B for Retired Employees

- (a) An employee-beneficiary or a dependent-beneficiary shall submit a Notice of Enrollment along with proof of enrollment in the federal Medicare Part B medical insurance plan when the employee-beneficiary or dependent-beneficiary becomes eligible to enroll in the federal Medicare Part B medical insurance plan. Notwithstanding Rule 4.05, the effective date of coverage shall be the later of the following:
- (1) The date that the employee-beneficiary or dependent-beneficiary becomes eligible for Medicare provided that proof of enrollment in Medicare Part B is submitted; or
 - (2) The first day of the month in which the Fund receives the employee-beneficiary or dependent-beneficiary's enrollment application and proof of enrollment in Medicare Part B.
- (b) Each public employer shall pay to the Fund a contribution equal to \$50 per month, or such other amount as is determined by the board, for voluntary medical insurance coverage under Medicare for retired members of the employees' retirement system, county pension system, or a police, firefighters, or bandsmen pension of the State or a county as set forth in Chapter 88 of the Hawaii Revised Statutes. Out of such contributions, the Fund shall reimburse the premiums paid, exclusive of any and all Medicare penalties, by the following persons for Medicare Part B medical insurance coverage in the amount of \$50 per month or such other amount as is determined by the board:
- (1) An employee-beneficiary who is a retired employee;
 - (2) The employee-beneficiary's spouse or domestic partner while the employee-beneficiary is living; and

- (3) The employee-beneficiary's spouse or domestic partner after the death of the employee-beneficiary, if the spouse or domestic partner qualifies as an employee-beneficiary under Rule 3.01(a).

Payment of these reimbursements shall be made only for those persons who are enrolled in the Medicare Part B medical insurance plan and pay their Medicare Part B medical insurance premiums to the Social Security Administration.

5.04 Cancellation Due to Failure to Enroll in Medicare; Effective Date of Cancellation

- (a) If an employee-beneficiary becomes eligible to enroll and fails to enroll in the federal Medicare Part B medical insurance plan, the employee-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be cancelled.
- (b) If a dependent-beneficiary becomes eligible to enroll and fails to enroll in the federal Medicare Part B medical insurance plan, the dependent-beneficiary's enrollment in all of the benefit plans offered or sponsored by the Fund shall be cancelled.
- (c) The effective date of any cancellation under this rule shall be the date upon which the employee-beneficiary or dependent-beneficiary, as applicable, first became eligible to enroll in the federal Medicare Part B medical insurance plan.

5.05 Termination of Enrollment; Effective Dates of Termination

- (a) Termination Due to Surviving Spouse's or Domestic Partner's Remarriage or Entry into Domestic Partnership. A surviving spouse's or domestic partner's enrollment in all benefit plans offered or sponsored by the Fund and all coverages for dependent-beneficiaries under that enrollment shall be terminated upon the surviving spouse's or domestic partner's remarriage or entry into a domestic partnership. The effective date of the termination shall be the first day of the pay period following the date of the surviving spouse's or domestic partner's remarriage or entry into a domestic partnership. Notwithstanding the foregoing, the child of a deceased retiree that is eligible to be an employee-beneficiary under Rules 3.01(a)(4) or Rule 3.01(a)(6) may continue his or her coverages by filing an enrollment application under Rule 5.01(g). The effective date of

coverage shall be as provided in Rule 4.08(b), the date of the event making the person eligible for enrollment being the date of termination of coverage due to the surviving spouse's or domestic partner's remarriage or entry into a domestic partnership.

- (b) Termination Due to Child's Loss of Eligibility. A child's enrollment in all benefit plans offered or sponsored by the Fund shall be terminated upon the occurrence of any of the following events:
- (1) The child marries;
 - (2) The child enters active military duty;
 - (3) The child reaches the age of nineteen and is not a full-time student;
 - (4) The child is between the ages of nineteen and twenty-four and ceases to be a full-time student;
 - (5) The child, while still a full-time student, reaches the age of twenty-four; or
 - (6) The employee-beneficiary fails to complete a legal adoption of the child within twelve months of the date that the child is covered by the Fund's benefit plans.

Notwithstanding Rule 5.05 (b) (6), the enrollment of a child placed for adoption shall not be terminated if the employee-beneficiary has custody of and an obligation to support the child under a court order or agreement with a government agency or licensed child placing organization.

With respect to subsections (1) and (2), the loss of eligibility as a dependent-beneficiary is permanent. Unless provided otherwise by these rules or applicable federal or state law, the effective date of the termination shall be the first day of the pay period following the date of the event or, in an event under Rule 5.05 (b) (6), the date stated in a written notice to the employee-beneficiary.

5.06 Reinstatement of Enrollment; Effective Dates of Reinstatement

- (a) Reinstatement in Employment. If as a result of an order or award from a court, arbitrator or other entity with proper jurisdiction over the matter, an employee-beneficiary is found to have been wrongfully terminated or suspended and is ordered to be reinstated in state or county employment, the employee-beneficiary shall be reinstated in the same Fund benefit plans from which the employee-beneficiary's coverage was terminated. The effective date of the reinstatement shall be the date of termination so

that the employee-beneficiary's coverage is continuous, provided that the employee-beneficiary pays the full cost of such coverage less any contribution paid by the employer on behalf of the employee-beneficiary as provided by statute, the employer's administrative rules, or an applicable bargaining unit agreement.

If the full cost of such coverage is not paid, the employee-beneficiary shall have the option of having the reinstatement effective upon any of the following dates: (i) the employee-beneficiary's return to active duty, (ii) the first day of the first pay period following the employee-beneficiary's return to active duty, or (iii) the first day of the second pay period following the employee-beneficiary's return to active duty. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within thirty (30) days of the date that the employee-beneficiary returns to active duty. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date the employee-beneficiary returns to active duty.

- (b) Return From an Authorized Leave of Absence. If an employee-beneficiary returns from an authorized leave of absence ("LOA") during which coverage was not provided by a Fund benefit plan, the employee-beneficiary may be reinstated in the same Fund benefit plans from which coverage was cancelled if the employee-beneficiary files a properly completed enrollment application. At the option of the employee-beneficiary, the reinstatement shall be effective upon any of the following dates: (i) the employee-beneficiary's return from the LOA provided the employee-beneficiary files an enrollment application in accordance with Rule 4.05 within thirty (30) days of his or her return from the LOA, (ii) the first day of the first pay period following the employee-beneficiary's return from the LOA, subject to the same conditions set forth above, or (iii) the first day of the second pay period following the employee-beneficiary's return from the LOA, subject to the same conditions set forth above. If the employee-beneficiary fails to timely file an enrollment application, the reinstatement shall be effective on the first day of the first pay period following the employee-beneficiary's proper filing of the enrollment application.
- (c) Return From a Leave of Absence Covered by the Family Medical Leave Act (FMLA) Or Uniform Services Employment and Reemployment Rights Act (USERRA). If an employee-beneficiary returns from a leave of absence covered under the FMLA or USERRA and the employee-

beneficiary's enrollment in the Fund benefit plans was canceled during that leave of absence, the employee-beneficiary shall be reinstated in the same Fund benefit plans from which coverage was canceled. At the option of the employee-beneficiary, reinstatement shall be effective upon any of the following dates: (i) the date of the employee-beneficiary's return to work, (ii) the first day of the first pay period following the date of the employee-beneficiary's return to work, or (iii) the first day of the second pay period following the date of the employee-beneficiary's return to work. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within thirty (30) days of the date that the employee-beneficiary returns to work. If the employee-beneficiary fails to make a selection, the effective date of coverage shall be the date of the employee-beneficiary's return to work.

- (d) Enrollment in Medicare by a Retired Employee. If the enrollment of an employee-beneficiary or the coverage of a dependent-beneficiary was terminated due to the employee-beneficiary's or dependent-beneficiary's failure to enroll in the federal Medicare Part B medical insurance plan, upon the employee-beneficiary's or dependent-beneficiary's enrollment in such plan and submission of a proper and complete enrollment application to the Fund, the employee-beneficiary or dependent-beneficiary shall be enrolled in or covered by the Medicare supplemental plan offered by the Fund. The coverage shall be effective on the date specified in Rule 5.03.
- (e) The public employer's premium contributions and the employee-beneficiary's premium contributions, if any, shall begin as of the first day of the pay period during which the employee-beneficiary's effective date of coverage occurs. Similarly, if there is a change in contributions due to an employee-beneficiary's change in enrollment or coverage, the change in contributions shall begin as of the first day of the pay period during which the change in enrollment or coverage occurs. As in Rule 5.01(h), contributions shall not be prorated based on when the employee-beneficiary's coverage begins during the pay period or on when an employee-beneficiary's change in enrollment or coverage occurs during the pay period.

The Hawaii Employer-Union Health Benefits Trust Fund Board of Trustees Administrative Rules were adopted during a regular meeting of the Board of Trustees on February 19, 2003, which were amended and approved on

May 19, 2004, August 25, 2004, September 28, 2005, March 22, 2006, September 26, 2007, August 20, 2008, and August 26, 2009. The rules shall take effect on the first day after filing with the Lieutenant Governor's Office.



George Kahooahano, Chairperson
Hawaii Employer-Union Health
Benefits Trust Fund

APPROVED



Linda Lingle
Governor
State of Hawaii

Date Filed, Office of the Lieutenant
Governor

10 JAN 21 P3:10

RECEIVED

APPROVED AS TO FORM:

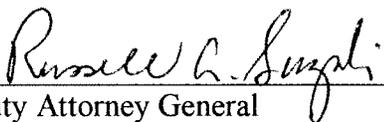

Deputy Attorney General

EXHIBIT D

CONTRACT AND GENERAL CONDITIONS



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

This Contract, executed on the respective dates indicated below, is effective as of
between
State of Hawaii ("STATE"), by its
(hereafter also referred to as the HEAD OF THE PURCHASING AGENCY or designee ("HOPA")),
whose address is
and
("CONTRACTOR"), a
under the laws of the State of
whose business address and federal
and state taxpayer identification numbers are as follows:

RECITALS

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

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

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

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

E. Pursuant to
the STATE is authorized to enter into this Contract.

F. Money is available to fund this Contract pursuant to:
(1)
(Identify state sources)

or (2)
(Identify federal sources)

or both, in the following amounts: State \$
Federal \$

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

1. Scope of Services. The CONTRACTOR shall, in a proper and satisfactory manner as determined by the STATE, provide all the goods or services, or both, set forth in the request for competitive sealed proposals number ("RFP") and the CONTRACTOR'S accepted proposal ("Proposal"), both of which, even if not physically attached to this Contract, are made a part of this Contract.

2. Compensation. The CONTRACTOR shall be compensated for goods supplied

or services performed, or both, under this Contract in a total amount not to exceed _____ DOLLARS

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

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

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

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

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

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

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

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

STATE

(Signature)

(Print Name)

(Print Title)

(Date)

CONTRACTOR

(Name of Contractor)

(Signature)

(Print Name)

(Print Title)

(Date)

CORPORATE SEAL
(If available)

APPROVED AS TO FORM:

Deputy Attorney General

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



STATE OF HAWAII

CONTRACTOR'S ACKNOWLEDGMENT

STATE OF _____)
) SS.
_____ COUNTY OF _____)

On this _____ day of _____, _____ before me appeared _____ and _____, to me known, to be the person(s) described in and, who, being by me duly sworn, did say that he/she/they is/are _____ and _____ of _____, the CONTRACTOR named in the foregoing instrument, and that he/she/they is/are authorized to sign said instrument on behalf of the CONTRACTOR, and acknowledges that he/she/they executed said instrument as the free act and deed of the CONTRACTOR.

