

Department of Budget and Finance

RELEASE DATE: January 2, 2020

REQUEST FOR PROPOSALS RFP No. 20-003

SEALED PROPOSALS FOR

Medical Benefits

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

Pharmacy Benefit Management Services

(for a standalone self-insured prescription drug plan)

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

WILL BE RECEIVED UP TO 12:00 NOON, HAWAII STANDARD TIME (HST) ON

FEBRUARY 4, 2020

IN THE HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND, CITY FINANCIAL TOWER, 201 MERCHANT STREET, SUITE 1700, HONOLULU, HAWAII 96813. DIRECT QUESTIONS RELATING TO THIS SOLICITATION TO DEREK M. MIZUNO VIA EMAIL AT EUTF.RFP@HAWAII.GOV.

Derek M. Mizuno
Procurement Officer

Re: Request for Proposals – RFP No. 20-003, Medical Benefits and Pharmacy Benefit Management Services

Proposal Due Date: February 4, 2020, 12:00 Noon, HST

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) is issuing this Request for Proposals (RFP), for its active employee and retiree Medical benefits, and chiropractic and prescription drug plans integrated with the medical benefits, and pharmacy benefit management services for a standalone self-insured prescription drug benefit.

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 emailed 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.

For Medical benefits, 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 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 Employee and Retiree Plans.

For Pharmacy Benefit Management Services for a standalone self-insured prescription drug plan, the EUTF intends to award contracts to the same OFFEROR for its commercial plan (active employees and non-Medicare retirees) and Medicare retirees. Separate contracts to the same OFFEROR will be awarded for Active Employee 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. Exceptions to Attachment 6, *Performance Guarantees* will not be accepted by the EUTF.

Respond to **all** questions in this RFP. **DO NOT ALTER THE QUESTIONS**. Mis-numbered, 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 (SLH). 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, 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 118,000 subscribers which include employees and retirees. When dependents are included, the participant count is approximately 198,000. The EUTF’s fiscal year is July 1 through June 30. Active employee plans are on a fiscal year term (July 1 to June 30) and retiree plans are on a calendar year term (January 1 to December 31).

The EUTF is administered by a board of 10 Trustees (Board), who are appointed by the Governor. Five (5) Trustees represent the employee-beneficiaries, one of whom represents retirees. These five (5) Trustees are selected by the Governor from a list of candidates provided by the exclusive employee representative organizations. The remaining five (5) 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 administer the EUTF (see Exhibit C, *EUTF 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, an Investment Office, a Benefits Office, a Member Services Branch Manager, a Financial Management Officer, and an Information Systems Chief. The Investment Office is responsible for all investment-related activities of the EUTF, and the Benefits Office is responsible for the benefit plan design, cost control through disease management and wellness programs, and auditing of enrollment and claims. The day-to-day operations of the EUTF are organized under three (3) branches: Member Services, Financial Services, and Information Systems. 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 responding to emails from members and processing enrollment submissions 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 Chief is supported by information technology (IT) specialists and provides internal IT support services, Health Insurance Portability and Accountability Act of 1996 (HIPAA) security responsibilities and coordinates additional support services provided by the State Department of Accounting and General Services

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 benefit 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 (active employees and retirees) were entitled to the same standard of coverage in benefits when they were transitioned to the EUTF on January 1, 2011. The enrollment of HSTA VEBA members into these new EUTF-created health and other benefit plans (HSTA VB) was done solely to comply with the Court's ruling and does not create any constitutional or contractual right to the benefits of these plans. If the ruling is overturned, stayed, or modified, the EUTF reserves the right to move HSTA VB members into regular EUTF plans.

The current Annual Report for the EUTF can be found online at eutf.hawaii.gov.

Active employees (also referred to as "actives") and retirees are currently offered medical plan options through HMSA, Kaiser, and HMA and prescription drug benefits through a standalone self-insured plan administered by Caremark PCS Health, LLC and SilverScript Insurance Company. The Employer currently pays a portion of the premium cost for medical and prescription drug coverage for actives and their dependents and 100% of the premium for most 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).

Be advised that Act 226, SLH 2013 (HB65) specifically prohibits the preference of a mail order pharmacy, by way of any inducement in plan design or requirement, when contrasted to the OFFEROR's retail pharmacy network. This includes any carve out of specialty medication or requirements that are in any way less favorable to a retail pharmacy when contrasted to a mail order service facility. OFFERORS are required to fully comply with all state legislation, including this law.

1.2 PURPOSE

The EUTF is soliciting proposals from qualified OFFERORS to provide medical and chiropractic benefits (chiropractic for actives and HSTA VB retirees) with an option to include an integrated fully insured prescription drug plan, and/or pharmacy benefit management services for a standalone self-insured prescription drug plan for the EUTF's active employees, non-Medicare retirees, Medicare retirees (which are provided prescription benefits through an EGWP Wrap Program), and eligible dependents. If a contract for pharmacy benefit management services for a standalone self-insured prescription drug plan is awarded, the EUTF intends to offer such contracts for actives, non-Medicare retirees, and Medicare retirees to the same OFFEROR. The 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 inasmuch 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.

For the prescription drug plan, OFFERORS may also provide pricing on their standard formulary with exclusions. However, the OFFEROR will only be evaluated on the current EUTF formulary.

1.3 TERMS AND ACRONYMS USED THROUGHOUT THE SOLICITATION

BAFO	=	Best and Final Offer
CPO	=	Chief Procurement Officer

EGWP	=	Employer Group Waiver Plan
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
PPACA	=	Patient Protection and Affordable Care Act (also referred to as ACA)
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:

- Active Employee Plans:
 1. First Contract Period – July 1, 2021 – June 30, 2023
 2. Optional Second Contract Period – July 1, 2023 – June 30, 2024
 3. Optional Third Contract Period – July 1, 2024 – June 30, 2025

- Retiree Plans (Non-Medicare and Medicare):
 1. First Contract Period – January 1, 2021 – December 31, 2022
 2. Optional Second Contract Period – January 1, 2023 – December 31, 2023
 3. Optional Third Contract Period – January 1, 2024 – December 31, 2024

All contract periods referenced throughout this RFP will be for these effective dates including proposal sheets. The term of the contract may be extended by the Board, at its sole discretion, to facilitate the transition to new contractors in progress at the end of the existing contract term. The terms of such extension shall be the same as the then prevailing terms. The EUTF's ability to conduct audits shall survive the termination of the contract for a period equivalent to the term of the contract.

1.5 AUTHORITY

This RFP is issued under the provisions of Chapters 87A and 103D, 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.

Derek M. Mizuno
Hawaii Employer-Union Health Benefits Trust Fund
City Financial Tower
201 Merchant Street, Suite 1700
Honolulu, HI 96813

1.7 RFP SCHEDULE AND SIGNIFICANT DATES

Proposals must be received by February 4, 2020, 12:00 noon, 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 HST. The EUTF reserves the right to change any date(s) as deemed necessary and in the best interest of the State.

Release of Request for Proposals	<i>January 2, 2020</i>
Pre-proposal conference	<i>January 7, 2020</i>
Due date to submit Intent to Bid Form and Signed Confidentiality Agreement	<i>January 14, 2020</i>
Due date to submit written questions	<i>January 17, 2020</i>
State's response to written questions distributed	<i>January 27, 2020</i>
Proposals due (date/time)	<i>February 4, 2020 12:00 Noon, HST</i>
Priority-listed OFFEROR interviews (if required)	<i>March 9, 2020</i>
Best and Final Offers due (if required)	<i>March 13, 2020</i>
Estimated date for notice of award	<i>March 25, 2020</i>

1.8 PRE-PROPOSAL CONFERENCE

The purpose of the pre-proposal conference is to provide OFFERORS with an opportunity to be briefed on this procurement and to ask any questions about this procurement. The pre-proposal conference is not mandatory; however, OFFERORS are encouraged to attend to gain a better understanding of the requirements of this RFP.

OFFERORS are advised that nothing discussed at the pre-proposal conference changes any part of this RFP. All changes and/or clarifications to this RFP shall be done in the form of a written addendum.

Those interested may participate in the pre-proposal conference in person or via conference call. If your firm will be participating in the pre-proposal conference via conference call, please email eutf.rfp@hawaii.gov and provide the names and titles of those attending. The telephone number of the conference line is 877-477-0014, passcode 630-378-9263#. The pre-proposal conference will be held as follows:

Date: January 7, 2020

Time: 9:00 a.m., HST

Location: EUTF Conference Room
Hawaii Employer-Union Health Benefits Trust Fund
City Financial Tower
201 Merchant Street, Suite 1700
Honolulu, Hawaii 96813

1.9 COMMUNICATIONS WITH THE EUTF

OFFERORS and potential 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 inquiries 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 EUTF will respond to questions through addenda/amendments by the date specified in Section 1.7, *RFP Schedule and Significant Dates*; responses to all questions will be available on the State Procurement Office's (SPO) website (<http://www.spo.hawaii.gov>) and the EUTF website (<http://www.eutf.hawaii.gov>). 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 individual listed below is the sole point of contact from the date of release of this RFP until the award to the successful OFFEROR. 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*.

Mr. Derek M. Mizuno
State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
Honolulu, HI 96813
Fax: (808) 586-2320

Email: eutf.rfp@hawaii.gov

A copy of this RFP can also be obtained from the EUTF website (<http://eutf.hawaii.gov/request-for-proposals>).

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 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 for Medical benefits 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 (1) for any plan. Proposals for alternate benefit plans will **not** be accepted.

Each qualified OFFEROR's proposal for pharmacy benefit management services for the standalone self-insured prescription drug plan must include the active plans, non-Medicare retiree plans, and Medicare retiree EGWP plans with the supplemental (wrap). Incomplete or partial proposals 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."
- Eight (8) hard copies of the proposal. Each copy shall be marked, "Copy __ of 8." Copies may be bound and double-sided.
- Two (2) electronic copies (on two (2) CDs or USB flash drives) of the master proposal and a redacted version 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. The redacted version of the proposal shall redact any proprietary and confidential, trade secret information in the form of marked-out pages (blacked 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 specified in Section 1.7, *RFP Schedule and Significant Dates*. Any proposal received after the closing date and time as specified in Section 1.7, *RFP Schedule and Significant Dates* will be rejected. No faxed or emailed proposals will be considered or accepted. Handwritten proposals will be rejected.

OFFERORS are encouraged to confirm their delivery agent's requirements for Hawaii. Proposals must be received by the EUTF via mail or hand delivery by **Tuesday, February 4, 2020, 12:00 noon, HST** and addressed to:

Mr. Derek M. Mizuno
State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
Honolulu, HI 96813

If proposal is to be hand delivered via courier (e.g., FedEx, UPS), the outside envelope shall be marked, “RFP No. 20-003, hand delivered, proposal due Tuesday, February 4, 2020, 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 No. 20-003, Medical Benefits and Pharmacy Benefit Management Services

In addition to the proposals submitted to EUTF, OFFEROR shall submit, as a courtesy, two (2) signed hard copies of the proposal and ONE (1) ELECTRONIC copy on CD or USB flash drive to SEGAL to be received no later than Tuesday, February 4, 2020, 12:00 noon, HST to the attention of:

Mr. Stephen Murphy
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 (2) State officials on or after the proposal submission deadline specified in Section 1.7, *RFP Schedule and Significant Dates* or as amended. Late proposals will not be accepted.

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** – OFFEROR provides a written notice delivered by hand, mail, or fax that accompanies the actual modification received by the Procurement Officer; or OFFEROR provides a written notice that accompanies the actual modification by email to eutf.rfp@hawaii.gov, provided that the OFFEROR submits the written notice accompanying the actual modification by hand delivery, mail or fax within two (2) working days of the Procurement Officer’s receipt of the electronic notification.
- **Withdrawal** – OFFEROR provides a written notice delivered by hand, mail or fax to the Procurement Officer; or a notice by email to eutf.rfp@hawaii.gov.

1.14 DISCUSSION AND PRESENTATIONS

Discussions may be conducted with PRIORITY-LISTED OFFERORS (PLOs), 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. An OFFEROR shall bear all responsibility for any and all costs related to making the presentations. The EUTF reserves the right to conduct the presentations in person in Honolulu and/or via conference call.

1.15 BEST AND FINAL OFFER

If the EUTF determines a Best and Final Offer (BAFO) is necessary, it shall request one from the PLOs. BAFOs must be received by the EUTF 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 the EUTF, or if requested and not submitted by a PLO, the previous submittal will be construed as its BAFO. After BAFOs are received, final evaluations will be conducted for an award. All proposals become the property of the EUTF. The EUTF may return copies of proposals to non-winning OFFERORS.

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 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 a 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.
- Handwritten 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 BAFOs. All amendments will be issued by written addendum and will be posted on the following websites:

- SPO HANDS (<https://hands.ehawaii.gov/hands/welcome>)
- EUTF (<https://eutf.hawaii.gov/about-eutf/procurement/>)

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, HRS, 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 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 discussions with PLOs, a priority list shall be generated consisting of OFFERORS who are 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 highest ranked, responsible OFFERORS. PLOs may be afforded the opportunity to submit BAFOs. If a BAFO is requested, final evaluations will be conducted after BAFOs are received. If a BAFO is requested and is not submitted, the previous submittals will be construed as the BAFO.

1.23 AWARD OF CONTRACT

Award will be made to the responsible OFFEROR whose proposal is determined to be the most advantageous to the EUTF 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 EUTF and shall

be required to sign a business associate agreement (BAA). The RFP, the OFFEROR's accepted proposal, the BAFO, 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 BAA 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 the RFP and successful proposal conflict, the terms of the RFP shall govern, unless otherwise agreed upon by EUTF in the contract.

The notice of award resulting from this solicitation shall be posted on the SPO HANDS website (<https://hands.ehawaii.gov/hands/welcome>).

1.24 CONTRACT EXECUTION

The successful OFFEROR shall enter into a formal written contract in the form of Exhibit D, *Contract Form and 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 General Conditions* unless the OFFEROR specifically identifies the provision to which objection is made and submits alternative language as part of Attachment 5, *Exceptions*. The EUTF shall have no obligation to accept terms and conditions that vary from those set forth in Exhibit D, *Contract Form and General Conditions*, this RFP and any amendments thereto. Exceptions to Attachment 6, *Performance Guarantees*, will not be accepted by the EUTF.

Upon selection and award of the contract(s), the 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 seven (7) calendar days after receipt by the OFFEROR or within such time as the EUTF may allow. Failure to keep this deadline may result in a cancellation of the award and contract. The EUTF reserves the right to cancel any contract, and request new proposals or negotiate with remaining OFFERORS, if the 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 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 HRS pursuant to HRS §103D-310(c) upon execution 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 contract execution, 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 State Department of Taxation, Federal Internal Revenue Service; State Department of Labor and Industrial Relations, and State Department of Commerce and Consumer Affairs.

OFFERORS who are interested in registering with 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:

Mr. Derek M. Mizuno
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
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 procurement officer’s debriefing was completed.

The notice of award, if any, resulting from this solicitation shall be posted on the Hawaii Awards and Notices Data Systems (HANDS), which is available on the SPO website: <https://hands.ehawaii.gov/hands/welcome>.

1.29 SPECIAL CONDITIONS

The following Special Conditions will supplement Exhibit D, *Contract Form and General Conditions*.

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 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 under 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. Except as otherwise required by law, Contractor shall maintain all records for at least three 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 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 is 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 \$5,000.00 per calendar day until the breach is remedied by Contractor.
7. Insurance. Prior to the contract start date, the Contractor shall procure, at its sole expense, and maintain insurance coverage acceptable to the State in full force and effect throughout the term of the contract. The Contractor shall provide proof of insurance for the following minimum insurance coverage(s) and limit(s) in order to be awarded a contract. The type of insurance is listed as follows:
 - 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 \$10,000,000, per occurrence and in the aggregate. The insurance policy shall be endorsed to provide that it is primary insurance and not contributing to or in 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 \$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 \$3,000,000 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 \$5,000,000. 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 or \$2,000,000 combined single limit.
 - e. Appropriate levels of per occurrence insurance coverage for workers' compensation and any other insurance coverage required by Federal or State law.
 - f. Cyber liability insurance with limits not less than \$25,000,000 per occurrence/claim, \$25,000,000 aggregate. Coverage shall be sufficiently broad in response to the duties and obligations as is undertaken by the scope of work within this contract and shall include, but not be limited to, claims involving infringement of intellectual property, including but not limited to, invasion of privacy violations, information theft, damage to or destruction of electronic information, release of private information, alteration of electronic information, extortion and network security. The policy shall also provide coverage for breach response costs and regulatory fines and penalties and credit monitoring expenses.

- g. 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.

If the Contractor maintains broader coverage and/or higher limits than the minimums shown above, the State requires and shall be entitled to the broader coverage and/or higher limits maintained by the Contractor. Any available insurance proceeds in excess of the specified minimum limits of insurance and coverage shall be available to the State.

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 A.M. Best's Insurance Reports. If the A.M. 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 required insurance policies except for professional liability/errors and omissions and worker's compensation policies. At the commencement of the contract, the Contractor shall provide the EUTF 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 EUTF with certificates of insurance showing the renewal or replacement of such insurance policies. All policies of insurance shall provide that the EUTF will be given thirty 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 1700, 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 EUTF 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. For prescription drug plans, this will include, but not be limited to:
 - All claim files for the entire contract period
 - Prior Authorization files
 - Exceptions to formulary approvals
 - True Out of Pocket balances
 - Medical Necessity Review Files
 - Quantity Limit information by participants and exceptions

- 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 costs 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

2.1 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 and/or IX)
- Network Analysis (Section VIII and IX)
- Required attachments:
 - Confidential Information, Attachment 4
 - Exceptions, Attachment 5
- Documents to demonstrate OFFEROR's financial stability (Section III)
- Any additional attachments/marketing information not required but that you want to present

2.2 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 email 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 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 or will obtain the 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 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 the work described in the RFP will not be subcontracted. If subcontractors will be used, append a statement to the cover letter from each subcontractor, signed by an individual authorized to legally bind the subcontractor stating: 1) the general scope of work to be performed by the subcontractor, and 2) the subcontractor’s willingness to perform the indicated tasks. 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 Board.
- Terms and Conditions of Contract – Affirm that the provisions of the sample contract in Exhibit D, *Contract Form and 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. Exceptions to Attachment 6, *Performance Guarantees*, will not be accepted by the EUTF.

2.3 OFFER FORM, OF-1

Include a signed, Attachment 1, *Offer Form OF-1* with the exact legal name, as registered with the State Department of Commerce and Consumer Affairs, if applicable, and address of OFFEROR's firm and the name, mailing address, telephone number, and fax number of the person the State should contact regarding the OFFEROR's proposal. The OFFEROR’s authorized signature on the Offer Form, OF-1 shall be an original signature, 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.

2.4 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.

2.5 AWARD OR REJECTION

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.

2.6 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.

2.7 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.

2.8 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.

2.9 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*. Late proposals will not be accepted.