(Notary Stamp or Seal)

(Signature)

(Print Name)

Notary Public, State of _____

My commission expires: _____

Doc. Date: _____ # Pages: _____

Notary Name: _____ Circuit _____

Doc. Description: _____

(Notary Stamp or Seal)

Notary Signature Date

NOTARY CERTIFICATION



STATE OF HAWAII
CONTRACTOR'S
STANDARDS OF CONDUCT DECLARATION

For the purposes of this declaration:

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

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

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

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

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

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

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

CONTRACTOR

By _____
(Signature)

Print Name _____

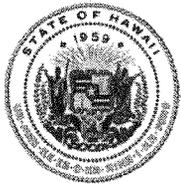
Print Title _____

Name of Contractor _____

Date _____



STATE OF HAWAII
SCOPE OF SERVICES



STATE OF HAWAII
COMPENSATION AND PAYMENT SCHEDULE



STATE OF HAWAII
TIME OF PERFORMANCE



STATE OF HAWAII

CERTIFICATE OF EXEMPTION FROM CIVIL SERVICE

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

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

(Signature)

(Date)

(Print Name)

(Print Title)

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

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

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

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

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

(Signature)

(Date)

(Print Name)

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

GENERAL CONDITIONS

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GENERAL CONDITIONS

1. Coordination of Services by the STATE. The head of the purchasing agency ("HOPA") (which term includes the designee of the HOPA) shall coordinate the services to be provided by the CONTRACTOR in order to complete the performance required in the Contract. The CONTRACTOR shall maintain communications with HOPA at all stages of the CONTRACTOR'S work, and submit to HOPA for resolution any questions which may arise as to the performance of this Contract. "Purchasing agency" as used in these General Conditions means and includes any governmental body which is authorized under chapter 103D, HRS, or its implementing rules and procedures, or by way of delegation, to enter into contracts for the procurement of goods or services or both.
2. Relationship of Parties: Independent Contractor Status and Responsibilities, Including Tax Responsibilities.
 - a. In the performance of services required under this Contract, the CONTRACTOR is an "independent contractor," with the authority and responsibility to control and direct the performance and details of the work and services required under this Contract; however, the STATE shall have a general right to inspect work in progress to determine whether, in the STATE'S opinion, the services are being performed by the CONTRACTOR in compliance with this Contract. Unless otherwise provided by special condition, it is understood that the STATE does not agree to use the CONTRACTOR exclusively, and that the CONTRACTOR is free to contract to provide services to other individuals or entities while under contract with the STATE.
 - b. The CONTRACTOR and the CONTRACTOR'S employees and agents are not by reason of this Contract, agents or employees of the State for any purpose, and the CONTRACTOR and the CONTRACTOR'S employees and agents shall not be entitled to claim or receive from the State any vacation, sick leave, retirement, workers' compensation, unemployment insurance, or other benefits provided to state employees.
 - c. The CONTRACTOR shall be responsible for the accuracy, completeness, and adequacy of the CONTRACTOR'S performance under this Contract. Furthermore, the CONTRACTOR intentionally, voluntarily, and knowingly assumes the sole and entire liability to the CONTRACTOR'S employees and agents, and to any individual not a party to this Contract, for all loss, damage, or injury caused by the CONTRACTOR, or the CONTRACTOR'S employees or agents in the course of their employment.
 - d. The CONTRACTOR shall be responsible for payment of all applicable federal, state, and county taxes and fees which may become due and owing by the CONTRACTOR by reason of this Contract, including but not limited to (i) income taxes, (ii) employment related fees, assessments, and taxes, and (iii) general excise taxes. The CONTRACTOR also is responsible for obtaining all licenses, permits, and certificates that may be required in order to perform this Contract.
 - e. The CONTRACTOR shall obtain a general excise tax license from the Department of Taxation, State of Hawaii, in accordance with section 237-9, HRS, and shall comply with all requirements thereof. The CONTRACTOR shall obtain a tax clearance certificate from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of the Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid and submit the same to the STATE prior to commencing any performance under this Contract. The CONTRACTOR shall also be solely responsible for meeting all requirements necessary to obtain the tax clearance certificate required for final payment under sections 103-53 and 103D-328, HRS, and paragraph 17 of these General Conditions.
 - f. The CONTRACTOR is responsible for securing all employee-related insurance coverage for the CONTRACTOR and the CONTRACTOR'S employees and agents that is or may be required by law, and for payment of all premiums, costs, and other liabilities associated with securing the insurance coverage.

- g. The CONTRACTOR shall obtain a certificate of compliance issued by the Department of Labor and Industrial Relations, State of Hawaii, in accordance with section 103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.
- h. The CONTRACTOR shall obtain a certificate of good standing issued by the Department of Commerce and Consumer Affairs, State of Hawaii, in accordance with section 103D-310, HRS, and section 3-122-112, HAR, that is current within six months of the date of issuance.
- i. In lieu of the above certificates from the Department of Taxation, Labor and Industrial Relations, and Commerce and Consumer Affairs, the CONTRACTOR may submit proof of compliance through the State Procurement Office's designated certification process.

3. Personnel Requirements.

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

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

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

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

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

- (1) The Assignee assumes all of the CONTRACTOR'S obligations;
- (2) The CONTRACTOR remains liable for all obligations under this Contract but waives all rights under this Contract as against the STATE; and
- (3) The CONTRACTOR shall continue to furnish, and the Assignee shall also furnish, all required bonds.

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

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

- c. Reports. All assignment contracts and amendments to this Contract effecting changes of the CONTRACTOR'S name or novations hereunder shall be reported to the chief procurement officer (CPO) as defined in section 103D-203(a), HRS, within thirty days of the date that the assignment contract or amendment becomes effective.
 - d. Actions affecting more than one purchasing agency. Notwithstanding the provisions of subparagraphs 6a through 6c herein, when the CONTRACTOR holds contracts with more than one purchasing agency of the State, the assignment contracts and the novation and change of name amendments herein authorized shall be processed only through the CPO's office.
7. Indemnification and Defense. The CONTRACTOR shall defend, indemnify, and hold harmless the State of Hawaii, the contracting agency, and their officers, employees, and agents from and against all liability, loss, damage, cost, and expense, including all attorneys' fees, and all claims, suits, and demands therefore, arising out of or resulting from the acts or omissions of the CONTRACTOR or the CONTRACTOR'S employees, officers, agents, or subcontractors under this Contract. The provisions of this paragraph shall remain in full force and effect notwithstanding the expiration or early termination of this Contract.
 8. Cost of Litigation. In case the STATE shall, without any fault on its part, be made a party to any litigation commenced by or against the CONTRACTOR in connection with this Contract, the CONTRACTOR shall pay all costs and expenses incurred by or imposed on the STATE, including attorneys' fees.
 9. Liquidated Damages. When the CONTRACTOR is given notice of delay or nonperformance as specified in paragraph 13 (Termination for Default) and fails to cure in the time specified, it is agreed the CONTRACTOR shall pay to the STATE the amount, if any, set forth in this Contract per calendar day from the date set for cure until either (i) the STATE reasonably obtains similar goods or services, or both, if the CONTRACTOR is terminated for default, or (ii) until the CONTRACTOR provides the goods or services, or both, if the CONTRACTOR is not terminated for default. To the extent that the CONTRACTOR'S delay or nonperformance is excused under paragraph 13d (Excuse for Nonperformance or Delay Performance), liquidated damages shall not be assessable against the CONTRACTOR. The CONTRACTOR remains liable for damages caused other than by delay.
 10. STATE'S Right of Offset. The STATE may offset against any monies or other obligations the STATE owes to the CONTRACTOR under this Contract, any amounts owed to the State of Hawaii by the CONTRACTOR under this Contract or any other contracts, or pursuant to any law or other obligation owed to the State of Hawaii by the CONTRACTOR, including, without limitation, the payment of any taxes or levies of any kind or nature. The STATE will notify the CONTRACTOR in writing of any offset and the nature of such offset. For purposes of this paragraph, amounts owed to the State of Hawaii shall not include debts or obligations which have been liquidated, agreed to by the CONTRACTOR, and are covered by an installment payment or other settlement plan approved by the State of Hawaii, provided, however, that the CONTRACTOR shall be entitled to such exclusion only to the extent that the CONTRACTOR is current with, and not delinquent on, any payments or obligations owed to the State of Hawaii under such payment or other settlement plan.
 11. Disputes. Disputes shall be resolved in accordance with section 103D-703, HRS, and chapter 3-126, Hawaii Administrative Rules ("HAR"), as the same may be amended from time to time.
 12. Suspension of Contract. The STATE reserves the right at any time and for any reason to suspend this Contract for any reasonable period, upon written notice to the CONTRACTOR in accordance with the provisions herein.
 - a. Order to stop performance. The Agency procurement officer may, by written order to the CONTRACTOR, at any time, and without notice to any surety, require the CONTRACTOR to stop all or any part of the performance called for by this Contract. This order shall be for a specified

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

- (1) Cancel the stop performance order; or
 - (2) Terminate the performance covered by such order as provided in the termination for default provision or the termination for convenience provision of this Contract.
- b. Cancellation or expiration of the order. If a stop performance order issued under this section is cancelled at any time during the period specified in the order, or if the period of the order or any extension thereof expires, the CONTRACTOR shall have the right to resume performance. An appropriate adjustment shall be made in the delivery schedule or contract price, or both, and the Contract shall be modified in writing accordingly, if:
- (1) The stop performance order results in an increase in the time required for, or in the CONTRACTOR'S cost properly allocable to, the performance of any part of this Contract; and
 - (2) The CONTRACTOR asserts a claim for such an adjustment within thirty (30) days after the end of the period of performance stoppage; provided that, if the Agency procurement officer decides that the facts justify such action, any such claim asserted may be received and acted upon at any time prior to final payment under this Contract.
- c. Termination of stopped performance. If a stop performance order is not cancelled and the performance covered by such order is terminated for default or convenience, the reasonable costs resulting from the stop performance order shall be allowable by adjustment or otherwise.
- d. Adjustment of price. Any adjustment in contract price made pursuant to this paragraph shall be determined in accordance with the price adjustment provision of this Contract.

13. Termination for Default.

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

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

- c. Compensation. Payment for completed goods and services delivered and accepted by the STATE shall be at the price set forth in the Contract. Payment for the protection and preservation of property shall be in an amount agreed upon by the CONTRACTOR and the Agency procurement officer. If the parties fail to agree, the Agency procurement officer shall set an amount subject to the CONTRACTOR'S rights under chapter 3-126, HAR. The STATE may withhold from amounts due the CONTRACTOR such sums as the Agency procurement officer deems to be necessary to protect the STATE against loss because of outstanding liens or claims and to reimburse the STATE for the excess costs expected to be incurred by the STATE in procuring similar goods and services.
- d. Excuse for nonperformance or delayed performance. The CONTRACTOR shall not be in default by reason of any failure in performance of this Contract in accordance with its terms, including any failure by the CONTRACTOR to make progress in the prosecution of the performance hereunder which endangers such performance, if the CONTRACTOR has notified the Agency procurement officer within fifteen (15) days after the cause of the delay and the failure arises out of causes such as: acts of God; acts of a public enemy; acts of the State and any other governmental body in its sovereign or contractual capacity; fires; floods; epidemics; quarantine restrictions; strikes or other labor disputes; freight embargoes; or unusually severe weather. If the failure to perform is caused by the failure of a subcontractor to perform or to make progress, and if such failure arises out of causes similar to those set forth above, the CONTRACTOR shall not be deemed to be in default, unless the goods and services to be furnished by the subcontractor were reasonably obtainable from other sources in sufficient time to permit the CONTRACTOR to meet the requirements of the Contract. Upon request of the CONTRACTOR, the Agency procurement officer shall ascertain the facts and extent of such failure, and, if such officer determines that any failure to perform was occasioned by any one or more of the excusable causes, and that, but for the excusable cause, the CONTRACTOR'S progress and performance would have met the terms of the Contract, the delivery schedule shall be revised accordingly, subject to the rights of the STATE under this Contract. As used in this paragraph, the term "subcontractor" means subcontractor at any tier.
- e. Erroneous termination for default. If, after notice of termination of the CONTRACTOR'S right to proceed under this paragraph, it is determined for any reason that the CONTRACTOR was not in default under this paragraph, or that the delay was excusable under the provisions of subparagraph 13d, "Excuse for nonperformance or delayed performance," the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to paragraph 14.
- f. Additional rights and remedies. The rights and remedies provided in this paragraph are in addition to any other rights and remedies provided by law or under this Contract.

14. Termination for Convenience.

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

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

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

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

- d. Compensation.

- (1) The CONTRACTOR shall submit a termination claim specifying the amounts due because of the termination for convenience together with the cost or pricing data, submitted to the extent required by chapter 3-122, HAR, bearing on such claim. If the CONTRACTOR fails to file a termination claim within one year from the effective date of termination, the Agency procurement officer may pay the CONTRACTOR, if at all, an amount set in accordance with subparagraph 14d(3) below.
- (2) The Agency procurement officer and the CONTRACTOR may agree to a settlement provided the CONTRACTOR has filed a termination claim supported by cost or pricing data submitted as required and that the settlement does not exceed the total Contract price plus settlement costs reduced by payments previously made by the STATE, the proceeds of any sales of goods and manufacturing materials under subparagraph 14c, and the Contract price of the performance not terminated.
- (3) Absent complete agreement under subparagraph 14d(2) the Agency procurement officer shall pay the CONTRACTOR the following amounts, provided payments agreed to under subparagraph 14d(2) shall not duplicate payments under this subparagraph for the following:
 - (A) Contract prices for goods or services accepted under the Contract;
 - (B) Costs incurred in preparing to perform and performing the terminated portion of the performance plus a fair and reasonable profit on such portion of the performance, such profit shall not include anticipatory profit or consequential damages, less amounts paid or to be paid for accepted goods or services; provided, however, that if it appears that the CONTRACTOR would have sustained a loss if the entire Contract would have been completed, no profit shall be allowed or included and the amount of compensation shall be reduced to reflect the anticipated rate of loss;
 - (C) Costs of settling and paying claims arising out of the termination of subcontracts or orders pursuant to subparagraph 14b. These costs must not include costs paid in accordance with subparagraph 14d(3)(B);
 - (D) The reasonable settlement costs of the CONTRACTOR, including accounting, legal, clerical, and other expenses reasonably necessary for the preparation of settlement claims and supporting data with respect to the terminated portion of the Contract and for the termination of subcontracts thereunder, together with reasonable storage, transportation, and other costs incurred in connection with the protection or disposition of property allocable to the terminated portion of this Contract. The total sum to be paid the CONTRACTOR under this subparagraph shall not exceed the

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

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

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

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

- (1) Written notice required. The CONTRACTOR shall give written notice to the Agency procurement officer:
- (A) Prior to the commencement of the performance involved, if at that time the CONTRACTOR knows of the occurrence of such action or omission;
 - (B) Within thirty (30) days after the CONTRACTOR knows of the occurrence of such action or omission, if the CONTRACTOR did not have such knowledge prior to the commencement of the performance; or
 - (C) Within such further time as may be allowed by the Agency procurement officer in writing.
- (2) Notice content. This notice shall state that the CONTRACTOR regards the act or omission as a reason which may entitle the CONTRACTOR to additional compensation, damages, or an extension of time. The Agency procurement officer, upon receipt of such notice, may rescind such action, remedy such omission, or take such other steps as may be deemed advisable in the discretion of the Agency procurement officer;
- (3) Basis must be explained. The notice required by subparagraph 15a(1) describes as clearly as practicable at the time the reasons why the CONTRACTOR believes that additional compensation, damages, or an extension of time may be remedies to which the CONTRACTOR is entitled; and
- (4) Claim must be justified. The CONTRACTOR must maintain and, upon request, make available to the Agency procurement officer within a reasonable time, detailed records to the extent practicable, and other documentation and evidence satisfactory to the STATE, justifying the claimed additional costs or an extension of time in connection with such changes.

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

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

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

- a. Reimbursement for air transportation shall be for actual cost or coach class air fare, whichever is less.
- b. Reimbursement for ground transportation costs shall not exceed the actual cost of renting an intermediate-sized vehicle.
- c. Unless prior written approval of the HOPA is obtained, reimbursement for subsistence allowance (i.e., hotel and meals, etc.) shall not exceed the applicable daily authorized rates for inter-island or out-of-state travel that are set forth in the current Governor's Executive Order authorizing adjustments in salaries and benefits for state officers and employees in the executive branch who are excluded from collective bargaining coverage.

17. Payment Procedures; Final Payment; Tax Clearance.

- a. Original invoices required. All payments under this Contract shall be made only upon submission by the CONTRACTOR of original invoices specifying the amount due and certifying that services requested under the Contract have been performed by the CONTRACTOR according to the Contract.
- b. Subject to available funds. Such payments are subject to availability of funds and allotment by the Director of Finance in accordance with chapter 37, HRS. Further, all payments shall be made in accordance with and subject to chapter 40, HRS.
- c. Prompt payment.
 - (1) Any money, other than retainage, paid to the CONTRACTOR shall be disbursed to subcontractors within ten (10) days after receipt of the money in accordance with the terms of the subcontract; provided that the subcontractor has met all the terms and conditions of the subcontract and there are no bona fide disputes; and
 - (2) Upon final payment to the CONTRACTOR, full payment to the subcontractor, including retainage, shall be made within ten (10) days after receipt of the money; provided that there are no bona fide disputes over the subcontractor's performance under the subcontract.
- d. Final payment. Final payment under this Contract shall be subject to sections 103-53 and 103D-328, HRS, which require a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid. Further, in accordance with section 3-122-112, HAR, CONTRACTOR shall provide a certificate affirming that the CONTRACTOR has remained in compliance with all applicable laws as required by this section.

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

19. Modifications of Contract.

- a. In writing. Any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract permitted by this Contract shall be made by written amendment to this Contract, signed by the CONTRACTOR and the STATE, provided that change orders shall be made in accordance with paragraph 20 herein.
- b. No oral modification. No oral modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract shall be permitted.

- c. Agency procurement officer. By written order, at any time, and without notice to any surety, the Agency procurement officer may unilaterally order of the CONTRACTOR:
- (A) Changes in the work within the scope of the Contract; and
 - (B) Changes in the time of performance of the Contract that do not alter the scope of the Contract work.
- d. Adjustments of price or time for performance. If any modification increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, an adjustment shall be made and this Contract modified in writing accordingly. Any adjustment in contract price made pursuant to this clause shall be determined, where applicable, in accordance with the price adjustment clause of this Contract or as negotiated.
- e. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if written modification of the Contract is not made prior to final payment under this Contract.
- f. Claims not barred. In the absence of a written contract modification, nothing in this clause shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under this Contract or for a breach of contract.
- g. CPO approval. If this is a professional services contract awarded pursuant to section 103D-303 or 103D-304, HRS, any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract which increases the amount payable to the CONTRACTOR by at least \$25,000.00 or ten per cent (10%) of the initial contract price, whichever increase is higher, must receive the prior approval of the CPO.
- h. Tax clearance. The STATE may, at its discretion, require the CONTRACTOR to submit to the STATE, prior to the STATE'S approval of any modification, alteration, amendment, change, or extension of any term, provision, or condition of this Contract, a tax clearance from the Director of Taxation, State of Hawaii, and the Internal Revenue Service, U.S. Department of Treasury, showing that all delinquent taxes, if any, levied or accrued under state law and the Internal Revenue Code of 1986, as amended, against the CONTRACTOR have been paid.
- i. Sole source contracts. Amendments to sole source contracts that would change the original scope of the Contract may only be made with the approval of the CPO. Annual renewal of a sole source contract for services should not be submitted as an amendment.
20. Change Order. The Agency procurement officer may, by a written order signed only by the STATE, at any time, and without notice to any surety, and subject to all appropriate adjustments, make changes within the general scope of this Contract in any one or more of the following:
- (1) Drawings, designs, or specifications, if the goods or services to be furnished are to be specially provided to the STATE in accordance therewith;
 - (2) Method of delivery; or
 - (3) Place of delivery.
- a. Adjustments of price or time for performance. If any change order increases or decreases the CONTRACTOR'S cost of, or the time required for, performance of any part of the work under this Contract, whether or not changed by the order, an adjustment shall be made and the Contract modified in writing accordingly. Any adjustment in the Contract price made pursuant to this provision shall be determined in accordance with the price adjustment provision of this Contract. Failure of the parties to agree to an adjustment shall not excuse the CONTRACTOR from proceeding with the Contract as changed, provided that the Agency procurement officer promptly and duly makes the provisional adjustments in payment or time for performance as may be reasonable. By

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

- b. Time period for claim. Within ten (10) days after receipt of a written change order under subparagraph 20a, unless the period is extended by the Agency procurement officer in writing, the CONTRACTOR shall respond with a claim for an adjustment. The requirement for a timely written response by CONTRACTOR cannot be waived and shall be a condition precedent to the assertion of a claim.
- c. Claim barred after final payment. No claim by the CONTRACTOR for an adjustment hereunder shall be allowed if a written response is not given prior to final payment under this Contract.
- d. Other claims not barred. In the absence of a change order, nothing in this paragraph 20 shall be deemed to restrict the CONTRACTOR'S right to pursue a claim under the Contract or for breach of contract.

21. Price Adjustment.

- a. Price adjustment. Any adjustment in the contract price pursuant to a provision in this Contract shall be made in one or more of the following ways:
 - (1) By agreement on a fixed price adjustment before commencement of the pertinent performance or as soon thereafter as practicable;
 - (2) By unit prices specified in the Contract or subsequently agreed upon;
 - (3) By the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as specified in the Contract or subsequently agreed upon;
 - (4) In such other manner as the parties may mutually agree; or
 - (5) In the absence of agreement between the parties, by a unilateral determination by the Agency procurement officer of the costs attributable to the event or situation covered by the provision, plus appropriate profit or fee, all as computed by the Agency procurement officer in accordance with generally accepted accounting principles and applicable sections of chapters 3-123 and 3-126, HAR.
- b. Submission of cost or pricing data. The CONTRACTOR shall provide cost or pricing data for any price adjustments subject to the provisions of chapter 3-122, HAR.