2.10 EXCEPTIONS

Any exceptions to terms, conditions, or other requirements in any part of these specifications must be listed in Attachment 5, *Exceptions*. The 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 this RFP, the RFP terms will be binding unless specifically accepted as an exception stipulated in the contract. The EUTF reserves the right to accept or reject any request for exceptions. Exceptions to Attachment 6, *Performance Guarantees*, will not be accepted by the EUTF.

2.11 SUBMISSION OF A SIGNED PROPOSAL

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, *Exceptions*. Failure to meet any of these conditions may result in disqualification of the proposal. 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.

2.12 EUTF ADMINISTRATIVE RULES

The OFFEROR agrees to comply with Exhibit C, *EUTF Administrative Rules*, as amended from time to time. Any proposed modifications to the specified eligibility rules are unacceptable.

2.13 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.

2.14 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.

2.15 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

All OFFEROR systems and services must be in compliance with the HIPAA, Privacy, and Security regulations on the appropriate dates established by the Department of Health & Human Services. A copy of the EUTF's standard BAA is attached as Exhibit F. The successful OFFEROR will be required to sign the BAA.

2.16 REQUESTED PLAN DESIGN AND FUNDING ARRANGEMENTS

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

OFFERORS 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 federal and state laws for fully insured plans, unless the Contractor's position differs from the EUTF and its legal counsel. This RFP requests bids on any of the following three options: (1) the current fully insured/refunding arrangement where surpluses are returned to the EUTF but deficits may not be collected or carried forward to future contract years/terms, (2) self-insured administrative services only basis and, (3) minimum premium funding whereas a maximum liability is set and claims up to that amount are collected from the EUTF as claims are paid with a fixed administrative and Disease Management/Integrated Health Management (DM/IHM) fee. The essence of the minimum plan should be considered self-insured for ACA Health Insurer Tax purposes. The maximum "pseudo-insured rate" will be submitted in the rate sheet as the maximum collectable rate for those rate sheets if OFFEROR is submitting a minimum premium bid.

If the OFFEROR is submitting a fully insured or standalone self-insured bid for pharmacy benefits, the OFFEROR will be responsible to administer pharmacy benefits for retirees where a Medicare dependent of a non-Medicare retiree is covered under the Medicare EGWP Wrap plan and a non-

Medicare dependent of a Medicare retiree is covered under the non-Medicare retiree plan (orphaned dependents). A fully insured pharmacy benefit must comply with all the requirements contained in the RFP for self-insured Pharmacy benefits.

PROPOSAL EVALUATION

3.1 INTRODUCTION: The EUTF seeks the highest quality organization to provide medical benefits and pharmacy benefit management services. 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.

3.2 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 (Optional)
- Phase 4 – Request for Best and Final Offers (Optional)
- Phase 5 – Final Evaluation of Proposals
- Phase 6 – Award

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

Criteria	Points Medical Services	Points Pharmacy Benefit Management Services (for a standalone self- insured prescription drug plan)
Fees/rates/network discounts	30	30
Network disruption	25	25
Agreement to perform services requested in RFP (including the Special Conditions in Section 1.29)	25	25
Experience offering services to similar sized entities and references including prior engagements with the EUTF and the State	10	10
Medical management programs, wellness programs and total health management approach	10	NA
Agreement to establish a local (in-state) mail order fulfillment center to be fully operational prior to January 1, 2021	NA	10
Total	100	100

- 1. Fees/Rates/Network Discounts: Medical.** 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 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 repricing of the claims submitted to the PLOs in the BAFO phase of the RFP process. The cost for the minimum premium options will be calculated in the same way as the self-insured options but will be capped at the maximum benefit cost paid by EUTF. The evaluation will exclude all ACA fees and tax.

Pharmacy Benefit Management: The net cost of benefits and administration will be determined from the pricing and discount and rebate guarantees included in the OFFEROR's proposal applied to the historical claims that were supplied to the OFFERORS as claims data. Only guaranteed pricing, discounts, rebates, and administrative expenses will be used in the evaluation. Estimated discounts and rebates will not be considered in the evaluation.

- 2. Network disruption:** Network disruption will be evaluated based upon the information that is submitted in this RFP and will be measured based upon the providers, facilities, and sources of care and services used by the participants in the plans for which a proposal is being submitted, as measured from the experience of the plan over the past three years (or the existence of the plan if less than three 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 as follows.

Medical

- The overall percent of the plan enrolled population that will 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

Pharmacy Benefit Management

- The percentage of pharmacy dispensing facilities that are in the OFFEROR's network that dispensed prescriptions that are included in the claim data provided in the RFP; and
- An evaluation of the number of facilities that are available to participants based upon a distribution per Island within the State.

- 3. Agreement to perform services requested in RFP (including Special Conditions in Section 1.29):** This category will be evaluated based upon the responses contained in the proposal with respect to the OFFEROR's agreement to perform all of the services required in a manner and to the specifications outlined in this RFP. The OFFEROR's thorough explanation of how it will complete the required tasks outlined in the RFP will be evaluated based upon its understanding of the tasks, the demonstrated ability to perform the tasks and agreement to dedicate the necessary resources to perform the tasks.

4. **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 (Trustee 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.
5. **Medical management programs, wellness programs, and total health management approach (medical only):** 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 and to provide quarterly reports to the EUTF on the outcomes of the efforts of the proposers' programs in a timely and complete manner as described by the EUTF.
6. **Agreement to establish a local (in-state) mail order fulfillment center to be fully operational prior to January 1, 2021 (pharmacy benefit management services for a standalone self-insured prescription drug plan only):** This category will be awarded on a pass/fail basis and the points in this category will only be awarded to those OFFERORS that have established or agree to establish a fully operational mail order prescription fulfillment center located in the state. The mail order center must be capable of fulfilling the projected number of prescriptions submitted by participants based upon previous experience of the EUTF. Should the mail order facility not be fully operational by January 1, 2021, liquidated damages will be assessed in accordance with Section 1.29, *Special Conditions*, No. 6. A physical examination of the facility may be required by the Evaluation Committee or its designee prior to the award of the points in this category.

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.

- Adhere to all proposal submission guidelines.
- Follow proposal submission timeline.
- The proposal must include proposed rates for the initial contract period and all extension contract periods.
- All proposed rates must be guaranteed for the term of the contract, including the proposed extensions. There shall be no contingencies on the proposed rates.
- There shall be no time limitations on the validity of the proposal.

- ❑ The OFFEROR must agree to be bound, in order of precedence, by 1) the contract between the STATE and the CONTRACTOR, 2) the RFP including all attachments and addenda, and 3) the CONTRACTOR's proposal.

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.” The Evaluation Committee will 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 PLOs as listed in the timeline provided in Section 1. This phase is optional and may not be included in the evaluation.

Phase 4 – Request for Best and Final Offers (Optional)

In this phase, the PLOs may be asked to submit a BAFO for the services that are being proposed. This phase is optional and may not be included in the evaluation.

Phase 5 – Final Evaluation of Proposals

In this phase, the Evaluation Committee will conduct final evaluations of the PLOs' 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 (Evidence of Coverage Documents 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*. Otherwise, the OFFEROR’s proposal will be deemed to accept and agree to all the contractual requirements. The EUTF reserves the right to accept or reject any request for exceptions. 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. Exceptions to Attachment 6, *Performance Guarantees*, will not be accepted by the EUTF. 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 EUTF is issuing this RFP for its active and retiree medical and chiropractic benefits with integrated fully insured prescription drug benefits or pharmacy benefit management services for a standalone self-insured prescription drug plan. 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 2020, the Contractor must maintain the following located in the State:

- a. Contractor shall have a call center in the State with knowledgeable staff available to answer inquiries from EUTF members 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. The call center must record and retain all calls for a minimum of one year from the date of the call.

100% of the medical calls between 7:00 AM to 7:00 PM, HST Monday through Friday, excluding State observed holidays, and 9:00 AM to 1:00 PM, HST on Saturday, shall be answered by the local call center. The medical plan must also have a toll-free line for EUTF members that is open and available during those hours.

The prescription drug plan must have a toll-free line for EUTF members that is open and available 24 hours a day, seven days a week. Calls outside of 7:00 AM to 7:00 PM, HST Monday through Friday, excluding State observed holidays, and 9:00 AM to 1:00 PM, HST on Saturday, may be answered at a call center not in the State but one whose employees have been trained on the EUTF benefits.

- b. A walk-in customer service center located in Honolulu to service plan participants. The walk-in customer service center shall be open during EUTF business hours, 7:45 AM to 4:30 PM, HST, Monday through Friday, except State observed holidays.
- c. Staff located in Honolulu to respond on a daily basis to the EUTF staff during EUTF business hours.
- d. Contractor shall have personnel, systems, and equipment at the service offices that is reasonably sufficient to provide all the customer services proposed by Contractor and required under the contract.
- e. 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.

3. Key Personnel

Within 30 calendar days of the award of contract, the Contractor shall provide the business addresses, email addresses, and telephone numbers of its authorized representatives listed in Section VII, *Questionnaire for Medical Benefits Only*, and Section IX, *Pharmacy Benefit*. 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, or the Attorney General's office with respect to Contractor's benefit plans, Contractor's performance of the contract, or any matter pertaining to the EUTF. The Contractor shall give the EUTF at least ten days' notice in advance of any change in the authorized representatives and are subject to the terms of Attachment 6, *Performance Guarantees*.

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 EUTF consultants. Contractor must provide responses to EUTF staff phone calls and emails promptly. Sufficient backup personnel must be in place to ensure 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 and EUTF Administrative Rules (Exhibit C). 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 and the employers' departmental personnel offices.

4. Processing Enrollments, Cancellations and Terminations

Weekly, the EUTF will provide a HIPAA compliant electronic data transmission that shows new enrollments, cancellations, terminations, and other changes applicable to Contractor's benefit plan(s). Subject to the following, Contractor shall process such enrollments, cancellations, terminations, and changes in a timely manner. 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. The EUTF is planning to change/upgrade its benefits administration system and 834 file formats with targeted completion of October 1, 2021. Contractor agrees to incur all expenses of any modifications that are necessary to its systems in order to process the information provided by the EUTF. The 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 requirements of this section shall be made prior to the commencement of this contract. However, the EUTF may agree to make changes to its 834 file format if time permits and if paid by the Contractors.

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 48 hours after receipt of the EUTF's request.

5. Open Enrollment

Each year, the EUTF holds at least one (1) open enrollment period for active employees and one (1) open enrollment period for retired employees. Historically, the active open enrollment period is conducted in the spring (April) and the retiree open enrollment period is conducted in the fall (October). 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 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 throughout the State on most islands. At its own cost, Contractor shall provide staff any 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.

7. 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 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 the EUTF's request and at its own cost, Contractor shall attend and/or provide staff any 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.

8. Worksite wellness activities

The EUTF supports planning and implementation of worksite wellness activities for its employers throughout the year. Such activities may include, but not limited to, wellness fairs, health promotion classes, biometric screenings and worksite challenges. Upon request and at no additional cost to the EUTF or its employers the EUTF contractor shall accommodate employer activities including, but not limited to, providing staff and resources including travel on Oahu and to the neighbor islands, biometric screening services with online scheduling and outcomes reporting, content experts or instructors, benefit and program materials and handouts, interactive displays, and participation incentives including door prizes, logo items, healthy meals or snacks. Other activities may be requested, for development, to align with improvement plans and strategic planning documents.

9. Coordination of Benefits/Medicare Claims

Contractor shall provide all services necessary to coordinate benefits ("COB") between its health and/or pharmacy benefit 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 benefit plans (or any self-insured plans it administers on behalf of the EUTF). Compliance will be in accordance with the National Association of Insurance Commissioner Guidelines.

10. Active Part-Time and Temporary Employee Plan Administration

The Employers participating in the EUTF, in order to comply with the requirements under the PPACA, offer temporary and part-time employees the opportunity to enroll themselves and their dependent children to age 26, in the lowest cost plan of the EUTF (currently the HMSA 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 be entirely paid by the employee. The EUTF requires the services described below

for the active part-time and temporary employee 75/25 PPO plan and Closed Panel Standard HMO plan from the Contractor who is awarded the 75/25 plan and the Closed Panel Standard HMO plan, respectively. 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 without including the spouse in the bid.*

Contractor shall:

- Conduct all open enrollment sessions;
- Receive enrollment election forms 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
- Ensure plans comply with federal and state laws;
- 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 RFP;
- 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.

The employer may terminate offering the optional part-time temporary plan should provisions of the PPACA which require it be modified or repealed.

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 operation 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 operation 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 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 electronically in Excel format. 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 also provide quarterly financial and enrollment reports by bargaining unit.

Contractor shall provide quarterly reports on performance standards in hard copy and electronically. The quarterly reports shall be due within 35 days after the end of the quarter that is the subject of the report.

Contractor shall provide an annual plan performance report with the incurred and paid accounting report within 120 days after each contract year, including a detailed line item report of how DM/IHM fees are used. The report shall be provided in hard copy and electronically. There shall be two 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 in Excel format.

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 and prescription drug 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. The 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 retrieving or receiving electronic data transmission from the EUTF regarding enrollments, changes to enrollments, premiums, and other matters related to the contract. Contractor shall, at its cost, develop all interfaces and system modifications to receive the data provided by the EUTF in EUTF's format, layout and content which is HIPAA 834 compliant. The EUTF will not make modifications to its systems in order to comply with any system requirements of the OFFEROR. All changes must be made to the Contractor's system and at the Contractor's expense prior to commencement of this contract. However, EUTF may agree to make changes to its 834 file format if time permits and if paid by the Contractor. A copy of the 834 File and content are included as Exhibit G of this RFP.

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/prescription drug claim information with the Pharmacy Benefit Management/Medical Contractor(s) on a monthly or quarterly basis throughout the term of the contract in order to develop a coordinated and integrated health management process and to assist the EUTF with the overall management of healthcare expenses, including pharmaceutical expenses. Contractor shall exchange on a daily basis out of pocket expense information with the Medical/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

Medical Benefits

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.

Pharmacy Benefit Management Services

The EUTF shall pay the Contractor all invoiced amounts within 20 days after the EUTF receives an invoice from the Contractor, on the 15th and 30th of each month.

Contractor may request a deposit in an amount equal to two (2) billing cycles based on the average of the last three (3) months of billing history.

All Services

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 by the EUTF as of a given

date of the month, to be selected by the EUTF. 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 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 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. Encounter data to EUTF at least once per quarter in accordance with the requirements and specifications defined by the EUTF
- b. Submit data to the All Payor Claims Database established by the State and pursuant to Act 139, SLH 2016, which amends section 323D-18.5, HRS. Contractor agrees to cooperate with State to effectuate all data transfers from Contractor to State or State's designee
- c. Data shall be in compliance with all NCQA compliant benchmarking
- d. Reporting on Integrated Health and Disease Management and Wellness programs shall include, but shall not be limited to:
 - i. HEDIS Benchmark performance – comparison of EUTF to HEDIS benchmark and to Contractor book of business for similar public entities
 - ii. Quarterly and Annual reports on Wellness, Cost Control Programs, Burden of Disease, Disease Management and Integrated Health Management
 - iii. Annual Program Planning for subsequent years

- iv. Annual return on investment for disease management and wellness programs.

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 twelve 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. Audit Sample Size

Contractor shall agree to provide a claim sampling size to the auditor sufficient to meet the required confidence rate of 95% with a plus or minus 3% precision (expected error rate not to exceed 3%).

19. Auditing Costs

Contractor shall share in the cost of any audits of the health benefit plans procured by the EUTF in the following amounts for each year of the contract:

- a. PPO/HMO Plans – \$0.55 per employee/retiree
- b. Closed Panel HMO Plans – \$35,000 (includes both active and retiree plans)
- c. Supplemental Medical and Prescription Drug Plans – \$15,000
- d. Pharmacy Benefit Active and Retiree contract – \$80,000 (includes both active and retiree plans)

If the aforementioned amounts are not used by the EUTF to offset audit costs, the EUTF may use any remaining amounts to offset any other amounts paid to the Contractor.

20. COBRA Administration

Contractor is required to administer all aspects of compliance under COBRA, including eligibility, election of coverage, billing and collection of premium, termination and annual termination notification.

Plan Offerings:

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

1) HMSA – Fully Insured*:

Active EUTF (including chiropractic)

- PPO 90/10 (Prescription Drug with CVS Caremark)
- PPO 80/20 (Prescription Drug with CVS Caremark)
- PPO 75/25 (Prescription Drug with CVS Caremark)
- HMO (Prescription Drug with CVS Caremark)

Active HSTA VB (including chiropractic)

- PPO 90/10 (Prescription Drug with CVS Caremark)
- PPO 80/20 (Prescription Drug with CVS Caremark)

Retiree EUTF

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

Retiree HSTA VB (including chiropractic)

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

**CVS Caremark and SilverScript prescription drug benefits are self-insured.*

2) HMA – Self Insured:

Active EUTF

- Supplemental Medical and Prescription Drug Copayment Reimbursement Plan

3) Kaiser – Fully Insured:

Active EUTF (including chiropractic)

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

Active HSTA VB (including chiropractic)

- Comprehensive HMO and Kaiser Prescription Drug

Retiree EUTF

- Comprehensive HMO and Kaiser Prescription Drug for Non-Medicare Retirees and Senior Advantage plan with Prescription Drug for Medicare Retirees

Retiree HSTA VB (including chiropractic)

- Comprehensive HMO and Kaiser Prescription Drug for Non-Medicare Retirees and Senior Advantage plan with Prescription Drug for Medicare Retirees

Additional Requested Plans:

- 1) **Plan for Part-Time and Temporary Employees:** The EUTF is requesting bids for temporary and part time employees and their dependent children up to age 26. Please provide a rate on Proposal Sheets 4 and 8.
- 2) **Fully Insured Chiropractic Integrated with the Medical Plan:** The EUTF is requesting bids for a fully insured chiropractic plan integrated into the Medical Plans for all active employees and HSTA VB retirees. OFFERORS should also provide pricing for fully insured chiropractic benefits for EUTF retirees. OFFERORS will not be evaluated on such pricing.
- 3) **Fully Insured Prescription Drug Plan Integrated with the Medical Plan and/or Self-Insured stand-alone prescription drug plan.** The EUTF is requesting bids for active employee prescription drug plans, non-Medicare prescription drug plans, and Medicare prescription drug plans (EGWP with supplemental wrap or Medicare Part D plan integrated with a Medicare Advantage plan).

Dental benefits are provided through Hawaii Dental Service (HDS) to actives and retirees. Vision benefits are provided through Vision Service Plan (VSP) to actives and retirees. Life Insurance benefits are provided under a contract with Minnesota Life Insurance Company.

PURPOSE

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

Separate contracts will be issued for active and retiree plans. If a contract for pharmacy benefit management services for a standalone self-insured prescription drug plan is awarded, the EUTF intends to award such contracts for actives, non-Medicare retirees, and Medicare retirees to the same OFFEROR.

ELIGIBILITY

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 19 and 24 if unmarried and full-time student). 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 ACA. EUTF and HSTA VB Retiree Plans are considered to be exempt under ACA as retiree-only 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 October 2019 by carrier.

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 & FEE PROPOSAL FORMS

PROPOSED BENEFITS

Detailed benefits information is provided in Exhibit E, *Evidence of Coverage Documents*. The EUTF is requesting that OFFERORS match the current benefits. If you are unable to match the benefits, 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.** If you are matching the current benefit, but are recommending a revision to the current benefits, please note the recommendation and provide pricing for the revision.

[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. PPACA fees are to be excluded from the rates should they no longer be mandated by law. The EUTF will reimburse the Contractor for the PCORI fee if reinstated.
2. All proposals must guarantee a fixed administration, plus retention profit, and DM/IHM fees as a fixed fee per employee/retiree per month. 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 with risk sharing, if the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. Each plan (e.g. EUTF PPO 80/20 is separate from the EUTF PPO 75/25 reconciliation and from the HSTA VB PPO 80/20 reconciliation) must be separately accounted and surpluses from one plan **may not** be applied to offset deficits of another plan. See example below. The financial reconciliation will be for each contract or extension year without the ability to carry-forward deficits or surpluses from one contract period to the next. The EUTF retiree PPO plan for non-Medicare and Medicare retirees is considered one plan but is separate from the HSTA VB PPO plan for non-Medicare and Medicare retirees which is another plan.

OFFERORS may propose a percentage discount off each plan’s monthly premium excluding the DM/IHM, chiropractic and administration and retention fees, if offsetting of plan surpluses and deficits is allowed within the same contract and period. The percentage discount should be specific to each period in the entire contract period. However, the active contract may not be merged with the retiree plan contract to offset deficits or surpluses. The two contracts must be accounted for independently.

Initial Reconciliation

Contractor agrees to an initial reconciliation that shall occur with six months of benefits run-out following the end of the contract period and a final reconciliation that shall occur with 12 months of

benefits run-out following the end of the contract period. Both reconciliations will be done within 45 days after the respective run-out periods.

The initial reconciliation shall be calculated by plan as follows: Paid premiums (excluding ACA insurer and PCORI fees), minus paid benefits, minus administration, retention and DM/IHM fees, minus reserves for incurred but not reported benefits. Administration, retention and DM/IHM fees shall be calculated by multiplying the fixed dollar amounts (per subscriber per month rates) by the number of subscribers in each month of the contract period. Any surplus shall be returned to EUTF (Example 1). Any deficit shall be the responsibility of Contractor (Example 2).

Example #1: Surplus returned to EUTF

\$1,000,000	paid premiums
-\$750,000	minus paid benefits
-\$60,000*	minus administration, retention, DM/IHM fees
-\$100,000	minus reserves for incurred but not reported benefits
\$90,000	surplus paid to EUTF

*\$4.00 per subscriber per month (\$4.00 is an example only) x 15,000 (sum of enrolled subscribers in each month of the contract period) = \$60,000

Example #2: Deficit is the responsibility of the Contractor

\$1,000,000	paid premiums
-\$850,000	minus paid benefits
-\$68,000*	minus administration, retention, DM/IHM fees
-\$100,000	minus reserves for incurred but not reported benefits
-\$18,000	Contractor may not invoice EUTF

*\$4.00 per subscriber per month (\$4.00 is an example only) x 17,000 (sum of enrolled subscribers in each month of the contract period) = \$68,000

Final Reconciliation

The final reconciliation shall be calculated by plan as follows: Paid premiums (excluding ACA insurer and PCORI fees), minus paid benefits, minus administration, retention, DM/IHM fees, minus reserves for incurred but not reported benefits (which will be calculated based upon the previous plan year run-out of claim experience for months 13-24 but not more than .20% of plan year benefits). Administration, retention, DM/IHM fees shall be calculated by multiplying the fixed dollar amounts (per subscriber per month rates) by the number of subscribers in each month of the contract period.

If the final reconciliation surplus is greater than the initial reconciliation surplus, then the surplus from the final reconciliation less any surplus paid to the EUTF for the initial reconciliation shall be returned to the EUTF (see example 1a). If the final reconciliation surplus is less than the initial reconciliation surplus, the Contractor may invoice EUTF for the difference (see example 1b). If the initial reconciliation resulted in a surplus and the final reconciliation resulted in a deficit, Contractor may invoice EUTF the amount of the initial reconciliation surplus (see example 1c).

Example #1a: (Contractor paid EUTF \$90,000 refund at initial reconciliation):

\$1,000,000	paid premiums
-\$840,000	minus paid benefits
-\$60,000	minus administration, retention, DM/IHM fees
-\$1,092	minus incurred but not reported benefits (for active employees, the calculation is \$840,000 x 0.0013)*

\$98,908	final reconciliation surplus
-\$90,000	minus initial reconciliation surplus paid to EUTF
\$8,908	additional surplus to be refunded to EUTF

Example #1b: (Contractor paid EUTF \$90,000 refund at initial reconciliation):

\$1,000,000	paid premiums
-\$900,000	minus paid benefits
-\$60,000	minus administration, retention, DM/IHM fees
-\$1,170	minus incurred but not reported benefits (for active employees, the calculation is \$900,000 x 0.0013)*
\$38,830	final reconciliation surplus

Contractor may invoice EUTF for \$51,170, which represents the difference between the initial reconciliation refund and the final reconciliation surplus (\$90,000 - \$38,830 = \$51,170).

Example #1c: (Contractor paid EUTF \$90,000 refund at initial reconciliation):

\$1,000,000	paid premiums
-\$1,000,000	minus paid benefits
-\$60,000	minus administration, retention, DM/IHM fees
-\$1,300	minus incurred but not reported benefits (for active employees, the calculation is \$1,000,000 x 0.0013)*
-\$61,300	final reconciliation surplus

Contractor may invoice EUTF for the \$90,000 initial reconciliation surplus.

If the initial reconciliation resulted in a deficit, and the final reconciliation also results in a deficit, Contractor shall not invoice EUTF (see example 2a). If the initial reconciliation resulted in a deficit, and the final reconciliation results in a surplus, the surplus from the final reconciliation shall be returned to EUTF (see example 2b).

Example #2a: (Contractor had an \$18,000 deficit at initial reconciliation):

\$1,000,000	paid premiums
-\$960,000	minus paid benefits
-\$68,000	minus administration, retention, DM/IHM fees
-\$1,248	minus incurred but not reported benefits (for active employees, the calculation is \$960,000 x 0.0013)*
-\$29,248	final reconciliation deficit

Contractor may not invoice EUTF for the final reconciliation deficit.

Example #2b: (Contractor had an \$18,000 deficit at initial reconciliation):

\$1,000,000	paid premiums
-\$850,000	minus paid benefits
-\$68,000	minus administration, retention, DM/IHM fees
-\$1,105	minus incurred but not reported benefits (for active employees, the calculation is \$850,000 x 0.0013)*
\$80,895	final reconciliation surplus to be refunded to EUTF

*Amount is for example purposes only.

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. 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, and any surpluses may not offset deficits of another plan.
7. The EUTF reserves the right to offer multiple carrier 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 must be filled out in the proposal sheets provided.
14. All rates must be guaranteed for the term of the contract including the proposed extensions (see Section 1.4, *Contract Period*).
15. If your proposal is accepted by the EUTF, the following additional rates will be required for various self-pay categories: Tiered Cobra Rates.
16. Amounts shall be in U.S. dollars unless a specific percent is requested.
17. All active rates must be rounded to even cents.
18. Extension period rates are limited to the dollar amounts of the total benefit cost **AND** the “Maximum Benefit Cost Percent Increase from Prior Contract Period” filled out on the proposal sheets, excluding future premium changes related to changes in the benefit.

Important Self-Insured Proposal Instruction and Information

1. All Administrative fees must include all fees, taxes and exclude fees mandated under PPACA which are to be listed separately.
2. The EUTF reserves the right to offer multiple carrier options, except for a standalone self-insured prescription drug plan which will be awarded to one OFFEROR for active employees and retirees.

3. No adjustments to the proposed fees based on actual initial enrollment or subsequent enrollment changes are acceptable.
4. Fees must be quoted on a three-tiered basis (self, two-party, and family).
5. Fees must exclude commissions and payments made to any third party.
6. Fees must be filled out in the proposal sheets provided.
7. All fees must be guaranteed for the term of the contract including the proposed extensions (see Section 1.4, *Contract Period*).
8. Individual fee components will be assumed to be self-supporting standalone services.
9. All services to be provided for the quoted fee should be listed including quantities and frequencies.
10. Your fees must include any fee for PPO Leasing/Network Access for a national network to cover all 50 states, and the District of Columbia.
11. List services/supplies not covered under the fees quoted above (i.e., custom reports, printing, etc.).
12. 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.
13. Amounts shall be in U.S. dollars unless a specific percent is requested.

Active
EUTF – 90/10 PPO Plan
Table and Proposal Sheets #1

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

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 1 - ACTIVE			
Plan Design	EUTF 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by HMSA		
General	In-Network	Out-of-Network*	
Calendar Year Deductible	None	\$100 per person \$300 per family	
Calendar Year Maximum Out-of-Pocket	\$2,000 per person \$4,000 per family		
Lifetime Benefit Maximum	None		
Plan Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	10%	30%	
Annual Health Exam	No Charge	No Charge**	
Diabetes Prevention Program	No Charge (one program/lifetime)	Not Covered	
Immunizations	No Charge	No Charge**	
Well Child Care Visits	No Charge	30%**	
Maternity	10%	30%	
Screening Mammography	No Charge	30%**	
Advance Care Planning	No Charge	30%	
EMERGENCY SERVICES			
Emergency Room	10%	10%**	
Ambulance	10%	30%	
INPATIENT CARE			
Room and Board	10%	30%	
Ancillary Services	10%	30%	
Physician Services	10%	30%	
Surgery	10%	30%	
Anesthesia	10%	30%	
Mental Health Services	10%	30%	
OUTPATIENT CARE			
Chemotherapy	10%	30%	
Radiation Therapy	10%	30%	
Lab and Pathology	10%	30%	
Diagnostic Testing and X-ray (including genetic testing and counseling)	10%	30%	
Allergy Testing	10%	30%	
Surgery	10%	30%	
Anesthesia	10%	30%	
Mental Health Services	10%	30%	

TABLE 1 - ACTIVE

Plan Design	EUTF 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
OTHER SERVICES			
Durable Medical Equipment	10%	30%	
Hearing Aids	10% (one device per ear every 60 months)	30% (one device per ear every 60 months)	
Home Health Care	No Charge (150 visits/CY)	30% (150 visits/CY)	
Hospice Care	No Charge	Not Covered	
Supportive Care	No Charge (90 days/ 12-month period)	Not Covered	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	10% (120 days/CY)	30% (120 days/CY)	
Physical and Occupational Therapy	10%	30%	
Reversing Heart Disease Program	\$20 per session (one program/ lifetime)	Not Covered	
Chiropractic Services	\$15 (20 visits/CY) through American Specialty Health Group, Inc.	Not Covered	
PRESCRIPTION DRUGS	Provided by CVS/caremark		
	Participating Pharmacy	Non-Participating Pharmacy*	
Calendar Year Maximum Out-of-Pocket***	\$4,350 per person \$8,700 per family		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Preferred Brand	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Non-Preferred Brand	\$50/\$100/\$150	\$50/\$100/\$150 + 20% of eligible charges	
Preferred Insulin	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Other Insulin	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Preferred Diabetic Supplies	No Charge	20% of eligible charges	
Other Diabetic Supplies	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Oral Contraceptives	No Charge	20% of eligible charges	
Injectables & Specialty Drug	30-day supply only		
Specialty Calendar Year Maximum Out-of-Pocket	\$2,500 per person		
Specialty Generic	10% of eligible charges (up to \$200 per fill)		
Specialty Preferred Brand	20% of eligible charges (up to \$300 per fill)		
Specialty Non-Preferred Brand	30% of eligible charges (up to \$400 per fill)		
Oral Oncology	\$30		

TABLE 1 - ACTIVE			
Plan Design	EUTF 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Retail 90 and Mail Order	Retail 90 or Mail Pharmacy	Non-Retail 90 Pharmacy	
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$10	\$5/\$10/\$15	
Preferred Brand	\$25/\$50/\$50	\$25/\$50/\$75	
Non-Preferred Brand	\$50/\$100/\$100	\$50/\$100/\$150	
Preferred Insulin	\$5/\$10/\$10	\$5/\$10/\$15	
Other Insulin	\$25/\$50/\$50	\$25/\$50/\$75	
Preferred Diabetic Supplies	No Charge	No Charge	
Other Diabetic Supplies	\$25/\$50/\$50	\$25/\$50/\$75	
Oral Contraceptives	No Charge	No Charge	
Injectables & Specialty Drug	Not Covered	See benefit described above	

NOTE: Prescription drug benefits are currently provided under a separate contract.

Footnotes applicable to Medical and Prescription Drug benefits:

* *Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

** *Deductible does not apply.*

*** *Applicable copayments and caps for specialty medications apply towards the total annual maximum out-of-pocket.*

† *Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

INSURED, RISK SHARING

Proposal Sheet 1A

90/10 PPO Plan – EUTF Active – All Bargaining Units

Premium Rate Table (Insured with Risk Sharing-Surplus Refund)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Medical Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

EUTF 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
PRESCRIPTION DRUG				
Monthly Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Prescription Drug Premium (Including Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Prescription Drug Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): ____%

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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

Proposal Sheet 1B

**90/10 PPO Plan – EUTF Active – All Bargaining Units
Target Claims, Retention and Fees Tables (Self-Insured ASO)**

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

EUTF 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Estimated Medical Claims Cost:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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

MINIMUM PREMIUM

Proposal Sheet 1C

**90/10 PPO Plan – EUTF Active – All Bargaining Units
Premium Rate Table (Insured with Limited Risk Sharing)**

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Maximum Medical Claims Cost (paid by EUTF):				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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 #2

ACTIVE
EUTF – 80/20 PPO PLAN
TABLE AND PROPOSAL SHEETS #2

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 2 - ACTIVE			
Plan Design	EUTF 80/20 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL			
Provided by HMSA			
General	In-Network	Out-of-Network*	
Calendar Year Deductible	None	\$250 per person \$750 per family	
Calendar Year Maximum Out-of-Pocket	\$2,500 per person \$5,000 per family		
Lifetime Benefit Maximum	None		
Plan Year Benefit Maximum	None		
PHYSICIAN SERVICES			
MEMBER PAYS			
Physician Office Visit (including primary care and specialist office visits)	20%	40%	
Annual Health Exam	No Charge	No Charge**	
Diabetes Prevention Program	No Charge (one program/lifetime)	Not Covered	
Immunizations	No Charge	No Charge**	
Well Child Care Visits	No Charge	40%**	
Maternity	20%	40%	
Screening Mammography	No Charge	40%**	
Advance Care Planning	No Charge	40%	
EMERGENCY SERVICES			
Emergency Room	20%	20%**	
Ambulance	20%	40%	
INPATIENT CARE			
Room and Board	20%	40%	
Ancillary Services	20%	40%	
Physician Services	20%	40%	
Surgery	20%	40%	
Anesthesia	20%	40%	
Mental Health Services	20%	40%	
OUTPATIENT CARE			
Chemotherapy	20%	40%	
Radiation Therapy	20%	40%	
Lab and Pathology	20%	40%	
Diagnostic Testing and X-ray (including genetic testing and counseling)	20%	40%	
Allergy Testing	20%	40%	
Surgery	20%	40%	
Anesthesia	20%	40%	
Mental Health Services	20%	40%	

TABLE 2 - ACTIVE

Plan Design	EUTF 80/20 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
OTHER SERVICES			
Durable Medical Equipment	20%	40%	
Hearing Aids	20% (one device per ear every 60 months)	40% (one device per ear every 60 months)	
Home Health Care	20% (150 visits/CY)	40% (150 visits/CY)	
Hospice Care	No Charge	Not Covered	
Supportive Care	No Charge (90 days/ 12-month period)	Not Covered	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	20% (120 days/CY)	40% (120 days/CY)	
Physical and Occupational Therapy	20%	40%	
Reversing Heart Disease Program	\$20 per session (one program/ lifetime)	Not Covered	
Chiropractic Services	\$15 (20 visits/CY) through American Specialty Health Group, Inc.	Not Covered	
PRESCRIPTION DRUGS	Provided by CVS/caremark		
	Participating Pharmacy	Non-Participating Pharmacy*	
Calendar Year Maximum Out-of-Pocket***	\$4,350 per person \$8,700 per family		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Preferred Brand	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Non-Preferred Brand	\$50/\$100/\$150	\$50/\$100/\$150 + 20% of eligible charges	
Preferred Insulin	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Other Insulin	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Preferred Diabetic Supplies	No Charge	20% of eligible charges	
Other Diabetic Supplies	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Oral Contraceptives	No Charge	20% of eligible charges	
Injectables & Specialty Drug	30-day supply only		
Specialty Calendar Year Maximum Out-of-Pocket	\$2,500 per person		
Specialty Generic	10% of eligible charges (up to \$200 per fill)		
Specialty Preferred Brand	20% of eligible charges (up to \$300 per fill)		
Specialty Non-Preferred Brand	30% of eligible charges (up to \$400 per fill)		
Oral Oncology	\$30		

TABLE 2 - ACTIVE			
Plan Design	EUTF 80/20 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Retail 90 and Mail Order	Retail 90 or Mail Pharmacy	Non-Retail 90 Pharmacy	
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$10	\$5/\$10/\$15	
Preferred Brand	\$25/\$50/\$50	\$25/\$50/\$75	
Non-Preferred Brand	\$50/\$100/\$100	\$50/\$100/\$150	
Preferred Insulin	\$5/\$10/\$10	\$5/\$10/\$15	
Other Insulin	\$25/\$50/\$50	\$25/\$50/\$75	
Preferred Diabetic Supplies	No Charge	No Charge	
Other Diabetic Supplies	\$25/\$50/\$50	\$25/\$50/\$75	
Oral Contraceptives	No Charge	No Charge	
Injectables & Specialty Drug	Not Covered	See benefit described above	

NOTE: Prescription drug benefits are currently provided under a separate contract.