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

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

- a. The Agency procurement officer may at any time by written order, and without notice to the sureties, if any, make changes within the general scope of the Contract in any one or more of the following:
 - (1) Description of performance (Attachment 1);
 - (2) Time of performance (i.e., hours of the day, days of the week, etc.);
 - (3) Place of performance of services;

- (4) Drawings, designs, or specifications when the supplies to be furnished are to be specially manufactured for the STATE in accordance with the drawings, designs, or specifications;
 - (5) Method of shipment or packing of supplies; or
 - (6) Place of delivery.
- b. If any change causes an increase or decrease in the estimated cost of, or the time required for performance of, any part of the performance under this Contract, whether or not changed by the order, or otherwise affects any other terms and conditions of this Contract, the Agency procurement officer shall make an equitable adjustment in the (1) estimated cost, delivery or completion schedule, or both; (2) amount of any fixed fee; and (3) other affected terms and shall modify the Contract accordingly.
 - c. The CONTRACTOR must assert the CONTRACTOR'S rights to an adjustment under this provision within thirty (30) days from the day of receipt of the written order. However, if the Agency procurement officer decides that the facts justify it, the Agency procurement officer may receive and act upon a proposal submitted before final payment under the Contract.
 - d. Failure to agree to any adjustment shall be a dispute under paragraph 11 of this Contract. However, nothing in this provision shall excuse the CONTRACTOR from proceeding with the Contract as changed.
 - e. Notwithstanding the terms and conditions of subparagraphs 23a and 23b, the estimated cost of this Contract and, if this Contract is incrementally funded, the funds allotted for the performance of this Contract, shall not be increased or considered to be increased except by specific written modification of the Contract indicating the new contract estimated cost and, if this contract is incrementally funded, the new amount allotted to the contract.
24. Confidentiality of Material.
- a. All material given to or made available to the CONTRACTOR by virtue of this Contract, which is identified as proprietary or confidential information, will be safeguarded by the CONTRACTOR and shall not be disclosed to any individual or organization without the prior written approval of the STATE.
 - b. All information, data, or other material provided by the CONTRACTOR to the STATE shall be subject to the Uniform Information Practices Act, chapter 92F, HRS.
25. Publicity. The CONTRACTOR shall not refer to the STATE, or any office, agency, or officer thereof, or any state employee, including the HOPA, the CPO, the Agency procurement officer, or to the services or goods, or both, provided under this Contract, in any of the CONTRACTOR'S brochures, advertisements, or other publicity of the CONTRACTOR. All media contacts with the CONTRACTOR about the subject matter of this Contract shall be referred to the Agency procurement officer.
26. Ownership Rights and Copyright. The STATE shall have complete ownership of all material, both finished and unfinished, which is developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract, and all such material shall be considered "works made for hire." All such material shall be delivered to the STATE upon expiration or termination of this Contract. The STATE, in its sole discretion, shall have the exclusive right to copyright any product, concept, or material developed, prepared, assembled, or conceived by the CONTRACTOR pursuant to this Contract.
27. Liens and Warranties. Goods provided under this Contract shall be provided free of all liens and provided together with all applicable warranties, or with the warranties described in the Contract documents, whichever are greater.

28. Audit of Books and Records of the CONTRACTOR. The STATE may, at reasonable times and places, audit the books and records of the CONTRACTOR, prospective contractor, subcontractor, or prospective subcontractor which are related to:
- a. The cost or pricing data, and
 - b. A state contract, including subcontracts, other than a firm fixed-price contract.

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

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

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

31. Records Retention.

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

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

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

34. Governing Law. The validity of this Contract and any of its terms or provisions, as well as the rights and duties of the parties to this Contract, shall be governed by the laws of the State of Hawaii. Any action at law or in equity to enforce or interpret the provisions of this Contract shall be brought in a state court of competent jurisdiction in Honolulu, Hawaii.
35. Compliance with Laws. The CONTRACTOR shall comply with all federal, state, and county laws, ordinances, codes, rules, and regulations, as the same may be amended from time to time, that in any way affect the CONTRACTOR'S performance of this Contract.
36. Conflict Between General Conditions and Procurement Rules. In the event of a conflict between the General Conditions and the procurement rules, the procurement rules in effect on the date this Contract became effective shall control and are hereby incorporated by reference.
37. Entire Contract. This Contract sets forth all of the agreements, conditions, understandings, promises, warranties, and representations between the STATE and the CONTRACTOR relative to this Contract. This Contract supersedes all prior agreements, conditions, understandings, promises, warranties, and representations, which shall have no further force or effect. There are no agreements, conditions, understandings, promises, warranties, or representations, oral or written, express or implied, between the STATE and the CONTRACTOR other than as set forth or as referred to herein.
38. Severability. In the event that any provision of this Contract is declared invalid or unenforceable by a court, such invalidity or unenforceability shall not affect the validity or enforceability of the remaining terms of this Contract.
39. Waiver. The failure of the STATE to insist upon the strict compliance with any term, provision, or condition of this Contract shall not constitute or be deemed to constitute a waiver or relinquishment of the STATE'S right to enforce the same in accordance with this Contract. The fact that the STATE specifically refers to one provision of the procurement rules or one section of the Hawaii Revised Statutes, and does not include other provisions or statutory sections in this Contract shall not constitute a waiver or relinquishment of the STATE'S rights or the CONTRACTOR'S obligations under the procurement rules or statutes.
40. Pollution Control. If during the performance of this Contract, the CONTRACTOR encounters a "release" or a "threatened release" of a reportable quantity of a "hazardous substance," "pollutant," or "contaminant" as those terms are defined in section 128D-1, HRS, the CONTRACTOR shall immediately notify the STATE and all other appropriate state, county, or federal agencies as required by law. The Contractor shall take all necessary actions, including stopping work, to avoid causing, contributing to, or making worse a release of a hazardous substance, pollutant, or contaminant, and shall promptly obey any orders the Environmental Protection Agency or the state Department of Health issues in response to the release. In the event there is an ensuing cease-work period, and the STATE determines that this Contract requires an adjustment of the time for performance, the Contract shall be modified in writing accordingly.
41. Campaign Contributions. The CONTRACTOR is hereby notified of the applicability of 11-355, HRS, which states that campaign contributions are prohibited from specified state or county government contractors during the terms of their contracts if the contractors are paid with funds appropriated by a legislative body.
42. Confidentiality of Personal Information.
- a. Definitions.
- "Personal information" means an individual's first name or first initial and last name in combination with any one or more of the following data elements, when either name or data elements are not encrypted:
- (1) Social security number;
 - (2) Driver's license number or Hawaii identification card number; or

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

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

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

b. Confidentiality of Material.

- (1) All material given to or made available to the CONTRACTOR by the STATE by virtue of this Contract which is identified as personal information, shall be safeguarded by the CONTRACTOR and shall not be disclosed without the prior written approval of the STATE.
- (2) CONTRACTOR agrees not to retain, use, or disclose personal information for any purpose other than as permitted or required by this Contract.
- (3) CONTRACTOR agrees to implement appropriate "technological safeguards" that are acceptable to the STATE to reduce the risk of unauthorized access to personal information.
- (4) CONTRACTOR shall report to the STATE in a prompt and complete manner any security breaches involving personal information.
- (5) CONTRACTOR agrees to mitigate, to the extent practicable, any harmful effect that is known to CONTRACTOR because of a use or disclosure of personal information by CONTRACTOR in violation of the requirements of this paragraph.
- (6) CONTRACTOR shall complete and retain a log of all disclosures made of personal information received from the STATE, or personal information created or received by CONTRACTOR on behalf of the STATE.

c. Security Awareness Training and Confidentiality Agreements.

- (1) CONTRACTOR certifies that all of its employees who will have access to the personal information have completed training on security awareness topics relating to protecting personal information.
- (2) CONTRACTOR certifies that confidentiality agreements have been signed by all of its employees who will have access to the personal information acknowledging that:
- (A) The personal information collected, used, or maintained by the CONTRACTOR will be treated as confidential;
- (B) Access to the personal information will be allowed only as necessary to perform the Contract; and
- (C) Use of the personal information will be restricted to uses consistent with the services subject to this Contract.

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

- (1) Provide an opportunity for the CONTRACTOR to cure the breach or end the violation; or
- (2) Immediately terminate this Contract.

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

e. Records Retention.

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

EXHIBIT E

EVIDENCE OF COVERAGE AND BENEFIT DESCRIPTIONS

Full benefit descriptions are available at the EUTF Web Site:

<http://eutf.hawaii.gov/links-to-carrier-sites/>

EXHIBIT F

BUSINESS ASSOCIATE AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

This Agreement, is effective as of _____, between the Hawai'i Employer-Union Health Benefits Trust Fund, State of Hawai'i (hereinafter the "STATE"), by its Acting Administrator, whose address is 201 Merchant Street, Suite 1520, Honolulu, Hawai'i 96813, and _____ (hereinafter "BUSINESS ASSOCIATE"), a _____, whose business address is as follows: _____.

RECITALS

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

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

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

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

TERMS AND CONDITIONS

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

The parties acknowledge that entry into this Agreement is necessary and desirable in order to: (a) protect the privacy and security of Protected Health Information and Electronic Protected Health Information in accordance with the Privacy and Security Laws and because BUSINESS ASSOCIATE is a “business associate” of the STATE as that term is used in 45 Code of Federal Regulations (“C.F.R.”) § 160.103; and (b) protect against the unauthorized use and disclosure of Personal Information that BUSINESS ASSOCIATE has been provided or to which BUSINESS ASSOCIATE has access by virtue of a contract with the STATE.

2. Definitions:

- a. Except as otherwise defined herein, any and all capitalized terms in this Agreement shall have the definitions set forth in the Privacy and Security Laws.
- b. Act 10. “Act 10” shall mean Act 10, 2008 Session Laws of Hawai‘i, Special Session.
- c. Agreement. “Agreement” shall mean this agreement between STATE and BUSINESS ASSOCIATE and any and all attachments, exhibits and special conditions attached hereto.
- d. ARRA. “ARRA” shall mean the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, and the rules and regulations promulgated under the ARRA.
- e. Breach. “Breach” shall have the meaning set forth in the ARRA.
- f. De-identified Information. “De-identified Information” shall have the meaning set forth in 45 C.F.R. §§ 164.514(a)-(b).
- g. Electronic Protected Health Information. “Electronic Protected Health Information” shall have the meaning set forth in 45 C.F.R. § 160.103. For purposes of this Agreement, “Electronic Protected Health Information” is limited to Electronic Protected Health Information that is: (i) disclosed to or used by BUSINESS ASSOCIATE by virtue of its contract with the STATE and/or its provision of goods and services to or for the STATE; and/or (ii) created, received, maintained, or transmitted by BUSINESS ASSOCIATE on behalf of the STATE.
- h. Electronic Transactions Rule. “Electronic Transactions Rule” shall mean the final rule set forth in 45 C.F.R. §§ 160 and 162.
- i. HIPAA. “HIPAA” shall mean the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191.
- j. Individual. “Individual” means the person who is the subject of Protected Health Information, and shall include a person who qualifies as a personal representative under 45 C.F.R. § 164.502(g).
- k. Individually Identifiable Health Information. “Individually Identifiable Health Information” shall have the meaning set forth in 45 C.F.R. § 160.103.
- l. Personal Information. “Personal Information” shall have the meaning set forth in Section 487N-1, Hawai‘i Revised Statutes. For purposes of this Agreement,

“Personal Information” is limited to Personal Information provided to BUSINESS ASSOCIATE or to which BUSINESS ASSOCIATE has access by virtue of a contract with the STATE.

- m. Privacy Rule. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R. Part 160 and Part 164, Subparts A and E, as the same may be amended from time to time.
 - n. Privacy and Security Laws. “Privacy and Security Laws” shall include: (1) the provisions of HIPAA that relate to the privacy and security of Protected Health Information and Electronic Protected Health Information; (2) the Privacy and Security Rules; (3) the provisions of ARRA, including the rules and regulations promulgated under the ARRA, that relate to the privacy and security of Protected Health Information and Electronic Protected Health Information; (4) Act 10 and, to the extent applicable, Chapters 487N and 487R, Hawai‘i Revised Statutes; and (5) other Federal and State privacy or security statutes and regulations that apply to Protected Health Information, Electronic Protected Health Information, or Personal Information.
 - o. Protected Health Information. “Protected Health Information” shall have the meaning set forth in 45 C.F.R. § 160.103. For purposes of this Agreement, “Protected Health Information” is limited to Protected Health Information that is: (i) disclosed to or used by BUSINESS ASSOCIATE by virtue of its contract with the STATE and/or its provision of goods and services to or for the STATE; and/or (ii) created, received, maintained, or transmitted by BUSINESS ASSOCIATE on behalf of the STATE .
 - p. Secretary. “Secretary” shall mean the Secretary of the U.S. Department of Health and Human Services or designee.
 - q. Security Rule. “Security Rule” shall mean the Health Insurance Reform: Security Standards at 45 C.F.R. Part 160, Part 162, and Part 164, Subparts A and C, as the same may be amended from time to time.
 - r. Unsecured Protected Health Information. “Unsecured Protected Health Information” shall have the meaning set forth in the ARRA.
3. Obligations and Activities of BUSINESS ASSOCIATE
- a. BUSINESS ASSOCIATE agrees to not use or disclose Protected Health Information, Electronic Protected Health Information, and Personal Information other than as permitted or required by this Agreement or as Required By Law.
 - b. BUSINESS ASSOCIATE agrees to use appropriate safeguards to prevent use or disclosure of Protected Health Information, Electronic Protected Health Information, and Personal Information other than as provided for by this Agreement.
 - c. BUSINESS ASSOCIATE agrees to implement administrative, physical, and technical safeguards (as those terms are defined in the Security Rule) that reasonably and appropriately protect the confidentiality, integrity and availability

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

- (i) Required Safeguards. BUSINESS ASSOCIATE shall use all appropriate safeguards to prevent use or disclosure of Protected Health Information received from, or created or received on behalf of, STATE, other than as provided for in this Agreement or as required by law. These safeguards will include, but are not limited to:
 - (I) Training. Providing annual training to relevant employees, contractors, and subcontractors on how to prevent the improper use or disclosure of Protected Health Information; and updating and repeating training on a regular basis;
 - (II) Administrative Safeguards. Adopting policies and procedures regarding the safeguarding of Protected Health Information; and Enforcing those policies and procedures, including sanctions for anyone not found in compliance;
 - (III) Technical and Physical Safeguards. Implementing appropriate technical safeguards to protect Protected Health Information, including access controls, authentication, and transmission security; and implementing appropriate physical safeguards to protect Protection Health Information, including workstation security and device and media controls.
- d. In accordance with Part V of Act 10, BUSINESS ASSOCIATE agrees to implement: (i) technological safeguards to reduce exposure to unauthorized access to Personal Information, (ii) mandatory training on security awareness topics relating to Personal Information protection for BUSINESS ASSOCIATE's employees, and (iii) confidentiality agreements to be signed by BUSINESS ASSOCIATE's employees. BUSINESS ASSOCIATE further agrees to safeguard Protected Health Information, Electronic Protected Health Information, and Personal Information in accordance with any rules, policies, procedures and directions adopted or implemented by STATE to the extent that such are communicated to BUSINESS ASSOCIATE.
- e. BUSINESS ASSOCIATE agrees to ensure that any agent (including a contractor or subcontractor) to whom it provides Protected Health Information, Electronic Protected Health Information, or Personal Information agrees to the same restrictions and conditions that apply to BUSINESS ASSOCIATE with respect to such information under this Agreement and the Privacy and Security Laws. BUSINESS ASSOCIATE further agrees to ensure that any such agent shall safeguard such Protected Health Information, Electronic Protected Health Information, and Personal Information in accordance with any rules, policies,

procedures and directions adopted or implemented by STATE to the extent that such are communicated to BUSINESS ASSOCIATE. BUSINESS ASSOCIATE agrees to ensure that any such agent shall implement reasonable and appropriate safeguards to protect Protected Health Information.

- f. BUSINESS ASSOCIATE agrees to implement reasonable policies and procedures to comply with 45 C.F.R. § 164.316, as and to the extent that such is required of business associates under the Privacy and Security Laws (as amended by the ARRA).
- g. BUSINESS ASSOCIATE agrees to provide access to Protected Health Information in the Designated Record Set to STATE or, as directed by STATE, to an Individual to the extent and in the manner required by 45 C.F.R. § 164.524.
- h. BUSINESS ASSOCIATE agrees to make Protected Health Information available for amendment and to incorporate any amendments to Protected Health Information that the STATE directs or agrees to in accordance with the requirements of 45 C.F.R. § 164.526.
- i. BUSINESS ASSOCIATE agrees to document disclosures of Protected Health Information, disclosures of Electronic Protected Health Information and information related to such disclosures as would be required for STATE to respond to a request by an Individual for an accounting of disclosures of: (1) Protected Health Information in accordance with 45 C.F.R. § 164.528; and (2) Electronic Protected Health Information in accordance Section 13405(c) of the ARRA. BUSINESS ASSOCIATE further agrees to collect and provide to STATE, any and all information that is reasonably necessary for STATE to timely respond to such requests by an Individual for an accounting of disclosures.
- j. BUSINESS ASSOCIATE agrees to keep a log of Breaches of Unsecured Protected Health Information in such form and with such information as to enable the STATE to comply with Section 13402(e)(3) of the ARRA and the rules and regulations promulgated under ARRA.
- k. BUSINESS ASSOCIATE agrees to keep a complete log of disclosures made of Personal Information in accordance with Section 8(b)(6) of Act 10.
- l. BUSINESS ASSOCIATE agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Protected Health Information and Electronic Protected Health Information available to STATE and/or to the Secretary, at reasonable times and places or as designated by the STATE and/or the Secretary, for purposes of determining compliance with the Privacy and Security Laws. BUSINESS ASSOCIATE further agrees to make its internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Personal Information available to STATE, at reasonable times and places or as designated by the STATE, for purposes of determining compliance with this Agreement, Act 10, and other Federal and State laws regarding the use and disclosure of Personal Information.

- m. BUSINESS ASSOCIATE agrees to report to STATE any disclosure or use of Protected Health Information not provided for by this Agreement, of which BUSINESS ASSOCIATE becomes aware, but in no event later than five (5) business days of first learning of any such use or disclosure. BUSINESS ASSOCIATE further agrees to report to STATE any security incidents that are required to be reported by or to the STATE under 45 C.F.R. Part 164, particularly 45 C.F.R. § 164.314. BUSINESS ASSOCIATE agrees that if any of its employees, agents, subcontractors, and/or representatives use and/or disclose Protected Health Information received from, or created or received on behalf of, STATE, or any derivative De-identified Information in a manner not provided for in this Agreement, BUSINESS ASSOCIATE shall ensure that such employees, agents, subcontractors, and/or representatives shall receive training on BUSINESS ASSOCIATE's procedures for compliance with the Privacy Rule, or shall be sanctioned or prevented from accessing any Protected Health Information BUSINESS ASSOCIATE receives from, or creates or receives on behalf of, STATE. Continued use of Protected Health Information in a manner contrary to the terms of this Agreement shall constitute a material breach of this Agreement.
- n. If there is a Breach of Unsecured Protected Health Information, BUSINESS ASSOCIATE shall: (i) notify the STATE in writing of the Breach no later than twenty (20) calendar days after BUSINESS ASSOCIATE's discovery of the Breach; (ii) investigate and report to STATE on the causes of the Breach, including without limitation, any steps that BUSINESS ASSOCIATE will take to mitigate the Breach and prevent the occurrence of future similar Breaches; (iii) in consultation with STATE, provide all notifications regarding the Breach that STATE and/or BUSINESS ASSOCIATE are required to make under ARRA, including without limitation, written notices to individuals, notices to the media, and notices to the Secretary or any other governmental entity, all such notices to be made in accordance with all ARRA requirements; (iv) unless the Breach is primarily caused by the negligence or other fault of the STATE, indemnify and hold STATE harmless from all claims, lawsuits, administrative proceedings, judgments, damages, liabilities, penalties, and costs arising from the Breach, including all costs of investigating the Breach, providing all required notices, and otherwise complying with all ARRA requirements; and (v) provide a log of all Breaches of Unsecured Protected Health Information to the STATE no later than twenty (20) calendar days after the end of each calendar year, which log shall include all information that STATE needs in order to comply with Section 13402(e)(3) of the ARRA.
- o. If there is a "security breach" regarding Personal Information as that term is defined in Section 487N-1, Hawai'i Revised Statutes, BUSINESS ASSOCIATE shall: (i) notify the STATE in writing of the security breach no later than twenty (20) calendar days after BUSINESS ASSOCIATE's discovery of the security breach; (ii) investigate and report to STATE on the causes of the security breach, including without limitation, any steps that BUSINESS ASSOCIATE will take to mitigate the Breach and prevent the occurrence of future similar Breaches; (iii) in consultation with STATE, provide all notifications regarding the security breach that STATE and/or BUSINESS ASSOCIATE are required to make under Chapter 487N and other applicable Hawai'i Revised Statutes; (iv) unless the security

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

- p. BUSINESS ASSOCIATE agrees to mitigate, to the extent practicable, any harmful effect that is known to BUSINESS ASSOCIATE of: (1) a security breach or disclosure or use of Protected Health Information, Electronic Protected Health Information, or Personal Information by BUSINESS ASSOCIATE in violation of the requirements of this Agreement; and/or (2) a Breach of Unsecured Protected Health Information by BUSINESS ASSOCIATE or any of its officers, employees, or agents (including contractors and subcontractors).
 - q. BUSINESS ASSOCIATE shall, upon notice from STATE, accommodate any restriction to the use or disclosure of Protected Health Information and any request for confidential communications to which STATE has agreed in accordance with the Privacy Rule.
 - r. BUSINESS ASSOCIATE shall comply with any other requirements of the Privacy Law, the Privacy Rule, the Security Law, and the Security Rule not expressly specified in this Agreement, as and to the extent that such requirements apply to business associates under the Privacy Law, the Privacy Rule, the Security Law, and the Security Rule, as they may be amended from time to time.
4. Permitted Uses and Disclosures by BUSINESS ASSOCIATE
- a. General Use and Disclosure Provisions. Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose or use Protected Health Information, Electronic Protected Health Information, and Personal Information to perform functions, activities, or services for, or on behalf of, STATE as specified in this Agreement, provided that such disclosure or use would not violate any Privacy and Security Laws if done by STATE.
 - b. Specific Use and Disclosure Provisions
 - (i) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may use Protected Health Information and Personal Information for the proper management and administration of the BUSINESS ASSOCIATE or to carry out the legal responsibilities of the BUSINESS ASSOCIATE.
 - (ii) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose Protected Health Information for the proper management and administration of the BUSINESS ASSOCIATE, for disclosures that are Required By Law, or where BUSINESS ASSOCIATE obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and be used or further disclosed only as Required

By Law or for the purpose for which it was disclosed to the person and the person agrees to notify BUSINESS ASSOCIATE of any instances where the confidentiality of the information has been breached. Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may disclose Personal Information where such disclosure is permitted by applicable Federal or State laws.

- (iii) Except as otherwise limited in this Agreement, BUSINESS ASSOCIATE may use Protected Health Information to provide Data Aggregation services to STATE as permitted by 45 C.F.R. § 164.504(e)(2)(i)(B).
 - (iv) BUSINESS ASSOCIATE may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 C.F.R. § 164.502(j)(1).
- c. Further Uses Prohibited. Except as provided in sections 4.a and 4.b, above, BUSINESS ASSOCIATE is prohibited from further using or disclosing any information received from STATE, or from any other Business Associate of STATE, for any commercial purposes of BUSINESS ASSOCIATE, including, for example, “data mining”.
5. Minimum Necessary. BUSINESS ASSOCIATE shall only request, use, and disclose the minimum amount of Protected Health Information necessary to accomplish the purpose of the request, use, or disclosure.
 6. Prohibited, Unlawful, or Unauthorized Use and Disclosure of Protected Health Information. BUSINESS ASSOCIATE shall not use or further disclose any Protected Health Information received from, or created or received on behalf of, STATE, in a manner that would violate the requirements of the Privacy Rule, if done by STATE.
 7. Indemnity by BUSINESS ASSOCIATE. BUSINESS ASSOCIATE shall defend, indemnify and hold harmless STATE and STATE’S officers, employees, and agents (including contractors and subcontractors) from and against any and all claims, demands, lawsuits, administrative or other proceedings, judgments, liabilities, damages, losses, fines, penalties, and costs, including reasonable attorneys’ fees, that are caused by or arise out of a breach or failure to comply with any provision of this Agreement and/or by a violation of any provision of the Privacy and Security Laws, including the ARRA, by BUSINESS ASSOCIATE or any of BUSINESS ASSOCIATE’S officers, employees, or agents (including contractors and subcontractors).
 8. Permissible Requests by STATE. STATE shall not request BUSINESS ASSOCIATE to disclose or use Protected Health Information, Electronic Protected Health Information, or Personal Information in any manner that would not be permissible under the Privacy and Security Laws if done by STATE.
 9. Standard Electronic Transactions. STATE and BUSINESS ASSOCIATE agree that BUSINESS ASSOCIATE shall, on behalf of STATE, transmit data for transactions that are required to be conducted in standardized format under the Electronic Transactions Rule. BUSINESS ASSOCIATE shall comply with the Electronic

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

10. Termination for Cause. In addition to any other remedies provided for by this Agreement, upon STATE's knowledge of a material breach or violation by BUSINESS ASSOCIATE of the terms of this Agreement, STATE may either:
- a. Provide an opportunity for BUSINESS ASSOCIATE to cure the breach or end the violation, and terminate this Agreement if Business Associate does not cure the breach or end the violation within the time specified by the STATE; or
 - b. Immediately terminate this Agreement if BUSINESS ASSOCIATE has breached or violated a material term of this Agreement and cure is not possible; and
 - c. If neither termination nor cure is feasible, STATE shall report any violation of the federal Privacy and Security Rules to the Secretary.