Footnotes applicable to Medical and Prescription Drug benefits:

* *Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

** *Deductible does not apply.*

*** *Applicable copayments and caps for specialty medications apply towards the total annual maximum out-of-pocket.*

† *Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

INSURED, RISK SHARING

Proposal Sheet 2A

80/20 PPO Plan – EUTF Active – All Bargaining Units

Premium Rate Table (Insured with Risk Sharing-Surplus Refund)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Medical Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

EUTF 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
PRESCRIPTION DRUG				
Monthly Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Prescription Drug Premium (Including Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Prescription Drug Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): ____%

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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

Proposal Sheet 2B

**80/20 PPO Plan – EUTF Active – All Bargaining Units
Target Claims, Retention and Fees Tables (Self-Insured ASO)**

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

EUTF 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Estimated Medical Claims Cost:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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

MINIMUM PREMIUM

Proposal Sheet 2C

**80/20 PPO Plan – EUTF Active – All Bargaining Units
Premium Rate Table (Insured with Limited Risk Sharing)**

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Maximum Medical Claims Cost (paid by EUTF):				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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 – 75/25 PPO Plan
Table and Proposal Sheets #3

ACTIVE
EUTF – 75/25 PPO PLAN
TABLE AND PROPOSAL SHEETS #3

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 3 - ACTIVE			
Plan Design	EUTF 75/25 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by HMSA		
General	In-Network	Out-of-Network*	
Calendar Year Deductible	\$300 per person \$900 per family		
Calendar Year Maximum Out-of-Pocket	\$5,000 per person \$10,000 per family		
Lifetime Benefit Maximum	None		
Plan Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	25%**	40%	
Annual Health Exam	No Charge**	No Charge**	
Diabetes Prevention Program	No Charge** (one program/ lifetime)	Not Covered	
Immunizations	No Charge**	No Charge**	
Well Child Care Visits	No Charge**	40%**	
Maternity	25%	40%	
Screening Mammography	No Charge**	40%**	
Advance Care Planning	No Charge**	40%	
EMERGENCY SERVICES			
Emergency Room	25%	25%	
Ambulance	25%	40%	
INPATIENT CARE			
Room and Board	25%	40%	
Ancillary Services	25%	40%	
Physician Services	25%**	40%	
Surgery	25%	40%	
Anesthesia	25%	40%	
Mental Health Services – Facility Services	25%	40%	
OUTPATIENT CARE			
Chemotherapy	25%	40%	
Radiation Therapy	25%	40%	
Lab and Pathology	25%**	40%	
Diagnostic Testing and X-ray (including genetic testing and counseling)	25%	40%	
Allergy Testing	25%	40%	
Surgery	25%	40%	
Anesthesia	25%	40%	
Mental Health Services – Facility Services	25%	40%	

TABLE 3 - ACTIVE

Plan Design	EUTF 75/25 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
OTHER SERVICES			
Durable Medical Equipment	25%	40%	
Hearing Aids	25% (one device per ear every 60 months)	40% (one device per ear every 60 months)	
Home Health Care	25% (150 visits/CY)	40% (150 visits/CY)	
Hospice Care	No Charge	Not Covered	
Supportive Care	No Charge (90 days/ 12-month period)	Not Covered	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	25% (120 days/CY)	40% (120 days/CY)	
Physical and Occupational Therapy	25%	40%	
Reversing Heart Disease Program	\$20 per session** (one program/ lifetime)	Not Covered	
Chiropractic Services	\$15 (20 visits/CY) through American Specialty Health Group, Inc.	Not Covered	
PRESCRIPTION DRUGS	Provided by CVS/caremark		
	Participating Pharmacy	Non-Participating Pharmacy*	
Calendar Year Maximum Out-of-Pocket***	\$3,150 per person \$6,300 per family		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Preferred Brand	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Non-Preferred Brand	\$50/\$100/\$150	\$50/\$100/\$150 + 20% of eligible charges	
Preferred Insulin	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Other Insulin	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Preferred Diabetic Supplies	No Charge	20% of eligible charges	
Other Diabetic Supplies	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Oral Contraceptives	No Charge	20% of eligible charges	
Injectables & Specialty Drug	30-day supply only		
Specialty Calendar Year Maximum Out-of-Pocket	\$2,500 per person		
Specialty Generic	10% of eligible charges (up to \$200 per fill)		
Specialty Preferred Brand	20% of eligible charges (up to \$300 per fill)		
Specialty Non-Preferred Brand	30% of eligible charges (up to \$400 per fill)		
Oral Oncology	\$30		

TABLE 3 - ACTIVE			
Plan Design	EUTF 75/25 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Retail 90 and Mail Order	Retail 90 or Mail Pharmacy	Non-Retail 90 Pharmacy	
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$10	\$5/\$10/\$15	
Preferred Brand	\$25/\$50/\$50	\$25/\$50/\$75	
Non-Preferred Brand	\$50/\$100/\$100	\$50/\$100/\$150	
Preferred Insulin	\$5/\$10/\$10	\$5/\$10/\$15	
Other Insulin	\$25/\$50/\$50	\$25/\$50/\$75	
Preferred Diabetic Supplies	No Charge	No Charge	
Other Diabetic Supplies	\$25/\$50/\$50	\$25/\$50/\$75	
Oral Contraceptives	No Charge	No Charge	
Injectables & Specialty Drug	Not Covered	See benefit described above	

NOTE: Prescription drug benefits are currently provided under a separate contract.

Footnotes applicable to Medical and Prescription Drug benefits:

* *Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

** *Deductible does not apply.*

*** *Applicable copayments and caps for specialty medications apply towards the total annual maximum out-of-pocket.*

† *Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

INSURED, RISK SHARING

Proposal Sheet 3A

75/25 PPO Plan – EUTF Active – All Bargaining Units

Premium Rate Table (Insured with Risk Sharing-Surplus Refund)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF 75/25 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Medical Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

EUTF 75/25 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
PRESCRIPTION DRUG				
Monthly Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Prescription Drug Premium (Including Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Prescription Drug Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): ____%

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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

Proposal Sheet 3B

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

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

EUTF 75/25 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Estimated Medical Claims Cost:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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

MINIMUM PREMIUM

Proposal Sheet 3C

**75/25 PPO Plan – EUTF Active – All Bargaining Units
Premium Rate Table (Insured with Limited Risk Sharing)**

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF 75/25 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Maximum Medical Claims Cost (paid by EUTF):				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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 – 75/25 PPO Plan
(Part-Time and Temporary Employees)
Table and Proposal Sheets #4

ACTIVE
EUTF – 75/25 PPO PLAN (PART-TIME AND TEMPORARY EMPLOYEES)
TABLE AND PROPOSAL SHEETS #4

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. Please note that the benefit plan design shall not change throughout the duration of the contract unless required otherwise by law.

TABLE 4 - ACTIVE			
Plan Design	EUTF 75/25 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by HMSA		
General	In-Network	Out-of-Network*	
Calendar Year Deductible	\$300 per person \$900 per family		
Calendar Year Maximum Out-of-Pocket	\$5,000 per person \$10,000 per family		
Lifetime Benefit Maximum	None		
Plan Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	25%**	40%	
Annual Health Exam	No Charge**	No Charge**	
Diabetes Prevention Program	No Charge** (one program/ lifetime)	Not Covered	
Immunizations	No Charge**	No Charge**	
Well Child Care Visits	No Charge**	40%**	
Maternity	25%	40%	
Screening Mammography	No Charge**	40%**	
Advance Care Planning	No Charge**	40%	
EMERGENCY SERVICES			
Emergency Room	25%	25%	
Ambulance	25%	40%	
INPATIENT CARE			
Room and Board	25%	40%	
Ancillary Services	25%	40%	
Physician Services	25%**	40%	
Surgery	25%	40%	
Anesthesia	25%	40%	
Mental Health Services – Facility Services	25%	40%	
OUTPATIENT CARE			
Chemotherapy	25%	40%	
Radiation Therapy	25%	40%	
Lab and Pathology	25%**	40%	
Diagnostic Testing and X-ray (including genetic testing and counseling)	25%	40%	
Allergy Testing	25%	40%	
Surgery	25%	40%	
Anesthesia	25%	40%	
Mental Health Services – Facility Services	25%	40%	
OTHER SERVICES			

TABLE 4 - ACTIVE

Plan Design	EUTF 75/25 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Durable Medical Equipment	25%	40%	
Hearing Aids	25% (one device per ear every 60 months)	40% (one device per ear every 60 months)	
Home Health Care	25% (150 visits/CY)	40% (150 visits/CY)	
Hospice Care	No Charge	Not Covered	
Supportive Care	No Charge (90 days/12-month period)	Not Covered	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	25% (120 days/CY)	40% (120 days/CY)	
Physical and Occupational Therapy	25%	40%	
Reversing Heart Disease Program	\$20 per session** (one program/lifetime)	Not Covered	
PRESCRIPTION DRUGS Provided by HMSA	Participating Pharmacy	Non-Participating Pharmacy*	
Calendar Year Maximum Out-of-Pocket***	\$3,150 per person \$6,300 per family		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Preferred Brand	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Non-Preferred Brand	\$50/\$100/\$150	\$50/\$100/\$150 + 20% of eligible charges	
Preferred Insulin	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Other Insulin	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Preferred Diabetic Supplies	No Charge	20% of eligible charges	
Other Diabetic Supplies	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Oral Contraceptives	No Charge	20% of eligible charges	
Injectables & Specialty Drug	30-day supply only		
Specialty Calendar Year Maximum Out-of-Pocket	\$2,500 per person		
Specialty Generic	10% of eligible charges (up to \$200 per fill)		
Specialty Preferred Brand	20% of eligible charges (up to \$300 per fill)		
Specialty Non-Preferred Brand	30% of eligible charges (up to \$400 per fill)		
Oral Oncology	\$30		
Retail 90 and Mail Order	Retail 90 or Mail Pharmacy	Non-Retail 90 Pharmacy	
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$10	\$5/\$10/\$15	
Preferred Brand	\$25/\$50/\$50	\$25/\$50/\$75	
Non-Preferred Brand	\$50/\$100/\$100	\$50/\$100/\$150	

TABLE 4 - ACTIVE			
Plan Design	EUTF 75/25 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
	Preferred Insulin	\$5/\$10/\$10	
Other Insulin	\$25/\$50/\$50	\$25/\$50/\$75	
Preferred Diabetic Supplies	No Charge	No Charge	
Other Diabetic Supplies	\$25/\$50/\$50	\$25/\$50/\$75	
Oral Contraceptives	No Charge	No Charge	
Injectables & Specialty Drug	Not Covered	See benefit described above	

Footnotes applicable to Medical and Prescription Drug benefits:

* *Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

** *Deductible does not apply.*

*** *Applicable copayments and caps for specialty medications apply towards the total annual maximum out-of-pocket.*

† *Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

INSURED

Proposal Sheet 4

**75/25 PPO Plan – EUTF Active – Part-Time and Temporary Employees
Premium Rate Table (Fully Insured)**

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

EUTF 75/25 PPO Plan (Part-Time and Temporary Employees)	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL AND PRESCRIPTION DRUG				
Monthly Medical Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Prescription Drug Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Medical and Prescription Drug Premium (Including Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Medical and Prescription Drug Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

NOTES:

- (1) The EUTF reserves the right to offer multiple carrier 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 – HMO Plan
Table and Proposal Sheets #5**

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

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 5 - ACTIVE		
Plan Design	EUTF HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
MEDICAL		
Provided by HMSA		
General		
HMO Network		
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	\$1,500 per person \$3,000 per family	
Lifetime Benefit Maximum	None	
Plan Year Benefit Maximum	None	
PHYSICIAN SERVICES		
MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	\$15	
Annual Health Exam	No Charge	
Diabetes Prevention Program	No Charge (one program/lifetime)	
Immunizations	No Charge	
Well Child Care Visits	No Charge	
Maternity	No Charge for routine prenatal visits, delivery, and one postpartum visit	
Screening Mammography	No Charge	
Advance Care Planning	No Charge	
EMERGENCY SERVICES		
Emergency Room	\$100	
Ambulance	20%	
INPATIENT CARE		
Room and Board	No Charge	
Ancillary Services	No Charge	
Physician Services	No Charge	
Surgery	No Charge	
Anesthesia	No Charge	
Mental Health Services – Facility Services	No Charge	
OUTPATIENT CARE		
Chemotherapy	\$15	
Radiation Therapy	\$15	
Lab and Pathology	No Charge	
Diagnostic Testing and X-ray (including genetic testing and counseling)	No Charge for diagnostic testing \$15 per X-ray	
Allergy Testing	\$15	
Surgery	No Charge for outpatient surgery center \$15 for outpatient professional charges	
Anesthesia	\$15	
Mental Health Services – Facility Services	No Charge	

TABLE 5 - ACTIVE			
Plan Design	EUTF HMO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
OTHER SERVICES			
Durable Medical Equipment	20%		
Hearing Aids	20% (one device per ear every 60 months)		
Home Health Care	No Charge (365 visits/illness or injury)		
Hospice Care	No Charge		
Supportive Care	No Charge (90 days/12-month period)		
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	No Charge (100 days/CY)		
Physical and Occupational Therapy	\$15 (Outpatient)		
Reversing Heart Disease Program	\$20 per session (one program/lifetime)		
Chiropractic Services	\$15 (20 visits/CY) through American Specialty Health Group, Inc.		
PRESCRIPTION DRUGS	Provided by CVS/caremark		
	Participating Pharmacy	Non-Participating Pharmacy*	
Calendar Year Maximum Out-of-Pocket**	\$4,350 per person \$8,700 per family		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Preferred Brand	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Non-Preferred Brand	\$50/\$100/\$150	\$50/\$100/\$150 + 20% of eligible charges	
Preferred Insulin	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Other Insulin	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Preferred Diabetic Supplies	No Charge	20% of eligible charges	
Other Diabetic Supplies	\$25/\$50/\$75	\$25/\$50/\$75 + 20% of eligible charges	
Oral Contraceptives	No Charge	20% of eligible charges	
Injectables & Specialty Drug	30-day supply only		
Specialty Calendar Year Maximum Out-of-Pocket	\$2,500 per person		
Specialty Generic	10% of eligible charges (up to \$200 per fill)		
Specialty Preferred Brand	20% of eligible charges (up to \$300 per fill)		
Specialty Non-Preferred Brand	30% of eligible charges (up to \$400 per fill)		
Oral Oncology	\$30		
Retail 90 and Mail Order	Retail 90 or Mail Pharmacy	Non-Retail 90 Pharmacy	
Day Supply	30/60/90	30/60/90	

TABLE 5 - ACTIVE			
Plan Design	EUTF HMO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Generic	\$5/\$10/\$10	\$5/\$10/\$15	
Preferred Brand	\$25/\$50/\$50	\$25/\$50/\$75	
Non-Preferred Brand	\$50/\$100/\$100	\$50/\$100/\$150	
Preferred Insulin	\$5/\$10/\$10	\$5/\$10/\$15	
Other Insulin	\$25/\$50/\$50	\$25/\$50/\$75	
Preferred Diabetic Supplies	No Charge	No Charge	
Other Diabetic Supplies	\$25/\$50/\$50	\$25/\$50/\$75	
Oral Contraceptives	No Charge	No Charge	
Injectables & Specialty Drug	Not Covered	See benefit described above	

NOTE: Prescription drug benefits are currently provided under a separate contract.

Footnotes applicable to Prescription Drug benefits:

* *Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

** *Applicable copayments and caps for specialty medications apply towards the total annual maximum out-of-pocket.*

*** *Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

INSURED, RISK SHARING

Proposal Sheet 5A

HMO Plan – EUTF Active – All Bargaining Units

Premium Rate Table (Insured with Risk Sharing-Surplus Refund)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Medical Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

EUTF HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
PRESCRIPTION DRUG				
Monthly Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Prescription Drug Premium (Including Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Prescription Drug Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): ____%

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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

Proposal Sheet 5B

**HMO Plan – EUTF Active – All Bargaining Units
Target Claims, Retention and Fees Tables (Self-Insured ASO)**

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

EUTF HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
HMO Leasing/Network Access Fees				
Capitation Fee				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Estimated Medical Claims Cost:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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

MINIMUM PREMIUM

Proposal Sheet 5C

HMO Plan – EUTF Active – All Bargaining Units

Premium Rate Table (Insured with Limited Risk Sharing)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
HMO Leasing/Network Access Fees				
Capitation Fee				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Maximum Medical Claims Cost (paid by EUTF):				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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 – Closed Panel Comprehensive HMO Plan
Table and Proposal Sheets #6

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

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 6 - ACTIVE		
Plan Design	EUTF CLOSED PANEL COMPREHENSIVE HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by Kaiser	
General	HMO Network	
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	\$2,000 per person \$6,000 per family	
Lifetime Benefit Maximum	None	
Plan Year Benefit Maximum	None	
PHYSICIAN SERVICES	MEMBER PAYS	
Physician Office Visit (including primary care and specialist office visits)	\$15	
Annual Health Exam	No Charge	
Diabetes Prevention Program	No Charge	
Immunizations	No Charge	
Well Child Care Visits	No Charge	
Maternity	No Charge for routine prenatal visits, delivery, and one postpartum visit	
Screening Mammography	No Charge	
Advance Care Planning	No Charge (Continuing Care)	
EMERGENCY SERVICES		
Emergency Room	\$50	
Ambulance	20%	
INPATIENT CARE		
Room and Board	No Charge	
Ancillary Services	No Charge	
Physician Services	No Charge	
Surgery	No Charge	
Anesthesia	No Charge	
Mental Health Services	No Charge	
OUTPATIENT CARE		
Chemotherapy	\$15	
Radiation Therapy	\$15	
Lab and Pathology	\$15 per day	
Diagnostic Testing and X-ray	\$15 per day	
Allergy Testing	\$15	
Surgery	\$15	
Anesthesia	\$15	
Mental Health Services	\$15	
OTHER SERVICES		
Durable Medical Equipment	20%	
Hearing Aids	60% (one device per ear every 36 months)	
Home Health Care	No Charge	
Hospice Care	No Charge	

TABLE 6 - ACTIVE		
Plan Design	EUTF CLOSED PANEL COMPREHENSIVE HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Skilled Nursing Facility Care	No Charge (100 days/benefit period)	
Physical and Occupational Therapy	\$15 (Outpatient)	
Chiropractic Services	\$15 (20 visits/CY) through American Specialty Health Group, Inc.	
PRESCRIPTION DRUGS	Provided by Kaiser	
Calendar Year Maximum Out-of-Pocket	Applies towards the medical maximum out-of-pocket	
Retail		
Day Supply	30/60/90	
Generic	\$5/\$10/\$15 – tier 1 \$10/\$20/\$30 – tier 2	
Preferred Brand	\$35/\$70/\$105	
Non-Preferred Brand	\$35/\$70/\$105	
Preferred Insulin	\$35/\$70/\$105	
Other Insulin	\$10/\$20/\$30 (Generic)	
Preferred Diabetic Supplies	\$35/\$70/\$105	
Other Diabetic Supplies	\$35/\$70/\$105	
Oral Contraceptives	No Charge	
Injectables & Specialty Drug	\$75/\$150/\$225	
Oral Oncology	No Charge	
Mail Order		
Day Supply	30/60/90	
Generic	\$5/\$10/\$10 – tier 1 \$10/\$20/\$20 – tier 2	
Preferred Brand	\$35/\$70/\$70	
Non-Preferred Brand	\$35/\$70/\$70	
Preferred Insulin	Not available through Mail Order	
Other Insulin	Not available through Mail Order	
Preferred Diabetic Supplies	\$35/\$70/\$70	
Other Diabetic Supplies	\$35/\$70/\$70	
Oral Contraceptives	No Charge	

INSURED

Proposal Sheet 6

**Closed Panel Comprehensive HMO Plan – EUTF Active – All Bargaining Units
Premium Rate Table (Fully Insured)**

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

EUTF Closed Panel Comprehensive HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL AND PRESCRIPTION DRUG				
Monthly Medical and Prescription Drug (Excluding DM/IHM and Chiropractic) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Medical and Prescription Drug Premium (Including DM/IHM, Chiropractic, and Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Medical and Prescription Drug Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

NOTES:

- (1) The EUTF reserves the right to offer multiple carrier 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