11. Effect of Termination.

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

Protected Health Information, and Personal Information, it is understood and agreed that BUSINESS ASSOCIATE shall retain no copies of such information. Destruction of Personal Information shall be performed in accordance with Chapter 487R, Hawai'i Revised Statutes. Notwithstanding the foregoing, BUSINESS ASSOCIATE shall not destroy any Protected Health Information in less than six (6) years from the date that it is received by BUSINESS ASSOCIATE.

- d. If STATE determines that return or destruction of all or any part of the Protected Health Information, Electronic Protected Health Information, and Personal Information is not feasible or opts not to require the return or destruction of such information, BUSINESS ASSOCIATE shall extend the protections, limitations, requirements, and other provisions of this Agreement to such information for so long as BUSINESS ASSOCIATE maintains such information. STATE understands that BUSINESS ASSOCIATE's need to maintain portions of the Protected Health Information in records of actuarial determinations and for other archival purposes related to memorializing advice provided, can render return or destruction infeasible.
- e. The provisions of this Section 8 shall apply with respect to all terminations of this Agreement, for any reason whatsoever, and to any and all Protected Health Information, Electronic Protected Health Information, and Personal Information in the possession or control of any and all agents and subcontractors of BUSINESS ASSOCIATE.

12. Miscellaneous

- a. Regulatory References. A reference in this Agreement to a section in the Privacy and Security Laws means the section in effect or as amended.
- b. Amendment. BUSINESS ASSOCIATE and STATE agree to take all actions necessary to amend this Agreement in order for STATE to comply with the requirements of the Privacy Rule, Security Rule, HIPAA, ARRA, and/or any other Federal or State law that is determined to apply to the Protected Health Information, Electronic Protected Health Information, or Personal Information covered by this Agreement. All amendments shall be in writing and executed by both parties.
- c. Survival. The respective rights and obligations of STATE and BUSINESS ASSOCIATE under Sections 3, 5, and 8 above, shall survive the termination of this Agreement.
- d. Interpretation. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the Privacy and Security Laws, as amended, the Privacy and Security Laws shall control. Where provisions of this Agreement are different than those mandated in the Privacy or Security Laws, but are nonetheless permitted by the Privacy or Security Laws, the provisions of this Agreement shall control. Any ambiguity in this Agreement shall be resolved to permit STATE to comply with the Privacy and Security Laws.

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

HAWAI‘I EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (“STATE”)

By _____
Its Acting Administrator

Date: _____, 2013

[*name of business associate*]
 (“BUSINESS ASSOCIATE”)

By _____
Its _____

Date: _____, 2013

APPROVED AS TO FORM:

Deputy Attorney General

EXHIBIT G

SAMPLE 834 FILES FOR EUTF ELIGIBILITY TRANSACTIONS

Full File Specifications								
INTERCHANGE CONTROL HEADER								
Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Interchange Control Header	ISA01	B.3	6	ISA*00		No Authorization Information Present	
1	Authorization Information	ISA02	B.3	11	*.....			Spaces are represented by "." for clarity
1	Security Information Qualifier	ISA03	B.4	3	*00		No Security Information Present	
1	Security Information	ISA04	B.4	11	*.....			Spaces are represented by "." for clarity
1	Sender Interchange ID Qualifier	ISA05	B.4	3	*30		US Federal Tax Identification Number to Follow	
1	Sender Interchange ID	ISA06	B.4	10	*990266961		SendersFederalTaxID	
1	Receiver Interchange ID Qualifier	ISA07	B.4 - B.5	3	*	30 01 ZZ	Provider Code	
1	Receiver Interchange ID	ISA08	B.5	10	*	To be supplied by Provider	ReceiversFederalTaxID	Provider supplied Federal Tax Identification Number
1	Interchange Date	ISA09	B.5	9	*CCYYMMDD			The calendar date the file was created.
1	Interchange Time	ISA10	B.5	5	*HHMM			The time the file was created.
1	Interchange Control Standards Identifier	ISA11	B.5	2	*U		US EDI Community of ASCX12	
1	Interchange Control Version Number	ISA12	B.5	5	*00401			
1	Interchange Control Number	ISA13	B.5	10	*000000001			
1	Acknowledgement Requested	ISA14	B.6	2	*0			
1	Usage Indicator	ISA15	B.6	2	*	T P	Test Production	
1	Component Element Separator	ISA16	B.6	2	*	Colon		
FUNCTIONAL GROUP HEADER								
Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
2	Functional Identifier Code	GS01	B.8	5	GS*BE		Benefit Enrollment and Maintenance (834)	
2	Application Sender's Code	GS02	B.8	10	*EUTF		SendersID	
2	Application Receiver's Code	GS03	B.8	10	*	To be assigned	Provider ID Code	Assigned Provider ID Code
2	Date	GS04	B.8	9	*CCYYMMDD			The calendar date the file was created.
2	Time	GS05	B.8	5	*HHMM			The time the file was created.
2	Group Control Number	GS06	B.9	10	*000000001			Control Number: Start with 0000001 and increment
2	Responsible Agency Code	GS07	B.9	2	*X		Accredited Standards Committee X12	
2	Version/Release/Industry Identifier Code	GS08	B.9	11	*004010X095			
TRANSACTION SET HEADER								
Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
3	Transaction Identifier Code	ST01	B.17	6	ST*834		Benefit Enrollment and Maintenance	
3	Transaction Control Number	ST02	B.17	9	*00000001			Control Number: Start with 0000001 and increment
BEGINNING SEGMENT								

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
 Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
4	Transaction Purpose Code	BGN01	28 - 29	6	BGN*00		First time transaction sent	
4	Transaction Identifier Code	BGN02	29	1/30	*			Identifies particular Transaction set, should increment on each transmission. Start with 01 and increment. Provider used in concatenation: provider, trans_set_control_num , plan_descr, as of date.
4	Transaction Date	BGN03	29	9	*CCYYMMDD			The calendar date the data within the file is effective
4	Transaction Time	BGN04	29	5	*HHMM			
4	Time Code	BGN05	29	2	*HS			Hawaii Daylight Time
4	Reference Identification	BGN06	29	0	*			Not Used
4	Reference Identification	BGN07	29	0	*			Not Used
4	Action Code	BGN08	29	1	*	4 (Verify - Full) 2 (Change - Trans)		
TRANSACTION SET POLICY NUMBER								
5	Entity Identification Qualifier	REF01	32	6	REF*38		Master Policy Number	
5	Entity Identification	REF02	33	9	*PolicyNumber		Based on Provider and Group Number.	Same as REF01 IL Provider Group Policy
FILE EFFECTIVE DATE								
6	Date/Time Qualifier	DTP01	34	3	DTP*303			
6	Date/Time Period Format Qualifier	DTP02	34	2	*D8			
6	Date/Time Period	DTP03	34	8	*CCYYMMDD			
SPONSOR NAME								
7	Sponsor Entity ID Code	N101	35	5	N1*P5		Plan Sponsor	
7	Sponsor Entity Name	N102	36	26	*EUTF		EmployerGroupName	
7	Sponsor Entity ID Code Qualifier	N103	36	3	*FI		Federal Taxpayer's Identification Number	
7	Sponsor Entity Identification Code	N104	36	10	*990266961			
PAYOR								
8	Insurer Identity Code	N101	35	5	N1*IN		Insurer	
8	Insurer Identity Name	N102	36	5	*	To be supplied by Provider	Provider Identity Name	Provider supplied Identity Name
8	Insurer Identification Code Qualifier	N103	36	3	*FI		Federal Taxpayer's Identification Number	
8	Insurer Identification Code	N104	36	10	*	To be supplied by Provider		Provider supplied Federal Tax Identification Number
DETAIL								
Line	Field	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Subscriber Indicator	INS01	44	5	INS*	Y N	Yes - Subscriber No - Not Subscriber	

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Individual Relationship Code	INS02	44 - 45	3	*	18 01 19 23 53	Subscriber Spouse Child Sponsored Dependent - Not Used Life Partner	
1	Maintenance Type Code	INS03	45	4	*30		Audit or Compare	
1	Maintenance Reason Code	INS04	46 - 47	3	*XN		Notification Only - Used in complete enrollment transmissions. Used when INS03 equal to 030.	
1	Benefit Status Code	INS05	47 - 48	2	*	A C S T	Active COBRA - Not Used Surviving Insured Tax Equity and Fiscal Responsibility Act (TEFRA) - Not Used	
1	Medicare Plan Code	INS06	48	2	*	C A B Blank	C - MedA and MedB A - MedA B - MedB Blank - None	
1	COBRA Qualifying Event Code	INS07	48	2	*	Not Used	No value is passed	
1	Employment Status Code	INS08	49	3	*	AC AO AU L1 RT FT	Active - Not Used Active Military - Overseas - Not Used Active Military - USA - Not Used Leave of Absence - Not Used Retired Full Time	
1	Student Status Code	INS09	49	2	*	F Blank	Full-time Not a student	
1	Handicap Indicator Code	INS10	49	2	*	Blank Y	Not Handicapped Handicapped	
1	Date Time Qualifier	INS11	50	3	*D8		Date Expressed in Format CCYYMMDD	
1	Member Date of Death	INS12	50	9	*CCYYMMDD			
2	Subscriber Number	REF01	51	6	REF*0F		Subscriber Number	Loop 2000, Data Element 128
2	Subscriber Identifier	REF02	52	10	*SSN			
3	Subscriber Number	REF01	53	6	REF*IL		Member Policy Number	Loop 2000, Data Element 128