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

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 7 - ACTIVE		
Plan Design	EUTF CLOSED PANEL STANDARD HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL		
Provided by Kaiser		
General		
HMO Network		
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	\$2,500 per person \$7,500 per family	
Lifetime Benefit Maximum	None	
Plan Year Benefit Maximum	None	
PHYSICIAN SERVICES		
MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	\$20	
Annual Health Exam	No Charge	
Diabetes Prevention Program	No Charge	
Immunizations	No Charge	
Well Child Care Visits	No Charge	
Maternity	No Charge for routine prenatal visits and one postpartum visit 15% for delivery	
Screening Mammography	No Charge	
Advance Care Planning	No Charge (Continuing Care)	
EMERGENCY SERVICES		
Emergency Room	\$100	
Ambulance	20%	
INPATIENT CARE		
Room and Board	15%	
Ancillary Services	15%	
Physician Services	15%	
Surgery	15%	
Anesthesia	15%	
Mental Health Services	15%	
OUTPATIENT CARE		
Chemotherapy	\$20	
Radiation Therapy	20%	
Lab and Pathology	\$10 per day for basic 20% for specialty	
Diagnostic Testing and X-ray	20% for testing services \$10 per day for general imaging services 20% for specialty imaging services	
Allergy Testing	\$20	
Surgery	15% for outpatient surgery center \$20 for outpatient professional charges	
Anesthesia	\$20	
Mental Health Services	\$20	

TABLE 7 - ACTIVE		
Plan Design	EUTF CLOSED PANEL STANDARD HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
OTHER SERVICES		
Durable Medical Equipment	50%	
Hearing Aids	60% (one device per ear every 36 months)	
Home Health Care	No Charge	
Hospice Care	No Charge	
Skilled Nursing Facility Care	15% (60 days/benefit period)	
Physical and Occupational Therapy	\$20 (Outpatient)	
Chiropractic Services	\$15 (20 visits/CY) through American Specialty Health Group, Inc.	
PRESCRIPTION DRUGS		
Provided by Kaiser		
Calendar Year Maximum Out-of-Pocket	Applies towards the medical maximum out-of-pocket	
Retail		
Day Supply	30/60/90	
Generic	\$5/\$10/\$15 – tier 1 \$15/\$30/\$45 – tier 2	
Preferred Brand	\$50/\$100/\$150	
Non-Preferred Brand	\$50/\$100/\$150	
Preferred Insulin	\$50/\$100/\$150	
Other Insulin	\$15/\$30/\$45 (Generic)	
Preferred Diabetic Supplies	50% of applicable charges	
Other Diabetic Supplies	50% of applicable charges	
Oral Contraceptives	No Charge	
Injectables & Specialty Drug	\$75/\$150/\$225	
Oral Oncology	Subject to applicable generic/brand/specialty copayments	
Mail Order		
Day Supply	30/60/90	
Generic	\$5/\$10/\$10 – tier 1 \$15/\$30/\$30 – tier 2	
Preferred Brand	\$50/\$100/\$100	
Non-Preferred Brand	\$50/\$100/\$100	
Preferred Insulin	Not available through Mail Order	
Other Insulin	Not available through Mail Order	
Preferred Diabetic Supplies	50% of applicable charges	
Other Diabetic Supplies	50% of applicable charges	
Oral Contraceptives	No Charge	

INSURED

Proposal Sheet 7

**Closed Panel Standard HMO Plan – EUTF Active – All Bargaining Units
Premium Rate Table (Fully Insured)**

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

EUTF Closed Panel Standard HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL AND PRESCRIPTION DRUG				
Monthly Medical and Prescription Drug (Excluding DM/IHM and Chiropractic) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Medical and Prescription Drug Premium (Including DM/IHM, Chiropractic, and Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Medical and Prescription Drug Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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
(Part-Time and Temporary Employees)
Table and Proposal Sheets #8

**ACTIVE
EUTF – CLOSED PANEL STANDARD HMO PLAN (PART-TIME AND TEMPORARY EMPLOYEES)
TABLE AND PROPOSAL SHEETS #8**

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. Please note that the benefit plan design shall not change throughout the duration of the contract unless required otherwise by law.

TABLE 8 – ACTIVE		
Plan Design	EUTF CLOSED PANEL STANDARD HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL		
Provided by Kaiser		
General		
HMO Network		
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	\$2,500 per person \$7,500 per family	
Lifetime Benefit Maximum	None	
Plan Year Benefit Maximum	None	
PHYSICIAN SERVICES		
MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	\$20	
Annual Health Exam	No Charge	
Diabetes Prevention Program	No Charge	
Immunizations	No Charge	
Well Child Care Visits	No Charge	
Maternity	No Charge for routine prenatal visits and one postpartum visit 15% for delivery	
Screening Mammography	No Charge	
Advance Care Planning	No Charge (Continuing Care)	
EMERGENCY SERVICES		
Emergency Room	\$100	
Ambulance	20%	
INPATIENT CARE		
Room and Board	15%	
Ancillary Services	15%	
Physician Services	15%	
Surgery	15%	
Anesthesia	15%	
Mental Health Services	15%	
OUTPATIENT CARE		
Chemotherapy	\$20	
Radiation Therapy	20%	
Lab and Pathology	\$10 per day for basic 20% for specialty	
Diagnostic Testing and X-ray	20% for testing services \$10 per day for general imaging services 20% for specialty imaging services	
Allergy Testing	\$20	
Surgery	15% for outpatient surgery center \$20 for outpatient professional charges	
Anesthesia	\$20	
Mental Health Services	\$20	
OTHER SERVICES		
Durable Medical Equipment	50%	

TABLE 8 – ACTIVE		
Plan Design	EUTF CLOSED PANEL STANDARD HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Home Health Care	No Charge	
Hospice Care	No Charge	
Skilled Nursing Facility Care	15% (60 days/benefit period)	
Physical and Occupational Therapy	\$20 (Outpatient)	
PRESCRIPTION DRUGS	Provided by Kaiser	
Calendar Year Maximum Out-of-Pocket	Applies towards the medical maximum out-of-pocket	
Retail		
Day Supply	30/60/90	
Generic	\$5/\$10/\$15 – tier 1 \$15/\$30/\$45 – tier 2	
Preferred Brand	\$50/\$100/\$150	
Non-Preferred Brand	\$50/\$100/\$150	
Preferred Insulin	\$50/\$100/\$150	
Other Insulin	\$15/\$30/\$45 (Generic)	
Preferred Diabetic Supplies	50% of applicable charges	
Other Diabetic Supplies	50% of applicable charges	
Oral Contraceptives	No Charge	
Injectables & Specialty Drug	\$75/\$150/\$225	
Oral Oncology	Subject to applicable generic/brand/specialty copayments	
Mail Order		
Day Supply	30/60/90	
Generic	\$5/\$10/\$10 – tier 1 \$15/\$30/\$30 – tier 2	
Preferred Brand	\$50/\$100/\$100	
Non-Preferred Brand	\$50/\$100/\$100	
Preferred Insulin	Not available through Mail Order	
Other Insulin	Not available through Mail Order	
Preferred Diabetic Supplies	50% of applicable charges	
Other Diabetic Supplies	50% of applicable charges	
Oral Contraceptives	No Charge	

INSURED

Proposal Sheet 8

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

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

EUTF Closed Panel Standard HMO Plan (Part-Time and Temporary Employees)	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL AND PRESCRIPTION DRUG				
Monthly Medical and Prescription Drug Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Medical and Prescription Drug Premium (Including Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Medical and Prescription Drug Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

NOTES:

- (1) The EUTF reserves the right to offer multiple carrier 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 – Supplemental Copay Plan
Table and Proposal Sheets #9

**ACTIVE
EUTF – SUPPLEMENTAL COPAY PLAN
TABLE AND PROPOSAL SHEETS #9**

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed fees on a tiered basis.

TABLE 9 – ACTIVE		
Plan Design	EUTF SUPPLEMENTAL COPAY PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
MEDICAL	Provided by HMA	
General		
Calendar Year Deductible	None	
Calendar Year Out-of-Pocket Limit	None	
Lifetime Benefit Maximum	None	
Plan Year Benefit Maximum	All Services: \$2,750 per person, including the Rx Sublimit listed below	
PHYSICIAN SERVICES	MEMBER PAYS	
Physician Office Visit (including primary care and specialist office visits)	Copay/Coinsurance covered	
Annual Health Exam	Copay/Coinsurance covered	
Immunizations	Copay/Coinsurance covered	
Well Baby Care Visits	Copay/Coinsurance covered	
Maternity	Copay/Coinsurance covered	
Screening Mammography	Copay/Coinsurance covered	
EMERGENCY SERVICES		
Emergency Room	Copay/Coinsurance covered	
Ambulance	Copay/Coinsurance covered	
INPATIENT HOSPITAL SERVICES		
Room and Board	Copay/Coinsurance covered	
Ancillary Services	Copay/Coinsurance covered	
Physician Services	Copay/Coinsurance covered	
Surgery	Copay/Coinsurance covered	
Anesthesia	Copay/Coinsurance covered	
Mental Health Services	Copay/Coinsurance covered	
OUTPATIENT SERVICES		
Chemotherapy	Copay/Coinsurance covered	
Radiation Therapy	Copay/Coinsurance covered	
Lab and Pathology	Copay/Coinsurance covered	
Diagnostic Testing and X-ray	Copay/Coinsurance covered	
Allergy Testing	Copay/Coinsurance covered	
Surgery	Copay/Coinsurance covered	
Anesthesia	Copay/Coinsurance covered	
Mental Health Services	Copay/Coinsurance covered	
OTHER SERVICES		
Durable Medical Equipment	Copay/Coinsurance covered	
Home Health Care	Copay/Coinsurance covered	
Hospice Care	Copay/Coinsurance covered	
Skilled Nursing Facility Care	Copay/Coinsurance covered	
Physical and Occupational Therapy	Copay/Coinsurance covered	

TABLE 9 – ACTIVE

Plan Design	EUTF SUPPLEMENTAL COPAY PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
PRESCRIPTION DRUGS	Reimbursement for prescription drug copays charges shall not exceed \$20 per 30-day supply, \$40 per 60-day supply, and \$60 per 90-day supply. Reimbursement for prescription drugs copay counts towards the Plan Year Benefit Maximum.	
Plan Year Benefit Maximum Rx Sublimit	\$250 per person	

SELF-INSURED

Proposal Sheet 9A

**Supplemental Copay Plan – EUTF Active – All Bargaining Units
Target Claims, Retention and Fees Tables (Self-Insured ASO)**

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

EUTF Supplemental Copay Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL AND PRESCRIPTION DRUG				
Monthly ASO Fees (PEPM):				
Claims Adjudication Fee				
Other*				
Total ASO Fees (PEPM):				
Total ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total ASO fees indicated above and this percentage):	N/A	____%	____%	____%

* 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 #10

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

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 10 – ACTIVE			
Plan Design	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL			
Provided by HMSA			
General	In-Network	Out-of-Network*	
Calendar Year Deductible	None	\$100 per person \$300 per family	
Calendar Year Maximum Out-of-Pocket	\$2,000 per person \$4,000 per family		
Lifetime Benefit Maximum	None		
Plan Year Benefit Maximum	None		
PHYSICIAN SERVICES			
MEMBER PAYS			
Physician Office Visit (including primary care and specialist office visits)	10%	30%	
Annual Health Exam	No Charge	No Charge**	
Diabetes Prevention Program	No Charge (one program/lifetime)	Not Covered	
Immunizations	No Charge	30%	
Well Child Care Visits	No Charge	30%**	
Maternity	10%	30%	
Screening Mammography	No Charge	30%	
Advance Care Planning	No Charge	30%	
EMERGENCY SERVICES			
Emergency Room	10%	10%**	
Ambulance	10%	30%	
INPATIENT CARE			
Room and Board	10%	30%	
Ancillary Services	10%	30%	
Physician Services	10%	30%	
Surgery	10%	30%	
Anesthesia	10%	30%	
Mental Health Services	10%	30%	
OUTPATIENT CARE			
Chemotherapy	10%	30%	
Radiation Therapy	10%	30%	
Lab and Pathology	10%	30%	
Diagnostic Testing and X-ray (including genetic testing and counseling)	10%	30%	
Allergy Testing	10%	30%	
Surgery	10%	30%	
Anesthesia	10%	30%	
Mental Health Services	10%	30%	
OTHER SERVICES			
Durable Medical Equipment	10%	30%	

TABLE 10 – ACTIVE			
Plan Design	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Hearing Aids	10% (one device per ear every 60 months)	30% (one device per ear every 60 months)	
Home Health Care	No Charge (150 visits/CY)	30% (150 visits/CY)	
Hospice Care	No Charge	Not Covered	
Supportive Care	No Charge (90 days/ 12-month period)	Not Covered	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	10% (120 days/CY)	30% (120 days/CY)	
Physical and Occupational Therapy	10%	30%	
Reversing Heart Disease Program	\$20 per session (one program/ lifetime)	Not Covered	
Chiropractic Services	\$12 (20 visits/CY) through American Specialty Health Group, Inc.	Not Covered	
PRESCRIPTION DRUGS	Provided by CVS/caremark		
	Participating Pharmacy	Non-Participating Pharmacy*	
Calendar Year Maximum Out-of-Pocket	\$4,350 per person \$8,700 per family		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$9/\$9	\$5/\$9/\$9 + 30% of eligible charges	
Brand	\$15/\$27/\$27	\$15/\$27/\$27 + 30% of eligible charges	
Insulin	\$5/\$9/\$9	\$5/\$9/\$9 + 30% of eligible charges	
Diabetic Supplies	No Charge	30% of eligible charges	
Oral Contraceptives	No Charge	30% of eligible charges	
Injectables & Specialty Drug	Subject to applicable generic/brand copayments		
Oral Oncology	No Charge	30% of eligible charges	
Mail Order	Participating Mail Pharmacy	Non-Participating Mail Pharmacy	
Day Supply	30/60/90	Not Covered	
Generic	\$5/\$9/\$9	Not Covered	
Brand	\$15/\$27/\$27	Not Covered	
Insulin	\$5/\$9/\$9	Not Covered	
Diabetic Supplies	No Charge	Not Covered	
Oral Contraceptives	No Charge	Not Covered	

NOTE: Prescription drug benefits are currently provided under a separate contract.

Footnotes applicable to Medical and Prescription Drugs:

* *Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

** *Deductible does not apply.*

INSURED, RISK SHARING

Proposal Sheet 10A

90/10 PPO Plan – HSTA VB Active – HSTA Bargaining Unit Only

Premium Rate Table (Insured With Risk Sharing-Surplus Refund)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

HSTA VB 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Medical Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

HSTA VB 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
PRESCRIPTION DRUG				
Monthly Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Prescription Drug Premium (Including Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Prescription Drug Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): ____%

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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

Proposal Sheet 10B

**90/10 PPO Plan – HSTA VB Active – HSTA Bargaining Unit Only
Target Claims, Retention and Fees Tables (Self-Insured ASO)**

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

HSTA VB 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Estimated Medical Claims Cost:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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

MINIMUM PREMIUM

Proposal Sheet 10C

90/10 PPO Plan – HSTA VB Active – HSTA Bargaining Unit Only

Premium Rate Table (Insured with Limited Risk Sharing)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

HSTA VB 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Maximum Medical Claims Cost (paid by EUTF):				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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 #11

ACTIVE
HSTA VB – 80/20 PPO PLAN
TABLE AND PROPOSAL SHEETS #11

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 11 – ACTIVE			
Plan Design	HSTA VB 80/20 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by HMSA		
General	In-Network	Out-of-Network*	
Calendar Year Deductible	None		
Calendar Year Maximum Out-of-Pocket	\$2,500 per person \$5,000 per family		
Lifetime Benefit Maximum	None		
Plan Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	20%	20%	
Annual Health Exam	No Charge	No Charge	
Diabetes Prevention Program	No Charge (one program/lifetime)	Not Covered	
Immunizations	No Charge	No Charge	
Well Child Care Visits	No Charge	No Charge	
Maternity	20%	20%	
Screening Mammography	No Charge	No Charge	
Advance Care Planning	No Charge	20%	
EMERGENCY SERVICES			
Emergency Room	20%	20%	
Ambulance	20%	20%	
INPATIENT CARE			
Room and Board	20%	20%	
Ancillary Services	20%	20%	
Physician Services	20%	20%	
Surgery	20%	20%	
Anesthesia	20%	20%	
Mental Health Services	20%	20%	
OUTPATIENT CARE			
Chemotherapy	20%	20%	
Radiation Therapy	20%	20%	
Lab and Pathology	No Charge	No Charge	
Diagnostic Testing and X-ray (including genetic testing and counseling)	20%	20%	
Allergy Testing	20%	20%	
Surgery	20%	20%	
Anesthesia	20%	20%	
Mental Health Services	20%	20%	
OTHER SERVICES			
Durable Medical Equipment	20%	20%	

TABLE 11 – ACTIVE			
Plan Design	HSTA VB 80/20 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Hearing Aids	20% (one device per ear every 60 months)	20% (one device per ear every 60 months)	
Home Health Care	No Charge (150 visits/CY)	No Charge (150 visits/CY)	
Hospice Care	No Charge	No Charge	
Supportive Care	No Charge (90 days/ 12-month period)	Not Covered	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	20% (120 days/CY)	20% (120 days/CY)	
Physical and Occupational Therapy	20%	20%	
Reversing Heart Disease Program	\$20 per session (one program/ lifetime)	Not Covered	
Chiropractic Services	\$12 (20 visits/CY) through American Specialty Health Group, Inc.	Not Covered	
PRESCRIPTION DRUGS	Provided by CVS/caremark		
	Participating Pharmacy	Non-Participating Pharmacy*	
Calendar Year Maximum Out-of-Pocket	\$4,350 per person \$8,700 per family		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$9/\$9	\$5/\$9/\$9 + 30% of eligible charges	
Brand	\$15/\$27/\$27	\$15/\$27/\$27 + 30% of eligible charges	
Insulin	\$5/\$9/\$9	\$5/\$9/\$9 + 30% of eligible charges	
Diabetic Supplies	No Charge	30% of eligible charges	
Oral Contraceptives	No Charge	30% of eligible charges	
Injectables & Specialty Drug	Subject to applicable generic/brand copayments		
Oral Oncology	No Charge	30% of eligible charges	
Mail Order	Participating Mail Pharmacy	Non-Participating Mail Pharmacy	
Day Supply	30/60/90	Not Covered	
Generic	\$5/\$9/\$9	Not Covered	
Brand	\$15/\$27/\$27	Not Covered	
Insulin	\$5/\$9/\$9	Not Covered	
Diabetic Supplies	No Charge	Not Covered	
Oral Contraceptives	No Charge	Not Covered	

NOTE: Prescription drug benefits are currently provided under a separate contract.

Footnotes applicable to Medical and Prescription Drugs:

* *Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

INSURED, RISK SHARING

Proposal Sheet 11A

**80/20 PPO Plan – HSTA VB Active – HSTA Bargaining Unit Only
Premium Rate Table (Insured with Risk Sharing-Surplus Refund)**

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

HSTA VB 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Medical Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

HSTA VB 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
PRESCRIPTION DRUG				
Monthly Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Prescription Drug Premium (Including Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Prescription Drug Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): ____%

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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

Proposal Sheet 11B

**80/20 PPO Plan – HSTA VB Active – HSTA Bargaining Unit Only
Target Claims, Retention and Fees Tables (Self-Insured ASO)**

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

HSTA VB 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Estimated Medical Claims Cost:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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

MINIMUM PREMIUM

Proposal Sheet 11C

80/20 PPO Plan – HSTA VB Active –HSTA VB Bargaining Unit Only

Premium Rate Table (Insured with Limited Risk Sharing)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

HSTA VB 80/20 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Maximum Medical Claims Cost (paid by EUTF):				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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 – Closed Panel Comprehensive HMO Plan
Table and Proposal Sheets #12

**ACTIVE
HSTA VB – CLOSED PANEL COMPREHENSIVE HMO PLAN
TABLE AND PROPOSAL SHEETS #12**

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 12 - ACTIVE		
Plan Design	HSTA VB CLOSED PANEL COMPREHENSIVE HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by Kaiser	
General	HMO Network	
Calendar Year Deductible	None	
Calendar Year Out-of-Pocket Limit	\$2,000 per person \$6,000 per family	
Lifetime Benefit Maximum	None	
Plan Year Benefit Maximum	None	
PHYSICIAN SERVICES	MEMBER PAYS	
Physician Office Visit (including primary care and specialist office visits)	\$15	
Annual Health Exam	No Charge	
Diabetes Prevention Program	No Charge	
Immunizations	No Charge	
Well Child Care Visits	No Charge	
Maternity	No Charge for routine prenatal visits, delivery, and one postpartum visit	
Screening Mammography	No Charge	
Advance Care Planning	No Charge (Continuing Care)	
EMERGENCY SERVICES		
Emergency Room	\$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	
Mental Health Services	No Charge	
OUTPATIENT SERVICES		
Chemotherapy	\$15	
Radiation Therapy	\$15	
Lab and Pathology	\$15 per day	
Diagnostic Testing and X-ray	\$15 per day	
Allergy Testing	\$15	
Surgery	\$15	
Anesthesia	\$15	
Mental Health Services	\$15	
OTHER SERVICES		
Durable Medical Equipment	20%	
Hearing Aids	60% (one device per ear every 36 months)	
Home Health Care	No Charge	
Hospice Care	No Charge	

TABLE 12 - ACTIVE		
Plan Design	HSTA VB CLOSED PANEL COMPREHENSIVE HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Skilled Nursing Facility Care	No Charge (100 days/benefit period)	
Physical and Occupational Therapy	\$15 (Outpatient)	
Chiropractic Services	\$12 (20 visits/CY) through American Specialty Health Group, Inc.	
PRESCRIPTION DRUGS	Provided by Kaiser	
Calendar Year Maximum Out-of-Pocket	Applies towards the medical maximum out-of-pocket	
Retail		
Day Supply	30/60/90	
Generic	\$10/\$20/\$30	
Brand	\$10/\$20/\$30	
Insulin	\$10/\$20/\$30	
Diabetic Supplies	50% of applicable charges	
Oral Contraceptives	No Charge	
Injectables & Specialty Drug	\$10/\$20/\$30	
Oral Oncology	No Charge	
Mail Order		
Day Supply	30/60/90	
Generic	\$10/\$20/\$20	
Brand	\$10/\$20/\$20	
Insulin	Not available through Mail Order	
Diabetic Supplies	50% of applicable charges	
Oral Contraceptives	No Charge	

INSURED

Proposal Sheet 12

**Closed Panel Comprehensive HMO Plan – HSTA VB Active – HSTA Bargaining Unit Only
Premium Rate Table (Fully Insured)**

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

HSTA VB Closed Panel Comprehensive HMO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL AND PRESCRIPTION DRUG				
Monthly Medical and Prescription Drug (Excluding DM/IHM and Chiropractic) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:				
Single				
Two-Party				
Family				
Monthly Chiropractic Benefit Cost:				
Single				
Two-Party				
Family				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Single				
Two-Party				
Family				
Total Medical and Prescription Drug Premium (Including DM/IHM, Chiropractic, and Administration and Retention):				
Single				
Two-Party				
Family				
Monthly ACA Fees to be Added to the Above <u>Total Medical and Prescription Drug Premium</u>				
Insurer Fee:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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
EUTF – 90/10 PPO Plan
Table and Proposal Sheets #13**

**NON-MEDICARE RETIREE
EUTF – 90/10 PPO PLAN
TABLE AND PROPOSAL SHEETS #13**

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 13 – NON-MEDICARE RETIREE			
Plan Design	EUTF 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by HMSA		
General	In-Network	Out-of-Network*	
Calendar Year Deductible	\$100 per person \$300 per family		
Calendar Year Maximum Out-of-Pocket	\$2,500 per person \$7,500 per family		
Lifetime Benefit Maximum	None		
Plan Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	10%**	30%	
Annual Health Exam	No Charge**	30%**	
Diabetes Prevention Program***	No Charge** (one program/ lifetime)	Not Covered	
Immunizations	No Charge**	No Charge	
Well Child Care Visits	No Charge**	30%**	
Maternity	10%**	30%	
Screening Mammography	20%**	30%**	
Advance Care Planning	No Charge**	10%**	
EMERGENCY SERVICES			
Emergency Room	10%**	10%**	
Ambulance	20%	30%	
INPATIENT HOSPITAL SERVICES			
Room and Board	10%**	30%	
Ancillary Services	10%**	30%	
Physician Services	10%**	30%	
Surgery	10%** (Cutting)	30%	
Anesthesia	10%**	30%	
Mental Health Services	10%**	30%	
OUTPATIENT SERVICES			
Chemotherapy	20%	30%	
Radiation Therapy	20%**	30%	
Lab and Pathology	20%**	30%	
Diagnostic Testing and X-ray (including genetic testing and counseling)	20%**	30%	
Allergy Testing	20%	30%	
Surgery	10%** (Cutting)	30%	
Anesthesia	10%**	30%	
Mental Health Services	10%** 20%** (Psych Testing)	30%	

TABLE 13 – NON-MEDICARE RETIREE

Plan Design	EUTF 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
OTHER SERVICES			
Durable Medical Equipment	20%	30%	
Hearing Aids	20% (one device per ear every 60 months)	30% (one device per ear every 60 months)	
Home Health Care	No Charge** (150 visits/CY)	30% (150 visits/CY)	
Hospice Care	No Charge**	Not Covered	
Supportive Care***	No Charge** (90 days/ 12-month period)	Not Covered	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	10%** (120 days/CY)	30% (120 days/CY)	
Physical and Occupational Therapy	20% (Outpatient)	30%	
Reversing Heart Disease Program***	\$20 per session** (one program/ lifetime)	Not Covered	
Chiropractic Services***	Not Covered	Not Covered	
PRESCRIPTION DRUGS	Provided by CVS/caremark		
	Participating Pharmacy	Non-Participating Pharmacy*	
Calendar Year Maximum Out-of-Pocket	None		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Preferred Brand	\$15/\$30/\$45	\$15/\$30/\$45 + 20% of eligible charges	
Non-Preferred Brand	\$30/\$60/\$90	\$30/\$60/\$90 + 20% of eligible charges	
Preferred Insulin	\$5/\$10/\$15	\$5/\$10/\$15 + 20% of eligible charges	
Other Insulin	\$15/\$30/\$45	\$15/\$30/\$45 + 20% of eligible charges	
Preferred Diabetic Supplies	No Charge	20% of eligible charges	
Other Diabetic Supplies	\$15/\$30/\$45	\$15/\$30/\$45 + 20% of eligible charges	
Oral Contraceptives	Subject to applicable generic/brand copayments	20% of eligible charges	
Injectables & Specialty Drug	20% of eligible charges; Up to \$250 maximum per fill; \$2,000 maximum out-of-pocket per calendar year. Specialty drugs are not available through mail order and only dispensed up to a 30-day supply.		
Oral Oncology	\$30		
Retail 90 and Mail Order	Retail 90 or Mail Pharmacy	Non-Retail 90 Pharmacy	
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$10	\$5/\$10/\$15	
Preferred Brand	\$15/\$30/\$30	\$15/\$30/\$45	

TABLE 13 – NON-MEDICARE RETIREE			
Plan Design	EUTF 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Non-Preferred Brand	\$30/\$60/\$60	\$30/\$60/\$90	
Preferred Insulin	\$5/\$10/\$10	\$5/\$10/\$15	
Other Insulin	\$15/\$30/\$30	\$15/\$30/\$45	
Preferred Diabetic Supplies	No Charge	No Charge	
Other Diabetic Supplies	\$15/\$30/\$30	\$15/\$30/\$45	
Oral Contraceptives	Subject to applicable generic/brand copayments	20% of eligible charges	
Injectables & Specialty Drug	Not Covered	See benefit described above	

NOTE: Prescription drug benefits are currently provided under a separate contract.

Footnotes applicable to Medical and Prescription Drugs:

* *Out-of-Network benefits are limited to usual customary and reasonable charges. Out-of-pocket expenses for out-of-network benefits apply towards the total annual maximum out-of-pocket (MOOP) but may exceed the MOOP once the MOOP is reached.*

** *Deductible does not apply.*

*** *The Diabetes Prevention, Reversing Heart Disease, and Supportive Care programs are currently pilot programs approved through December 31, 2020. In a separate attachment, please include the proposed rate on a tiered basis to continue these programs into the term of the new contract. Chiropractic services are currently not covered under this plan. In the same attachment, please also include the proposed rate on a tiered basis for a fully insured in-network chiropractic benefit (in-network \$15 per visit limited to 20 visits per calendar year and not covered out-of-network).*

† *Maintenance medications must be filled in a 90-day supply after the first three 30-day initial fills; can be filled at any retail network or mail pharmacy.*

**MEDICARE RETIREE
EUTF – 90/10 PPO PLAN
TABLE AND PROPOSAL SHEETS #13 Continued**

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 13 Continued – MEDICARE RETIREE			
Plan Design	EUTF 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by HMSA		
General	In-Network	Out-of-Network*	
Calendar Year Deductible	\$100 per person \$300 per family		
Calendar Year Maximum Out-of-Pocket	\$2,500 per person \$7,500 per family		
Lifetime Benefit Maximum	None		
Plan Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	10%**	30%	
Annual Wellness Visit (Covered under Medicare)	No Charge**	No Charge**	
Annual Health Exam	No Charge**	30%**	
Diabetes Prevention Program***	No Charge** (one program/lifetime)	Not Covered	
Immunizations	No Charge**	No Charge	
Well Child Care Visits	No Charge**	30%**	
Maternity	10%**	30%	
Screening Mammography	20%**	30%**	
Advance Care Planning	No Charge**	10%**	
EMERGENCY SERVICES			
Emergency Room	10%**	10%**	
Ambulance	20%	30%	
INPATIENT HOSPITAL SERVICES			
Room and Board	10%**	30%	
Ancillary Services	10%**	30%	
Physician Services	10%**	30%	
Surgery	10%** (Cutting)	30%	
Anesthesia	10%**	30%	
Mental Health Services	10%**	30%	
OUTPATIENT SERVICES			
Chemotherapy	20%	30%	
Radiation Therapy	20%**	30%	
Lab and Pathology	20%**	30%	
Diagnostic Testing and X-ray (including genetic testing and counseling)	20%**	30%	
Allergy Testing	20%	30%	
Surgery	10%** (Cutting)	30%	
Anesthesia	10%**	30%	

TABLE 13 Continued – MEDICARE RETIREE

Plan Design	EUTF 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Mental Health Services	10%** 20%** (Psych Testing)	30%	
OTHER SERVICES			
Durable Medical Equipment	20%	30%	
Hearing Aids	20% (one device per ear every 60 months)	30% (one device per ear every 60 months)	
Home Health Care	No Charge** (150 visits/CY)	30% (150 visits/CY)	
Hospice Care	No Charge**	Not Covered	
Supportive Care***	No Charge** (90 days/ 12-month period)	Not Covered	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	10%** (120 days/CY)	30% (120 days/CY)	
Physical and Occupational Therapy	20% (Outpatient)	30%	
Reversing Heart Disease Program***	\$20 per session** (one program/ lifetime)	Not Covered	
Chiropractic Services***	Not Covered	Not Covered	
MEDICARE PART D PRESCRIPTION DRUGS	Provided by SilverScript		
	Participating Pharmacy	Non-Participating Pharmacy	
Calendar Year Maximum Out-of-Pocket	None		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$10	\$5/\$10/\$10 + 20% of eligible charges	
Preferred Brand	\$15/\$30/\$30	\$15/\$30/\$30 + 20% of eligible charges	
Non-Preferred Brand	\$30/\$60/\$60	\$30/\$60/\$60 + 20% of eligible charges	
Insulin	\$5/\$10/\$10	\$5/\$10/\$10 + 20% of eligible charges	
Diabetic Supplies	No Charge Meters: Covered by Medicare Part B and the EUTF 90/10 PPO medical plan.	20% of eligible charges Meters: Covered by Medicare Part B and the EUTF 90/10 PPO medical plan.	

TABLE 13 Continued – MEDICARE RETIREE

Plan Design	EUTF 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Injectables & Specialty Drug	20% of eligible charges; Up to \$250 maximum per fill; \$2,000 maximum out-of-pocket per calendar year. Specialty drugs are not available through mail order and only dispensed up to a 30-day supply.	50% of eligible charges	
Oral Oncology	\$30/\$60/\$60	\$30/\$60/\$60 + 20% of eligible charges	
Mail Order	Participating Mail Pharmacy	Non-Participating Mail Pharmacy	
Day Supply	30/60/90	Not Covered	
Generic	\$5/\$10/\$10	Not Covered	
Preferred Brand	\$15/\$30/\$30	Not Covered	
Non-Preferred Brand	\$30/\$60/\$60	Not Covered	
Insulin	\$5/\$10/\$10	Not Covered	
Diabetic Supplies	No Charge	Not Covered	

NOTE: Prescription drug benefits are currently provided under a separate contract.

Footnotes applicable to Medical:

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

** *Deductible does not apply.*

*** *The Diabetes Prevention, Reversing Heart Disease, and Supportive Care programs are currently pilot programs approved through December 31, 2020. In a separate attachment, please include the proposed rate on a tiered basis to continue these programs into the term of the new contract. Chiropractic services are currently not covered under this plan. In the same attachment, please also include the proposed rate on a tiered basis for a fully insured in-network chiropractic benefit (in-network \$15 per visit limited to 20 visits per calendar year and not covered out-of-network).*

INSURED, RISK SHARING

Proposal Sheet 13A

90/10 PPO Plan – EUTF Retiree

Premium Rate Table (Insured with Risk Sharing-Surplus Refund)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF 90/10 PPO Plan	Contract Period 1		Contract Period 2		Contract Period 3		Contract Period 4	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
MEDICAL								
Monthly Medical (Excluding DM/IHM) Benefit Cost:								
Single								
Two-Party								
Family								
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:								
Single								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A		_____%		_____%		_____%	
Monthly Administration and Retention:								
Single								
Two-Party								
Family								
Total Medical Premium (Including DM/IHM and Administration and Retention):								
Single								
Two-Party								
Family								
Monthly ACA Fees to be Added to the Above <u>Total Medical Premium</u>								
Insurer Fee:								
Single								
Two-Party								
Family								

EUTF 90/10 PPO Plan	Contract Period 1		Contract Period 2		Contract Period 3		Contract Period 4	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
PRESCRIPTION DRUG								
Monthly Benefit Cost:								
Single								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):	N/A		____%		____%		____%	
Monthly Administration and Retention:								
Single								
Two-Party								
Family								
Total Prescription Drug Premium (Including Administration and Retention):								
Single								
Two-Party								
Family								
Monthly ACA Fees to be Added to the Above <u>Total Prescription Drug Premium</u>								
Insurer Fee:								
Single								
Two-Party								
Family								

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): ____%

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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

Proposal Sheet 13B

90/10 PPO Plan – EUTF Retiree

Target Claims, Retention and Fees Tables (Self-Insured ASO)

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

EUTF 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Estimated Medical Claims Cost:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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

MINIMUM PREMIUM

Proposal Sheet 13C

90/10 PPO Plan – EUTF Retiree

Premium Rate Table (Insured with Limited Risk Sharing)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Maximum Medical Claims Cost (paid by EUTF):				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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 #14

**NON-MEDICARE RETIREE
EUTF – CLOSED PANEL HMO PLAN
TABLE AND PROPOSAL SHEETS #14**

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 14 – NON-MEDICARE RETIREE		
Plan Design	EUTF CLOSED PANEL HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by Kaiser	
General	HMO Network	
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	\$2,000 per person \$6,000 per family	
Lifetime Benefit Maximum	None	
Plan Year Benefit Maximum	None	
PHYSICIAN SERVICES	MEMBER PAYS	
Physician Office Visit (including primary care and specialist office visits)	\$15	
Annual Health Exam	No Charge	
Diabetes Prevention Program	No Charge	
Immunizations	No Charge	
Well Child Care Visits	No Charge	
Maternity	No Charge for routine prenatal visits, delivery, and one postpartum visit	
Screening Mammography	No Charge	
Advance Care Planning	No Charge (Continuing Care)	
EMERGENCY SERVICES		
Emergency Room	\$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	
Mental Health Services	No Charge	
OUTPATIENT SERVICES		
Chemotherapy	\$15	
Radiation Therapy	\$15	
Lab and Pathology	\$15	
Diagnostic Testing and X-ray	\$15	
Allergy Testing	\$15	
Surgery	\$15	
Anesthesia	\$15	
Mental Health Services	\$15	
OTHER SERVICES		
Durable Medical Equipment	20% (including Diabetes Equipment)	
Hearing Aids*	Not Covered	
Home Health Care	No Charge	
Hospice Care	No Charge	
Skilled Nursing Facility Care	No Charge (100 days/benefit period)	

TABLE 14 – NON-MEDICARE RETIREE		
Plan Design	EUTF CLOSED PANEL HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Physical and Occupational Therapy	\$15 (Outpatient)	
Chiropractic Services*	Not Covered	
PRESCRIPTION DRUGS	Provided by Kaiser	
Calendar Year Maximum Out-of-Pocket	Applies towards the medical maximum out-of-pocket	
Retail		
Day Supply	30/60/90	
Generic	\$15/\$30/\$45	
Preferred Brand	\$15/\$30/\$45	
Non-Preferred Brand	\$15/\$30/\$45	
Preferred Insulin	\$15/\$30/\$45	
Other Insulin	\$15/\$30/\$45	
Preferred Diabetic Supplies	\$15/\$30/\$45	
Other Diabetic Supplies	\$15/\$30/\$45	
Oral Contraceptives	50% of applicable charges	
Injectables & Specialty Drug	\$15 up to a 30-day supply Not all drugs can be mailed; restrictions and limitations apply	
Oral Oncology	No Charge	
Mail Order		
Day Supply	30/60/90	
Generic	\$15/\$30/\$30	
Preferred Brand	\$15/\$30/\$30	
Non-Preferred Brand	\$15/\$30/\$30	
Preferred Insulin	Not available through Mail Order	
Other Insulin	Not available through Mail Order	
Preferred Diabetic Supplies	\$15/\$30/\$30	
Other Diabetic Supplies	\$15/\$30/\$30	
Oral Contraceptives	50% of applicable charges	

Footnotes applicable to Medical:

* Hearing aids and chiropractic services are currently not covered under this plan. In a separate attachment, please include the proposed rates on a tiered basis for fully insured hearing aid (in-network 40% benefit per ear every 36 months) and chiropractic benefits (in-network \$15 per visit limited to 20 visits per calendar year and not covered out-of-network).