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000

Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
3	Subscriber Identifier	REF02	53	10	*Member Policy Number			Uses Master Policy Number Same as REF01 38
4	Member Identification Number Qualifier	REF01	55 - 56	6	REF*DX		Billing Location	Loop 2000, Data Element 128
4	Member Identification Division Number	REF02	56	5	*Dept			
5	Member Identification Number Qualifier	REF01	55 - 56	6	REF*17		Bargaining Unit	Loop 2000/Loop 2300, Data Element 128
5	Member Identification Division Number	REF02	56	5	*Bargaining Unit			
6	Member Identification Number Qualifier	REF01	55-56	6	REF*F6		Health Insurance Claim (HIC) Number	To be sent for medical plan only
6	Member Identification Division Number	REF02	56	30	*Member HICN		Use when reporting Medicare eligibility for a member	Loop 2000, Data Element 128
7	Subscriber Number	REF01	55 - 56	6	REF*23		Employee ID	Loop 2000, Data Element 128
7	Subscriber Identifier	REF02	56	10	*Employee ID			
8	Subscriber Number	REF01	152 - 153	6	REF*6O		Dependent SSN	Loop 2320, Data Element 128
8	Subscriber Identifier	REF02	153	10	*Dependent SSN			
9	Subscriber Number	REF01	152 - 153	6	REF*Q4		VEBA Grandfather Status	Loop 2320, Data Element 128
9	Subscriber Identifier	REF02	153	10	*Y or N		Y - VEBA Grandfather Member N - Not VEBA Grandfather Member	
10	Member Event Date Qualifier	DTP01	59 - 60	7	DTP*303		Maintenance Effective	Loop 2000, Data Element 374
10	Member Event Date Format Qualifier	DTP02	60	3	*D8		Date Expressed in Format CCYYMMDD	
10	Member Event Date	DTP03	60	9	*CCYYMMDD			
10	Member Entity Identifier Code	NM101	62, 81	6	NM1*IL		Insured or Subscriber	Loop 2100, Data Element 98
11	Member Entity Type Qualifier	NM102	62, 81 - 82	2	*1		Person	
11	Member Last Name	NM103	62, 81 - 82	1/35	*LastName			
11	Member First Name	NM104	62, 81 - 82	11	*FirstName			
11	Member Middle Name	NM105	62, 81 - 82	2	*MiddleInitial			
11	Name Prefix	NM106	62, 81 - 82	3	*	Not Used	No value is passed	
11	Name Suffix	NM107	62, 81 - 82	3	*	JR SR Not Used		
11	Member Identification Number Qualifier	NM108	62, 81 - 82	3	*34		Social Security Number	
11	Member Identification Number	NM109	62, 81 - 82	10	*SSN			
12	Member Residence Street Address - 1	N301	67	53	N3*SubscriberStreetAddress1			
12	Member Residence Street Address - 2	N302	67	51	*SubscriberStreetAddress2			
13	Member Residence City	N401	68	19	N4*SubscriberCityName			
13	Member Residence State	N402	68	3	*SubscriberStateAbbreviationCode			
13	Member Residence Zip Code - 1	N403	69	6	*SubscriberZipCode1			
13	Member Residence Zip Code - 2	N403	69	4	SubscriberZipCode2			

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000

Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
13	Member Residence Country Code	N404	69	4	*	USA CAN JPN	United States Canada Japan	Required only if country is not USA.
14	Member Demographic Date Format Qualifier	DMG01	70	6	DMG*D8		Date Expressed in Format CCYYMMDD	
14	Member Birth Date	DMG02	71	9	*CCYYMMDD		Birth date	
14	Member Gender Code	DMG03	71	2	*	F M	Female Male	
14	Member Martial Status	DMG04	71	1	*	I M B	Single Married Domestic Partner	
10	Member Entity Identifier Code	NM101	62, 81	6	NM1*31		Postal Mailing Address	Optional only if subscriber has separate mailing address
11	Member Entity Type Qualifier	NM102	62, 81 - 82	2	*1		Person	
12	Member Residence Street Address - 1	N301	67	53	N3*SubscriberStreetAddress1			
12	Member Residence Street Address - 2	N302	67	51	*SubscriberStreetAddress2			
13	Member Residence City	N401	68	19	N4*SubscriberCityName			
13	Member Residence State	N402	68	3	*SubscriberStateAbbreviationCode			
13	Member Residence Zip Code - 1	N403	69	6	*SubscriberZipCode1			
13	Member Residence Zip Code - 2	N403	69	4	SubscriberZipCode2			
13	Member Residence Country Code	N404	69	4	*	USA CAN JPN	United States Canada Japan	Required only if country is not USA.
15	Member Coverage Maintenance Type Code	HD01	128 - 129	6	HD*030		Audit or Compare	
15	Member Coverage Type Code	HD03	129 - 130	4	*	DEN HLT LIF CRO PDG VIS	Dental Health Life Ins Chiro Prescription Drug Vision	
15	Plan coverage description	HD04	130	6	*		Benefit Plan	If required by insurer

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
15	Member Coverage Level Code	HD05	130 - 131	4	*	EMP FAM TWO CHD ESP	Employee Only Family Two Party Children Only Employee + Spouse	
16	Member Coverage Date Qualifier	DTP01	132 - 133	7	DTP*303		Maintenance Effective Date	Loop 2300, Data Element 374
16	Member Coverage Date Format Qualifier	DTP02	133	3	*D8		Date Expressed in Format CCYYMMDD	
16	Member Coverage Date	DTP03	134	9	*CCYYMMDD			
TRANSACTION SET TRAILER								
Line	Field	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Transaction Segment Count	SE01	158	13	SE* <i>TotalNumber</i>			Number of segments in transaction set
1	Transaction Set Control Number	SE02	158	10	* <i>Same number as Header Control Number</i>			
FUNCTIONAL GROUP TRAILER								
Line	Field	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Number of Transaction Sets Included	GE01	B.10	9	GE* <i>TotalNumber</i>			Number of transaction sets
1	Group Control Number	GE02	B.10	10	* <i>Same number as Header Control Number</i>			
INTERCHANGE CONTROL TRAILER								
Line	Field	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Number of Included Functional Groups	IEA01	B.7	9	IEA* <i>TotalNumber</i>			Number of functional groups
1	Interchange Control Number	IEA02	B.7	10	* <i>Same number as Header Control Number</i>			

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
 Note: Content column with an asterisk refers to Valid values column

Transactional File Specifications								
INTERCHANGE CONTROL HEADER								
Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Interchange Control Header	ISA01	B.3	6	ISA*00		No Authorization Information Present	
1	Authorization Information	ISA02	B.3	11	*.....			Spaces are represented by "." for clarity
1	Security Information Qualifier	ISA03	B.4	3	*00		No Security Information Present	
1	Security Information	ISA04	B.4	11	*.....			Spaces are represented by "." for clarity
1	Sender Interchange ID Qualifier	ISA05	B.4	3	*30		US Federal Tax Identification Number to Follow	
1	Sender Interchange ID	ISA06	B.4	10	*990266961		SendersFederalTaxID	
1	Receiver Interchange ID Qualifier	ISA07	B.4 - B.5	3	*	30 01 ZZ	Provider Code	
1	Receiver Interchange ID	ISA08	B.5	10	*	To be supplied by Provider	ReceiversFederalTaxID	Provider supplied Federal Tax Identification Number
1	Interchange Date	ISA09	B.5	9	*CCYYMMDD			The calendar date the file was created.
1	Interchange Time	ISA10	B.5	5	*HHMM			The time the file was created.
1	Interchange Control Standards Identifier	ISA11	B.5	2	*U		US EDI Community of ASCX12	
1	Interchange Control Version Number	ISA12	B.5	5	*00401			
1	Interchange Control Number	ISA13	B.5	10	*000000001			
1	Acknowledgement Requested	ISA14	B.6	2	*0			
1	Usage Indicator	ISA15	B.6	2	*	T P	Test Production	
1	Component Element Separator	ISA16	B.6	2	*:	Colon		
FUNCTIONAL GROUP HEADER								
Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
2	Functional Identifier Code	GS01	B.8	5	GS*BE		Benefit Enrollment and Maintenance (834)	
2	Application Sender's Code	GS02	B.8	10	*EUTF		SendersID	
2	Application Receiver's Code	GS03	B.8	10	*	To be assigned	Provider ID Code	Assigned Provider ID Code
2	Date	GS04	B.8	9	*CCYYMMDD			The calendar date the file was created.
2	Time	GS05	B.8	5	*HHMM			The time the file was created.
2	Group Control Number	GS06	B.9	10	*000000001			Control Number: Start with 0000001 and increment
2	Responsible Agency Code	GS07	B.9	2	*X		Accredited Standards Committee X12	
2	Version/Release/Industry Identifier Code	GS08	B.9	11	*004010X095			
TRANSACTION SET HEADER								

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
 Note: Content column with an asterisk refers to Valid values column

Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
3	Transaction Identifier Code	ST01	B.17	6	ST*834		Benefit Enrollment and Maintenance	
3	Transaction Control Number	ST02	B.17	9	*00000001			Control Number: Start with 0000001 and increment
BEGINNING SEGMENT								
4	Transaction Purpose Code	BGN01	28 - 29	6	BGN*00		First time transaction sent	
4	Transaction Identifier Code	BGN02	29	1/30	*			Identifies particular Transaction set, should increment on each transmission. Start with 01 and increment. Provider used in concatenation: provider, trans_set_control_num , plan_descr, as of date.
4	Transaction Date	BGN03	29	9	*CCYYMMDD			The calendar date the data within the file is effective
4	Transaction Time	BGN04	29	5	*HHMM			
4	Time Code	BGN05	29	2	*HS			Hawaii Daylight Time
4	Reference Identification	BGN06	29	0	*			Not Used
4	Reference Identification	BGN07	29	0	*			Not Used
4	Action Code	BGN08	29	1	*	4 (Verify - Full) 2 (Change - Trans)		
TRANSACTION SET POLICY NUMBER								
5	Entity Identification Qualifier	REF01	32	6	REF*38		Master Policy Number	
5	Entity Identification	REF02	33	9	*PolicyNumber		Based on Provider and Group Number.	Same as REF01 IL Provider Group Policy
FILE EFFECTIVE DATE								
6	Date/Time Qualifier	DTP01	34	3	DTP*303			
6	Date/Time Period Format Qualifier	DTP02	34	2	*D8			
6	Date/Time Period	DTP03	34	8	*CCYYMMDD			
SPONSOR NAME								
7	Sponsor Entity ID Code	N101	35	5	N1*P5		Plan Sponsor	
7	Sponsor Entity Name	N102	36	26	*EUTF		EmployerGroupName	
7	Sponsor Entity ID Code Qualifier	N103	36	3	*FI		Federal Taxpayer's Identification Number	
7	Sponsor Entity Identification Code	N104	36	10	*990266961			
PAYOR								

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

8	Insurer Identity Code	N101	35	5	N1*IN		Insurer	
8	Insurer Identity Name	N102	36	5	*	To be supplied by Provider	Provider Identity Name	Provider supplied Identity Name
8	Insurer Identification Code Qualifier	N103	36	3	*FI		Federal Taxpayer's Identification Number	
8	Insurer Identification Code	N104	36	10	*	To be supplied by Provider		Provider supplied Federal Tax Identification Number
DETAIL								
Line	Field	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Subscriber Indicator	INS01	44	5	INS*	Y N	Yes - Subscriber No - Not Subscriber	
1	Individual Relationship Code	INS02	44 - 45	3	*	18 01 19 23 53	Subscriber Spouse Child Sponsored Dependent - Not Used Life Partner	
1	Maintenance Type Code	INS03	45	4	*	001 021 024 025	Change Addition Cancellation or Termination Reinstatement - Not Used	

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

1	Maintenance Reason Code	INS04	46 - 47	3	*	02 05 20 32 01 03 07 08 11 21 31 15 25 33 28 AI 04 22 29 14 41 XT 43	Birth Adoption Active - Not Used Marriage Divorce Death Termination of Benefits Termination of Employment Surviving Spouse - Not Used Disability - Not Used Legal separation - Not Used PCP Change - Not Used Change in Identifying Data (e.g. name) Personal Data Initial Enrollment No Reason Given Retirement Plan Change Benefit Selections Voluntary Withdrawal Re-enrollment Transfer Change of Address	AI used when reason is data correction
1	Benefit Status Code	INS05	47 - 48	2	*	A C S T	Active COBRA - Not Used Surviving Insured Tax Equity and Fiscal Responsibility Act (TEFRA) - Not Used	
1	Medicare Plan Code	INS06	48	2	*	C A B Blank	C - MedA and MedB A - MedA B - MedB Blank - None	Any new values sent on transaction file
1	COBRA Qualifying Event Code	INS07	48	2	*	Not Used	No value is passed	