**MEDICARE RETIREE
EUTF – CLOSED PANEL HMO PLAN
TABLE AND PROPOSAL SHEETS #14 Continued**

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 14 Continued – MEDICARE RETIREE		
Plan Design	EUTF CLOSED PANEL HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by Kaiser	
General	HMO Network	
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	\$2,000 per person \$6,000 per family	
Lifetime Benefit Maximum	None	
Plan Year Benefit Maximum	None	
PHYSICIAN SERVICES	MEMBER PAYS	
Physician Office Visit (including primary care and specialist office visits)	\$15	
Annual Wellness Visit	No Charge	
Annual Health Exam	No Charge	
Medicare Diabetes Prevention Program	No Charge	
Immunizations	No Charge	
Screening Mammography	No Charge	
Advance Care Planning	No Charge (Continuing Care)	
EMERGENCY SERVICES		
Emergency Room	\$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	
Mental Health Services	No Charge	
OUTPATIENT SERVICES		
Chemotherapy	\$15	
Radiation Therapy	\$15	
Lab and Pathology	No Charge	
Diagnostic Testing and X-ray	No Charge	
Allergy Testing	\$15	
Surgery	\$15	
Anesthesia	\$15	
Mental Health Services	\$15	
OTHER SERVICES		
Durable Medical Equipment	20% (including Diabetes Equipment)	
Hearing Aids*	Not Covered	
Home Health Care	No Charge	
Hospice Care	No Charge	
Skilled Nursing Facility Care	No Charge (100 days/benefit period)	

TABLE 14 Continued – MEDICARE RETIREE		
Plan Design	EUTF CLOSED PANEL HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Physical and Occupational Therapy	\$15 (Outpatient)	
Chiropractic Services*	Not Covered	
PRESCRIPTION DRUGS	Provided by Kaiser	
Calendar Year Maximum Out-of-Pocket	Applies towards the medical maximum out-of-pocket	
Retail		
Day Supply	30/60/90	
Generic	\$15/\$30/\$45	
Preferred Brand	\$15/\$30/\$45	
Non-Preferred Brand	\$15/\$30/\$45	
Insulin	\$15/\$30/\$45	
Diabetic Supplies	Lancets, Strips & Meters: 20% Syringes/Needles: \$15/\$30/\$45	
Injectables & Specialty Drug	\$15 up to a 30-day supply Not all drugs can be mailed; restrictions and limitations apply	
Oral Oncology	\$15/\$30/\$45	
Mail Order		
Day Supply	30/60/90	
Generic	\$15/\$30/\$30	
Preferred Brand	\$15/\$30/\$30	
Non-Preferred Brand	\$15/\$30/\$30	
Insulin	Not available through Mail Order	
Diabetic Supplies	Lancets, Strips & Meters: 20% Syringes/Needles: \$15/\$30/\$30	

Footnotes applicable to Medical:

* Hearing aids and chiropractic services are currently not covered under this plan. In a separate attachment, please include the proposed rates on a tiered basis for fully insured hearing aid (in-network 40% benefit per ear every 36 months) and chiropractic benefits (in-network \$15 per visit limited to 20 visits per calendar year and not covered out-of-network).

INSURED

Proposal Sheet 14

Closed Panel HMO Plan – EUTF Retiree

Premium Rate Table (Fully Insured)

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

EUTF Closed Panel HMO Plan	Contract Period 1		Contract Period 2		Contract Period 3		Contract Period 4	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
MEDICAL AND PRESCRIPTION DRUG								
Monthly Medical and Prescription Drug (Excluding DM/IHM) Benefit Cost:								
Single								
Two-Party								
Family								
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:								
Single								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A		_____%		_____%		_____%	
Monthly Administration and Retention:								
Single								
Two-Party								
Family								
Total Medical and Prescription Drug Premium (Including DM/IHM and Administration and Retention):								
Single								
Two-Party								
Family								
Monthly ACA Fees to be Added to the Above <u>Total Medical and Prescription Drug Premium</u>								
Insurer Fee:								
Single								
Two-Party								
Family								

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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

**Medicare Retiree
EUTF – Medicare Advantage LPPO Plan
Table and Proposal Sheets #15**

**MEDICARE RETIREE
EUTF – MEDICARE ADVANTAGE LPPO PLAN
TABLE AND PROPOSAL SHEETS #15**

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 requested benefit plan. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on tiered basis.

TABLE 15 – MEDICARE (AND NON-MEDICARE, IF OFFERED) RETIREE			
Plan Design	EUTF MEDICARE ADVANTAGE LPPO PLAN (AND NON-MEDICARE IF OFFERED)		NOTE ALL DEVIATIONS IN YOUR COMPANY’S PROPOSED BENEFITS
MEDICAL	Requested		
General	In-Network	Out-of-Network	
Calendar Year Deductible	\$100 per person		
Calendar Year Maximum Out-of-Pocket	\$2,500 per person		
Lifetime Benefit Maximum	None		
Plan Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	10%*	10%	
Annual Wellness Visit	No Charge*	No Charge*	
Annual Health Exam	No Charge*	No Charge*	
Diabetes Prevention Program**	No Charge* (one program for non-Medicare and Medicare/lifetime)	Not Covered	
Immunizations	No Charge*	No Charge*	
Screening Mammography	10%*	10%*	
Advance Care Planning	No Charge*	10%	
EMERGENCY SERVICES			
Emergency Room	10%	10%	
Ambulance	10%	10%	
INPATIENT HOSPITAL SERVICES			
Room and Board	10%	10%	
Ancillary Services	10%	10%	
Physician Services	10%	10%	
Surgery	10%	10%	
Anesthesia	10%	10%	
Mental Health Services	10%	10%	
OUTPATIENT SERVICES			
Chemotherapy	10%	10%	
Radiation Therapy	10%	10%	
Lab and Pathology	10%	10%	
Diagnostic Testing	10%	10%	
Allergy Testing	10%	10%	
Surgery	10%	10%	
Anesthesia	10%	10%	
Mental Health Services	10%	10%	
OTHER SERVICES			
Medicare Part B Covered Diabetic Supplies	10%*	10%	

TABLE 15 – MEDICARE (AND NON-MEDICARE, IF OFFERED) RETIREE

Plan Design	EUTF MEDICARE ADVANTAGE LPPO PLAN (AND NON-MEDICARE IF OFFERED)		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Durable Medical Equipment	10%	10%	
Hearing Aids	20% (one device per ear every 60 months)	30% (one device per ear every 60 months)	
Home Health Care	No Charge* (150 visits/CY)	10% (150 visits/CY)	
Hospice Care	No Charge*	Not Covered	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	10% (120 days/CY)	10% (120 days/CY)	
Physical and Occupational Therapy	10%	10%	
Fitness Program	No Charge	Not Covered	
MEDICARE PART D PRESCRIPTION DRUGS†	Participating Pharmacy	Non-Participating Pharmacy	
Calendar Year Maximum Out-of-Pocket	\$4,350 per person \$8,700 per family		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$10/\$10	\$5/\$10/\$10 + 20% of eligible charges	
Preferred Brand	\$25/\$50/\$50	\$25/\$50/\$50 + 20% of eligible charges	
Non-Preferred Brand	\$50/\$100/\$100	\$50/\$100/\$100 + 20% of eligible charges	
Preferred Insulin	\$5/\$10/\$10	\$5/\$10/\$10 + 20% of eligible charges	
Other Insulin	\$25/\$50/\$50	\$25/\$50/\$50 + 20% of eligible charges	
Preferred Diabetic Supplies	No Charge	20% of eligible charges	
Other Diabetic Supplies	\$25/\$50/\$50	\$25/\$50/\$50 + 20% of eligible charges	
Injectables & Specialty Drug	30-day supply only		
Specialty Calendar Year Maximum Out-of-Pocket	\$2,500 per person		
Specialty Generic	10% of eligible charges (up to \$200 per fill)		
Specialty Preferred Brand	20% of eligible charges (up to \$300 per fill)		
Specialty Non-Preferred Brand	30% of eligible charges (up to \$400 per fill)		
Oral Oncology	\$30		
Mail Order	Participating Mail Pharmacy	Non-Participating Mail Pharmacy	
Day Supply	30/60/90	Not Covered	
Generic	\$5/\$10/\$10	Not Covered	
Preferred Brand	\$25/\$50/\$50	Not Covered	
Non-Preferred Brand	\$50/\$100/\$100	Not Covered	
Preferred Insulin	\$5/\$10/\$10	Not Covered	
Other Insulin	\$25/\$50/\$50	Not Covered	

TABLE 15 – MEDICARE (AND NON-MEDICARE, IF OFFERED) RETIREE

Plan Design	EUTF MEDICARE ADVANTAGE LPPO PLAN (AND NON-MEDICARE IF OFFERED)		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Preferred Diabetic Supplies	No Charge	Not Covered	
Other Diabetic Supplies	\$25/\$50/\$50	Not Covered	
Injectables and Specialty Drug	Not Covered	Not Covered	

Footnotes applicable to Medical:

* *Deductible does not apply.*

** *In a separate attachment, please include the proposed rate on a tiered basis for the Reversing Heart Disease Program (in-network \$20 per session/once per lifetime and not covered out-of-network), Supportive Care (in-network 90-days/12 month period and not covered out-of-network), and fully insured in-network chiropractic benefit (in-network \$15 per visit limited to 20 visits per calendar year and not covered out-of-network).*

† *The Medicare Part D drug plan is optional.*

INSURED

Proposal Sheet 15A

**Medicare Advantage LPPO Plan ONLY– EUTF Medicare Retiree and Medicare Retiree Spouses ONLY
Premium Rate Table (Fully Insured)**

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF Medicare Advantage LPPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical (Excluding DM/IHM) Benefit Cost:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Total Medical Premium (Including DM/IHM and Administration and Retention):				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Monthly ACA Fees to be Added to the Above <u>Total Medical Premium</u>				
Insurer Fee:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				

EUTF Medicare Advantage LPPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
PRESCRIPTION DRUG (optional)				
Monthly Benefit Cost:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):	N/A	____%	____%	____%
Monthly Administration and Retention:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Total Prescription Drug Premium (Including Administration and Retention):				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				
Monthly ACA Fees to be Added to the Above <u>Total Prescription Drug Premium</u>				
Insurer Fee:				
Medicare Retiree				
Medicare Retiree + Medicare Spouse				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): ____%

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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

INSURED

Proposal Sheet 15B

**Medicare Advantage LPPO and Non-Medicare Plans – EUTF Retirees
Premium Rate Table (Fully Insured)**

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

EUTF Medicare Advantage LPPO and Non-Medicare Plans	Contract Period 1		Contract Period 2		Contract Period 3		Contract Period 4	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
MEDICAL								
Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:								
Single								
Two-Party								
Family								
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:								
Single								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A		_____%		_____%		_____%	
Monthly Administration and Retention:								
Single								
Two-Party								
Family								
Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):								
Single								
Two-Party								
Family								
Monthly ACA Fees to be Added to the Above <u>Total Medical Premium</u>								
Insurer Fee:								
Single								
Two-Party								
Family								

EUTF Medicare Advantage LPPO Plan	Contract Period 1		Contract Period 2		Contract Period 3		Contract Period 4	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
PRESCRIPTION DRUG (optional)								
Monthly Benefit Cost:								
Single								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):	N/A		_____%		_____%		_____%	
Monthly Administration and Retention:								
Single								
Two-Party								
Family								
Total Prescription Drug Premium (Including Administration and Retention):								
Single								
Two-Party								
Family								
Monthly ACA Fees to be Added to the Above <u>Total Prescription Drug Premium</u>								
Insurer Fee:								
Single								
Two-Party								
Family								

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): _____%

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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 – 90/10 PPO Plan
Table and Proposal Sheets #16

**NON-MEDICARE RETIREE
HSTA VB – 90/10 PPO PLAN
TABLE AND PROPOSAL SHEETS #16**

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 16 – NON-MEDICARE RETIREE			
Plan Design	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by HMSA		
General	In-Network	Out-of-Network*	
Calendar Year Deductible	None	\$100 per person \$300 per family	
Calendar Year Maximum Out-of-Pocket	\$2,000 per person \$6,000 per family		
Lifetime Benefit Maximum	\$2,000,000 per person		
Plan Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	10%	30%	
Annual Health Exam	No Charge (up to CY dollar max depending on age)	No Charge** (up to CY dollar max depending on age)	
Diabetes Prevention Program***	No Charge (one program/lifetime)	Not Covered	
Immunizations	No Charge	30%	
Well Child Care Visits	No Charge	30%**	
Maternity	10%	30%	
Screening Mammography	10%	30%	
Advance Care Planning	No Charge	30%	
EMERGENCY SERVICES			
Emergency Room	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%	
Mental Health Services	10%	30%	
OUTPATIENT SERVICES			
Chemotherapy	10%	30%	
Radiation Therapy	10%	30%	
Lab and Pathology	10%	30%	
Diagnostic Testing and X-ray (including genetic testing and counseling)	10%	30%	
Allergy Testing	10%	30%	
Surgery	10%	30%	
Anesthesia	10%	30%	
Mental Health Services	10%	30%	

TABLE 16 – NON-MEDICARE RETIREE

Plan Design	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
OTHER SERVICES			
Durable Medical Equipment	10%	30%	
Hearing Aids	10% (one device per ear every 60 months)	30% (one device per ear every 60 months)	
Home Health Care	No Charge (150 visits/CY)	30% (150 visits/CY)	
Hospice Care	No Charge	Not Covered	
Supportive Care***	No Charge (90 days/ 12-month period)	Not Covered	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	10% (120 days/CY)	30% (120 days/CY)	
Physical and Occupational Therapy	10%	30%	
Reversing Heart Disease Program***	\$20 per session (one program/ lifetime)	Not Covered	
Chiropractic Services	\$12 (20 visits/CY) through American Specialty Health Group, Inc.	Not Covered	
PRESCRIPTION DRUGS	Provided by CVS/caremark		
	Participating Pharmacy	Non-Participating Pharmacy*	
Calendar Year Maximum Out-of-Pocket	None		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$5/\$9/\$9	\$5/\$9/\$9 + 30% of eligible charges	
Brand	\$15/\$27/\$27	\$15/\$27/\$27 + 30% of eligible charges	
Insulin	\$5/\$9/\$9	\$5/\$9/\$9 + 30% of eligible charges	
Diabetic Supplies	No Charge	No Charge	
Oral Contraceptives	Subject to applicable generic/brand copayments	30% of eligible charges	
Injectables & Specialty Drug	Subject to applicable generic/brand copayments. Specialty drugs are not available through mail order and only dispensed up to a 30-day supply.		
Oral Oncology	No Charge	30% of eligible charges	
Mail Order	Participating Mail Pharmacy	Non-Participating Mail Pharmacy	
Day Supply	30/60/90	Not Covered	
Generic	\$5/\$9/\$9	Not Covered	
Brand	\$15/\$27/\$27	Not Covered	
Insulin	\$5/\$9/\$9	Not Covered	
Diabetic Supplies	No Charge	Not Covered	

TABLE 16 – NON-MEDICARE RETIREE			
Plan Design	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Oral Contraceptives	Subject to applicable generic/brand copayments	30% of eligible charges	
Injectables & Specialty Drug	Not Covered	Not Covered	

NOTE: Prescription drug benefits are currently provided under separate contracts.

Footnotes applicable to Medical:

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

** *Deductible does not apply.*

*** *The Diabetes Prevention, Reversing Heart Disease, and Supportive Care programs are currently pilot programs approved through December 31, 2020. In a separate attachment, please include the proposed rate on a tiered basis to continue these programs into the term of the new contract.*

**MEDICARE RETIREE
HSTA VB – 90/10 PPO PLAN
TABLE AND PROPOSAL SHEETS #16 Continued**

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a tiered basis.

TABLE 16 Continued – MEDICARE RETIREE			
Plan Design	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL	Provided by HMSA		
General	In-Network	Out-of-Network*	
Calendar Year Deductible	None	\$100 per person \$300 per family	
Calendar Year Maximum Out-of-Pocket	\$2,000 per person \$6,000 per family		
Lifetime Benefit Maximum	\$2,000,000 per person		
Plan Year Benefit Maximum	None		
PHYSICIAN SERVICES	MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	10%	30%	
Annual Wellness Visit (Covered under Medicare)	No Charge	No Charge**	
Annual Health Exam	No Charge (up to CY dollar max depending on age)	No Charge** (up to CY dollar max depending on age)	
Diabetes Prevention Program***	No Charge (one program/lifetime)	Not Covered	
Immunizations	No Charge	30%	
Well Child Care Visits	No Charge	30%**	
Maternity	10%	30%	
Screening Mammography	10%	30%	
Advance Care Planning	No Charge	30%	
EMERGENCY SERVICES			
Emergency Room	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%	
Mental Health Services	10%	30%	
OUTPATIENT SERVICES			
Chemotherapy	10%	30%	
Radiation Therapy	10%	30%	
Lab and Pathology	10%	30%	
Diagnostic Testing and X-ray (including genetic testing and counseling)	10%	30%	
Allergy Testing	10%	30%	
Surgery	10%	30%	
Anesthesia	10%	30%	

TABLE 16 Continued – MEDICARE RETIREE

Plan Design	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Mental Health Services	10%	30%	
OTHER SERVICES			
Durable Medical Equipment	10%	30%	
Hearing Aids	10% (one device per ear every 60 months)	30% (one device per ear every 60 months)	
Home Health Care	No Charge (150 visits/CY)	30% (150 visits/CY)	
Hospice Care	No Charge	Not Covered	
Supportive Care***	No Charge (90 days/ 12-month period)	Not Covered	
Extended Care Facility (Skilled Nursing, Sub-Acute, and Long-Term Acute Care Facilities)	10% (120 days/CY)	30% (120 days/CY)	
Physical and Occupational Therapy	10%	30%	
Reversing Heart Disease Program***	\$20 per session (one program/ lifetime)	Not Covered	
Chiropractic Services	\$12 (20 visits/CY) through American Specialty Health Group, Inc.	Not Covered	
MEDICARE PART D PRESCRIPTION DRUGS	Provided by SilverScript		
	Participating Pharmacy	Non-Participating Pharmacy	
Calendar Year Maximum Out-of-Pocket	None		
Retail			
Day Supply	30/60/90	30/60/90	
Generic	\$3/\$9/\$9	\$3/\$9/\$9 + 30% of eligible charges	
Brand	\$9/\$27/\$27	\$9/\$27/\$27 + 30% of eligible charges	
Insulin	\$3/\$9/\$9	\$3/\$9/\$9 + 30% of eligible charges	
Diabetic Supplies	No Charge Meters: Covered by Medicare Part B and the HSTA VB 90/10 PPO medical plan.	30% of eligible charges Meters: Covered by Medicare Part B and the HSTA VB 90/10 PPO medical plan.	
Injectables & Specialty Drug	Specialty medications are subject to the applicable Generic/Brand copay. Specialty drugs are not available through mail order and only dispensed up to a 30-day supply.		
Oral Oncology	No Charge	30% of eligible charges	
Mail Order	Participating Mail Pharmacy	Non-Participating Mail Pharmacy	
Day Supply	30/60/90	Not Covered	
Generic	\$3/\$9/\$9	Not Covered	

TABLE 16 Continued – MEDICARE RETIREE			
Plan Design	HSTA VB 90/10 PPO PLAN		NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Brand	\$9/\$27/\$27	Not Covered	
Insulin	\$3/\$9/\$9	Not Covered	
Diabetic Supplies	No Charge	Not Covered	

NOTE: Prescription drug benefits are currently provided under separate contracts.