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

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1	Employment Status Code	INS08	49	3	*	AC AO AU L1 RT TE FT	Active - Not Used Active Military - Overseas - Not Used Active Military - USA - Not Used Leave of Absence - Not Used Retired Terminated Full Time	
1	Student Status Code	INS09	49	2	*	F Blank	Full-time Not a student	Any new values sent on transaction file
1	Handicap Indicator Code	INS10	49	2	*	Blank Y	Not Handicapped Handicapped	Any new values sent on transaction file
1	Date Time Qualifier	INS11	50	3	*D8		Date Expressed in Format CCYYMMDD	
1	Member Date of Death	INS12	50	9	*CCYYMMDD			
2	Subscriber Number	REF01	51	6	REF*OF		Subscriber Number	Loop 2000, Data Element 128
2	Subscriber Identifier	REF02	52	10	*SSN			
3	Subscriber Number	REF01	53	6	REF*IL		Member Policy Number	Loop 2000, Data Element 128
3	Subscriber Identifier	REF02	53	10	*Member Policy Number			Uses Master Policy Number Same as REF01 38
4	Member Identification Number Qualifier	REF01	55 - 56	6	REF*DX		Billing Location	Loop 2000, Data Element 128
4	Member Identification Division Number	REF02	56	5	*Dept			Any new values sent on transaction file
5	Member Identification Number Qualifier	REF01	55 - 56	6	REF*17		Bargaining Unit	Loop 2000/Loop 2300, Data Element 128 To be sent with every record
5	Member Identification Division Number	REF02	56	5	*Bargaining Unit			
6	Member Identification Number Qualifier	REF01	55-56	6	REF*F6		Health Insurance Claim (HIC) Number	To be sent for medical plan only
6	Member Identification Division Number	REF02	56	30	*Member HICN		Use when reporting Medicare eligibility for a member	Loop 2000, Data Element 128
7	Subscriber Number	REF01	55 - 56	6	REF*23		Employee ID	Loop 2000, Data Element 128
7	Subscriber Identifier	REF02	56	10	*Employee ID			
8	Subscriber Number	REF01	152 - 153	6	REF*6O		Dependent SSN	Loop 2320, Data Element 128
8	Subscriber Identifier	REF02	153	10	*Dependent SSN			
9	Subscriber Number	REF01	152 - 153	6	REF*Q4		VEBA Grandfather Status	Loop 2320, Data Element 128
9	Subscriber Identifier	REF02	153	10	*Y or N		Y - VEBA Grandfather Member N - Not VEBA Grandfather Member	

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

10	Member Event Date Qualifier	DTP01	59 - 60	7	DTP*	340 341 356 357 303 348 349 360 361 286	COBRA Begin - Not Used COBRA End - Not Used Eligibility Begin - sent if add Eligibility End - sent if term Maintenance Effective - sent if changed Benefit Begin - sent if add Benefit End - sent if term Disability Begin - sent if disabled changed to "yes" Disability End - sent if disabled changed from "yes" Retirement - sent if employment status changed to retired	Loop 2000, Data Element 374 Eligibility and benefit dates handled in concert - when one changes the other changes. Not found on EUTF Full File even though it's in the file specification
10	Member Event Date Format Qualifier	DTP02	60	3	*D8		Date Expressed in Format CCYYMMDD	Not found on EUTF Full File even though it's in the file specification
10	Member Event Date	DTP03	60	9	*CCYYMMDD			Not found on EUTF Full File even though it's in the file specification
11	Member Entity Identifier Code	NM101	62, 81	6	NM1*	IL 70 74	Insured or Subscriber Corrected Name or Demographics Changed Corrected Insured	Loop 2100, Data Element 98 IL - Use this code for enrolling a new member or updating a member with no change in identifying information. 74 - Use this code if this transmission is correcting the identifier information on a member already enrolled. Usage of this code requires the sending of an NM1 with code '70' in loop 2100B. 70 - Use this code if correcting identifying or demographic information on a member enrolled. If only demographic information is being corrected, NM101 in Loop 2100A will be IL.
11	Member Entity Type Qualifier	NM102	62, 81 - 82	2	*1		Person	
11	Member Last Name	NM103	62, 81 - 82	1/35	*LastName			
11	Member First Name	NM104	62, 81 - 82	11	*FirstName			
11	Member Middle Name	NM105	62, 81 - 82	2	*MiddleInitial			
11	Name Prefix	NM106	62, 81 - 82	3	*	Not Used	No value is passed	

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
 Note: Content column with an asterisk refers to Valid values column

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11	Name Suffix	NM107	62, 81 - 82	3	*	JR SR Not Used		
11	Member Identification Number Qualifier	NM108	62, 81 - 82	3	*34		Social Security Number	
11	Member Identification Number	NM109	62, 81 - 82	10	*SSN			
12	Member Residence Street Address - 1	N301	67	53	N3*SubscriberStreetAddress1			
12	Member Residence Street Address - 2	N302	67	51	*SubscriberStreetAddress2			
13	Member Residence City	N401	68	19	N4*SubscriberCityName			
13	Member Residence State	N402	68	3	*SubscriberStateAbbreviationCode			
13	Member Residence Zip Code - 1	N403	69	6	*SubscriberZipCode1			
13	Member Residence Zip Code - 2	N403	69	4	SubscriberZipCode2			
13	Member Residence Country Code	N404	69	4	*	USA CAN JPN	United States Canada Japan	Required only if country is not USA.
14	Member Demographic Date Format Qualifier	DMG01	70	6	DMG*D8		Date Expressed in Format CCYYMMDD	
14	Member Birth Date	DMG02	71	9	*CCYYMMDD		Birth date	
14	Member Gender Code	DMG03	71	2	*	F M	Female Male	
14	Member Martial Status	DMG04	71	1	*	I M B	Single Married Domestic Partner	If marital status not included then transmitting old birth date and sex.
10	Member Entity Identifier Code	NM101	62, 81	6	NM1*31		Postal Mailing Address	Optional only if subscriber has separate mailing address
11	Member Entity Type Qualifier	NM102	62, 81 - 82	2	*1		Person	
12	Member Residence Street Address - 1	N301	67	53	N3*SubscriberStreetAddress1			
12	Member Residence Street Address - 2	N302	67	51	*SubscriberStreetAddress2			
13	Member Residence City	N401	68	19	N4*SubscriberCityName			
13	Member Residence State	N402	68	3	*SubscriberStateAbbreviationCode			
13	Member Residence Zip Code - 1	N403	69	6	*SubscriberZipCode1			
13	Member Residence Zip Code - 2	N403	69	4	SubscriberZipCode2			
13	Member Residence Country Code	N404	69	4	*	USA CAN JPN	United States Canada Japan	Required only if country is not USA.
14	Member Disability Type Code	DSB01	124-125		DSB*	3 4	New Disability No New Disability	
14	Member Disability Date Qualifier	DTP01	126 - 127	7	DTP*	360 361	Disability Begin Disability End	Loop 2200, Data Element 374
14	Member Disability Date Format Qualifier	DTP02	126	3	*D8		Date Expressed in Format CCYYMMDD	
14	Member Disability Date	DTP03	126	9	*CCYYMMDD			

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000

Note: Content column with an asterisk refers to Valid values column

15	Member Coverage Maintenance Type Code	HD01	128 - 129	6	HD*	001 021 024 025 030	Change Addition Cancellation or Termination Reinstatement - Not Used Audit or Compare	
15	Member Coverage Type Code	HD03	129 - 130	4	*	DEN HLT LIF CRO PDG VIS	Dental Health Life Ins Chiro Prescription Drug Vision	
15	Plan coverage description	HD04	130	6	*		Benefit Plan	To be sent with every record
15	Member Coverage Level Code	HD05	130 - 131	4	*	EMP FAM TWO CHD ESP	Employee Only Family Two Party Children Only Employee + Spouse	
16	Member Coverage Date Qualifier	DTP01	132 - 133	7	DTP*	303 348 349	Maintenance Effective Date Benefit Begin - Audit Action 'A'dd Benefit End - Audit Action 'T'er	Loop 2300, Data Element 374
16	Member Coverage Date Format Qualifier	DTP02	133	3	*D8		Date Expressed in Format CCYYMMDD	
16	Member Coverage Date	DTP03	134	9	*CCYYMMDD			
TRANSACTION SET TRAILER								
Line	Field	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Transaction Segment Count	SE01	158	13	SE* <i>TotalNumber</i>			Number of segments in transaction set including ST and SE segments
1	Transaction Set Control Number	SE02	158	10	* <i>Same number as Header Control Number</i>			
FUNCTIONAL GROUP TRAILER								
Line	Field	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Number of Transaction Sets Included	GE01	B.10	9	GE* <i>TotalNumber</i>			Number of transaction sets
1	Group Control Number	GE02	B.10	10	* <i>Same number as Header Control Number</i>			
INTERCHANGE CONTROL TRAILER								
Line	Field	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
1	Number of Included Functional Groups	IEA01	B.7	9	IEA* <i>TotalNumber</i>			Number of functional groups
1	Interchange Control Number	IEA02	B.7	10	* <i>Same number as Header Control Number</i>			

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
Note: Content column with an asterisk refers to Valid values column

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION IX

EXHIBIT H

ENROLLMENT COUNTS

The following table shows the enrollment count, by carrier as of September 2013.

<i>Actives – EUTF</i>	
HMSA 90/10 PPO	
Single	4,084
Two-Party	1,097
Family	1,524
HMSA 80/20 PPO	
Single	12,672
Two-Party	4,128
Family	6,768
HMSA 75/25 PPO	
Single	428
Two-Party	131
Family	117
HMSA HMO	
Single	1,829
Two-Party	415
Family	565
HMSA Supplemental Medical <i>(To be eliminated 6/30/14)</i>	
Single	168
Two-Party	110
Family	150
Royal State Supplemental Medical	
Single	87
Two-Party	87
Family	212
Kaiser HMO Comprehensive	
Single	4,168
Two-Party	1,269
Family	1,828
Kaiser HMO Standard	
Single	1,451
Two-Party	384
Family	478

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION IX

Royal State Chiropractic	
Single	24,832
Two-Party	7,638
Family	11,529
<i>Actives – HSTA VB</i>	
HMSA 90/10 PPO	
Single	1,287
Two-Party	284
Family	801
HMSA 80/20 PPO	
Single	1,654
Two-Party	556
Family	1,588
HMSA Supplemental Medical (<i>To be eliminated 6/30/14</i>)	
Single	44
Two-Party	37
Family	116
Kaiser HMO	
Single	984
Two-Party	241
Family	558
Royal State Chiropractic	
Single	3,611
Two-Party	1,038
Family	2,920
<i>Retirees without Medicare – EUTF</i>	
HMSA PPO	
Single	2,552
Two-Party	2,714
Family	904
Kaiser HMO	
Single	552
Two-Party	512
Family	163
<i>Retirees without Medicare – HSTA VB</i>	
HMSA PPO	
Single	202
Two-Party	308
Family	38

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION IX

Kaiser HMO	
Single	72
Two-Party	66
Family	7
<i>Retirees with Medicare – EUTF</i>	
HMSA PPO	
Single	16,376
Two-Party	9,324
Family	511
Kaiser HMO	
Single	3,131
Two-Party	1,632
Family	121
<i>Retirees with Medicare – HSTA VB</i>	
HMSA PPO	
Single	849
Two-Party	788
Family	32
Kaiser HMO	
Single	714
Two-Party	313
Family	19
<i>All Retirees with or without Medicare – HSTA VB</i>	
Royal State Chiropractic	
Single	1,175
Two-Party	1,197
Family	80

EXHIBIT I

CENSUS DATA

Census data will be supplied upon completion of the Intent to Bid Form (Attachment 2) and signed Confidentiality Agreement (Attachment 3).