Footnotes applicable to Medical:

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

** *Deductible does not apply.*

*** *The Diabetes Prevention, Reversing Heart Disease, and Supportive Care programs are currently pilot programs approved through December 31, 2020. In a separate attachment, please include the proposed rate on a tiered basis to continue these programs into the term of the new contract.*

INSURED, RISK SHARING

Proposal Sheet 16A

90/10 PPO Plan – HSTA VB Retiree

Premium Rate Table (Insured with Risk Sharing-Surplus Refund)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. If the total benefit paid at the end of the runout period is less than the proposed benefit cost, the excess amount will be refunded to the EUTF. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

HSTA VB 90/10 PPO Plan	Contract Period 1		Contract Period 2		Contract Period 3		Contract Period 4	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
MEDICAL								
Monthly Medical (Excluding DM/IHM and Chiropractic) Benefit Cost:								
Single								
Two-Party								
Family								
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:								
Single								
Two-Party								
Family								
Monthly Chiropractic Benefit Cost:								
Single								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A		_____%		_____%		_____%	
Monthly Administration and Retention:								
Single								
Two-Party								
Family								
Total Medical Premium (Including DM/IHM, Chiropractic, and Administration and Retention):								
Single								
Two-Party								
Family								
Monthly ACA Fees to be Added to the Above <u>Total Medical Premium</u>								
Insurer Fee:								
Single								
Two-Party								
Family								

HSTA VB 90/10 PPO Plan	Contract Period 1		Contract Period 2		Contract Period 3		Contract Period 4	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
PRESCRIPTION DRUG								
Monthly Benefit Cost:								
Single								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the monthly benefit cost indicated above and this percentage):	N/A		____%		____%		____%	
Monthly Administration and Retention:								
Single								
Two-Party								
Family								
Total Prescription Drug Premium (Including Administration and Retention):								
Single								
Two-Party								
Family								
Monthly ACA Fees to be Added to the Above <u>Total Prescription Drug Premium</u>								
Insurer Fee:								
Single								
Two-Party								
Family								

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

Indicate adjustment to proposed Medical Premium if your company is also awarded the prescription drug contract (fully insured or self-insured): ____%

NOTES:

(1) The EUTF reserves the right to offer multiple carrier 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

Proposal Sheet 16B

90/10 PPO Plan – HSTA VB Retiree

Target Claims, Retention and Fees Tables (Self-Insured ASO)

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

HSTA VB 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Estimated Medical Claims Cost:				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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

MINIMUM PREMIUM

Proposal Sheet 16C

90/10 PPO Plan – HSTA VB Retiree

Premium Rate Table (Insured with Limited Risk Sharing)

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

The Medical Benefit Cost, Prescription Drug Benefit Cost, and Retention components must stand on their own. The EUTF will pay the Medical ASO Fees, and actual medical claims up to the Maximum Medical Claims Cost indicated below. If the total claims paid at the end of the runout period is greater than the Maximum Medical Claims Cost indicated below, the excess amount will not be collected from the EUTF. Only actual claims and fees up to the targeted claim maximum will be charged. The EUTF reserves the right to carve-out the prescription drugs from this proposal.

HSTA VB 90/10 PPO Plan	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
MEDICAL				
Monthly Medical ASO Fees (PEPM):				
PPO Leasing/Network Access Fees				
Claims Adjudication Fee				
Utilization Management Fees				
Disease Management (DM)				
Integrated Health Management (IHM)				
Other*				
Total Medical ASO Fees (PEPM):				
Total Medical ASO Fees by Tier:				
Single				
Two-Party				
Family				
Maximum Medical ASO Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total medical ASO fees indicated above and this percentage):	N/A	____%	____%	____%
Maximum Medical Claims Cost (paid by EUTF):				
Single				
Two-Party				
Family				

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

* 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 – Closed Panel HMO Plan
Table and Proposal Sheets #17

**NON-MEDICARE RETIREE
HSTA VB – CLOSED PANEL HMO PLAN
TABLE AND PROPOSAL SHEETS #17**

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on tiered basis.

TABLE 17 – NON-MEDICARE RETIREE		
Plan Design	HSTA VB CLOSED PANEL HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL		
Provided by Kaiser		
General		
HMO Network		
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	\$2,000 per person \$6,000 per family	
Lifetime Benefit Maximum	None	
Plan Year Benefit Maximum	None	
PHYSICIAN SERVICES		
MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	\$15	
Annual Health Exam	No Charge	
Diabetes Prevention Program	No Charge	
Immunizations	No Charge	
Well Child Care Visits	No Charge	
Maternity	No Charge for routine prenatal visits, delivery, and one postpartum visit	
Screening Mammography	No Charge	
Advance Care Planning	No Charge (Continuing Care)	
EMERGENCY SERVICES		
Emergency Room	\$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	
Mental Health Services	No Charge	
OUTPATIENT SERVICES		
Chemotherapy	\$15	
Radiation Therapy	\$15	
Lab and Pathology	\$15	
Diagnostic Testing and X-ray	\$15	
Allergy Testing	\$15	
Surgery	\$15	
Anesthesia	\$15	
Mental Health Services	\$15	
OTHER SERVICES		
Durable Medical Equipment	20% (50% Diabetes Equipment)	
Hearing Aids	\$500 allowance (up to 2 hearing aids every 36 months)	
Home Health Care	No Charge	
Hospice Care	No Charge	

TABLE 17 – NON-MEDICARE RETIREE

Plan Design	HSTA VB CLOSED PANEL HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Skilled Nursing Facility Care	No Charge (100 days/benefit period)	
Physical and Occupational Therapy	\$15 (Outpatient)	
Chiropractic Services	\$12 (20 visits/CY) through American Specialty Health Group, Inc.	
PRESCRIPTION DRUGS	Provided by Kaiser	
Calendar Year Maximum Out-of-Pocket	Applies towards the medical maximum out-of-pocket	
Retail		
Day Supply	30/60/90	
Generic	\$10/\$20/\$30	
Brand	\$10/\$20/\$30	
Insulin	\$10/\$20/\$30	
Diabetic Supplies	50% of applicable charges	
Oral Contraceptives	50% of applicable charges	
Injectables & Specialty Drug	\$10 up to a 30-day supply Not all drugs can be mailed; restrictions and limitations apply.	
Oral Oncology	No Charge	
Mail Order		
Day Supply	30/60/90	
Generic	\$10/\$20/\$20	
All Covered Brand	\$10/\$20/\$20	
Insulin	Not available through Mail Order	
Diabetic Supplies	50% of applicable charges	
Oral Contraceptives	50% of applicable charges	

**MEDICARE RETIREE
HSTA VB – CLOSED PANEL HMO PLAN
TABLE AND PROPOSAL SHEETS #17 Continued**

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. If you are proposing benefit changes, they may be included as a separate attachment with the respective increase to the proposed rates on a percent and PMPM basis.

TABLE 17 Continued – MEDICARE RETIREE		
Plan Design	HSTA VB CLOSED PANEL HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
MEDICAL		
Provided by Kaiser		
General		
HMO Network		
Calendar Year Deductible	None	
Calendar Year Maximum Out-of-Pocket	\$2,000 per person \$6,000 per family	
Lifetime Benefit Maximum	None	
Plan Year Benefit Maximum	None	
PHYSICIAN SERVICES		
MEMBER PAYS		
Physician Office Visit (including primary care and specialist office visits)	\$15	
Annual Wellness Visit	No Charge	
Annual Health Exam	No Charge	
Medicare Diabetes Prevention Program	No Charge	
Immunizations	No Charge	
Screening Mammography	No Charge	
Advance Care Planning	No Charge (Continuing Care)	
EMERGENCY SERVICES		
Emergency Room	\$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	
Mental Health Services	No Charge	
OUTPATIENT SERVICES		
Chemotherapy	\$15	
Radiation Therapy	\$15	
Lab and Pathology	No Charge	
Diagnostic Testing and X-ray	No Charge	
Allergy Testing	\$15	
Surgery	\$15	
Anesthesia	\$15	
Mental Health Services	\$15	
OTHER SERVICES		
Durable Medical Equipment	20% (including Diabetes Equipment)	
Hearing Aids	\$500 allowance (up to 2 hearing aids every 36 months)	
Home Health Care	No Charge	
Hospice Care	No Charge (Home Hospice Only)	
Skilled Nursing Facility Care	No Charge (100 days/benefit period)	

TABLE 17 Continued – MEDICARE RETIREE		
Plan Design	HSTA VB CLOSED PANEL HMO PLAN	NOTE ALL DEVIATIONS IN YOUR COMPANY'S PROPOSED BENEFITS
Physical and Occupational Therapy	\$15 (Outpatient)	
Chiropractic Services	\$12 (20 visits/year) through American Specialty Health Group, Inc.	
PRESCRIPTION DRUGS	Provided by Kaiser	
Calendar Year Maximum Out-of-Pocket	Applies towards the medical maximum out-of-pocket	
Retail		
Day Supply	30/60/90	
Generic	\$10/\$20/\$30	
Brand	\$10/\$20/\$30	
Insulin	\$10/\$20/\$30	
Diabetic Supplies	20% of applicable charges	
Injectables & Specialty Drug	\$10 up to a 30-day supply Not all drugs can be mailed; restrictions and limitations apply.	
Oral Oncology	\$10/\$20/\$30	
Mail Order		
Day Supply	30/60/90	
Generic	\$10/\$20/\$20	
Brand	\$10/\$20/\$20	
Insulin	Not available through Mail Order	
Diabetic Supplies	20% of applicable charges	

INSURED

Proposal Sheet 17

Closed Panel HMO Plan – HSTA VB Retiree

Premium Rate Table (Fully Insured)

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

HSTA VB Closed Panel HMO Plan	Contract Period 1		Contract Period 2		Contract Period 3		Contract Period 4	
	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare	Non-Medicare	Medicare
MEDICAL AND PRESCRIPTION DRUG								
Monthly Medical and Prescription Drug (Excluding DM/IHM and Chiropractic) Benefit Cost:								
Single								
Two-Party								
Family								
Monthly Disease Management (DM) / Integrated Health Management (IHM) Benefit Cost:								
Single								
Two-Party								
Family								
Monthly Chiropractic Benefit Cost:								
Single								
Two-Party								
Family								
Maximum Benefit Cost Percent Increase from Prior Contract Period (Increase will be capped at the lower of the total benefit cost indicated above and this percentage):	N/A		_____%		_____%		_____%	
Monthly Administration and Retention:								
Single								
Two-Party								
Family								
Total Medical and Prescription Drug Premium (Including DM/IHM, Chiropractic, and Administration and Retention):								
Single								
Two-Party								
Family								
Monthly ACA Fees to be Added to the Above <u>Total Medical and Prescription Drug Premium</u>								
Insurer Fee:								
Single								
Two-Party								
Family								

Provide a detailed breakout of the services and costs included in DM/IHM on a PEPM basis:	Contract Period 1	Contract Period 2	Contract Period 3	Contract Period 4
DM/IHM Services (PEPM):				

NOTES:

- (1) The EUTF reserves the right to offer multiple carrier 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 question 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 an 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 and to the extent that the RFP and successful proposal conflict, the terms of the RFP shall govern, unless otherwise agreed upon by EUTF in the contract.
- 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 or USB flash drive

DO NOT PDF or otherwise protect the CD or USB flash drive

**QUESTIONNAIRE
Medical Benefits Only**

GENERAL INFORMATION	
	OFFEROR RESPONSE
1. Do you agree that if this proposal results in your company being awarded a contract and if there are inconsistencies between what was requested in the RFP and what is contained in the Proposal Response that any controversy arising over such discrepancy will be resolved in favor of the language contained in the RFP, unless specifically modified by the contract?	
2. Do you agree to perform all of the services contained in this RFP? If NO and there are exceptions to these requirements, please specify in Attachment 5, <i>Exceptions</i> , as a separate section to your proposal and provide a complete explanation of each exception. Failure to respond to the services required in this RFP may result in your proposal being deemed incomplete.	
3. Do you agree to all the terms and conditions in Section I of this RFP? If NO, list all exceptions to this RFP in Attachment 5, <i>Exceptions</i> .	
4. Verify that all deviations from the requested plan design and coverage are included in the tables in Section V.	
5. Is your organization currently or in the near future undertaking any mergers, acquisitions, sell-offs, change of ownership, etc.? If yes, explain.	
6. The EUTF requires written notification of renewal actions 240 days preceding the expiration of the contract. Confirm your agreement to this requirement.	
7. What are the most recent ratings for your company by the following:	
Standard and Poor's - Rating	
Standard and Poor's - Date	
Fitch - Rating	
Fitch - Date	
A.M. Best - Rating	
A.M. Best - Date	
Moody's - Rating	
Moody's - Date	
Has there been any downgrade in your ratings in the last 2 years? If your firm is not rated, submit documentation of a similar nature which attests to your firm's financial stability.	

GENERAL INFORMATION	
	OFFEROR RESPONSE
<p>8. Confirm that you will provide the following minimum reporting requirements:</p> <ul style="list-style-type: none"> a) Monthly Enrollment Reports b) Monthly Financial Claim Reports c) Semi-Annual Utilization Reports d) Annual Utilization Reports e) All required Disease Management, Integrated Health Management and Wellness Program Reports 	
<p>9. 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>	
A. ORGANIZATIONAL EXPERIENCE AND STABILITY	
Network Ownership and Background	
<p>1. Name of Parent Company, if any:</p>	
<p>2. Identify service team:</p> <ul style="list-style-type: none"> a) Local Overall Account Manager b) Senior Account Manager (supervisor of above) c) Local Enrollment Manager d) Local IT Manager 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 	
<p>3. Is your firm anticipating restructuring or reorganization in the next year? If yes, please explain. Include any major staff relocations or office closings.</p>	
<p>4. In the past 12 months, has your organization closed any network service areas? If yes, please list the centers.</p>	
<p>5. In the past 12 months, has your organization combined/consolidated member service or claims service centers? If yes, please list the centers.</p>	
<p>6. In the past 12 months, has your organization closed/consolidated or relocated any claims offices. If yes, please list the offices?</p>	
<p>7. In the past 24 months, has your organization acquired, been acquired by, or merged with another organization? If yes, please explain.</p>	
<p>8. Please provide annual Membership counts for three years.</p>	

GENERAL INFORMATION	
	OFFEROR RESPONSE
National PPO <ul style="list-style-type: none"> • 2019 • 2018 • 2017 	
Hawaii PPO <ul style="list-style-type: none"> • 2019 • 2018 • 2017 	
National HMO <ul style="list-style-type: none"> • 2019 • 2018 • 2017 	
Hawaii HMO <ul style="list-style-type: none"> • 2019 • 2018 • 2017 	
9. Please provide the percentage client retention rates requested below (Group Accounts Only):	
Client Retention Rates	
PPO Fully Insured Plans <ul style="list-style-type: none"> • 1 year • 2 years • 3 years 	
HMO Fully Insured Plans <ul style="list-style-type: none"> • 1 year • 2 years • 3 years 	
Self-Insured Plans <ul style="list-style-type: none"> • 1 year • 2 years • 3 years 	
Fully-Insured Pharmacy <ul style="list-style-type: none"> • 1 year • 2 years • 3 years 	
Termination Rates	
PPO <ul style="list-style-type: none"> • 1 year • 2 years • 3 years 	
HMO <ul style="list-style-type: none"> • 1 year • 2 years • 3 years 	

GENERAL INFORMATION	
	OFFEROR RESPONSE
Self-Insured Plans <ul style="list-style-type: none"> • 1 year • 2 years • 3 years 	
Fully-Insured Pharmacy <ul style="list-style-type: none"> • 1 year • 2 years • 3 years 	
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? (Answer Yes or No)	
2. Are there any Special Conditions outlined in Section I that you cannot meet? (Answer Yes or No)	
3. Payment Options: EUTF to Vendor (Choose only one) <ul style="list-style-type: none"> a) Electronic Funds Transfer b) Manual Invoicing c) Both options available 	
4. Do customer service representatives have online access to real-time claim status information? (Answer Yes or 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? (Answer Yes or No)	
6. a) Do you offer any services with respect to reporting requirements under PPACA? (Answer Yes or No)	
b) If yes, what services do you offer?	
c) Indicate any additional charges required to provide the service.	

GENERAL INFORMATION	
	OFFEROR RESPONSE
<p>7. a) What online services/functions will be made available to the EUTF administrative staff via the Internet? (List all that apply)</p> <ul style="list-style-type: none"> • Claims Summary • Billing History • Premium Rates • Provider Directory • Eligibility Summary • Enrollment Counts • Plan Details/Benefit Summary • Health Topics/Medical Information • Address Changes • Other 	
<p>b) What online services/functions will be made available to the EUTF members via the Internet? (List all that apply)</p> <ul style="list-style-type: none"> • Claims Summary • Billing History • Premium Rates • Provider Directory • Eligibility Summary • Enrollment Counts • Plan Details/Benefit Summary • Health Topics/Medical Information • Address Changes • Other 	
<p>c) Provide name of website and sample password, if applicable.</p>	
<p>8. For each of the services listed below, please indicate if the service is available and if the cost is included in the basic fee. If not, please provide any additional fee that may apply.</p>	
<p>a) SPDs and SBC</p> <ul style="list-style-type: none"> • Available/not available • Included in basic fee • Indicate additional cost 	
<p>b) Claims Forms</p> <ul style="list-style-type: none"> • Available/not available • Included in basic fee • Indicate additional cost 	
<p>c) EOBs</p> <ul style="list-style-type: none"> • Available/not available • Included in basic fee • Indicate additional cost 	

GENERAL INFORMATION	
	OFFEROR RESPONSE
d) Network Directory <ul style="list-style-type: none"> • Available/not available • Included in basic fee • Indicate additional cost 	
e) Other, please describe <ul style="list-style-type: none"> • Available/not available • Included in basic fee • Indicate additional cost 	
Audit Requirements	
9. a) Do you agree to allow the EUTF the right to audit the performance of the plan and services provided?	
b) Indicate what services, records and access will be made available to the EUTF at no additional charge.	
c) Indicate frequency and notice requirements that are part of the right to audit provision and all other limitations or restrictions on the conduct of an audit.	
10. Will you agree to an independent annual audit that measures performance through random sampling? Please include a copy of your audit policy.	
11. Will you agree to provide a comprehensive data file to the auditor that will facilitate electronic analysis with target samples validated through the auditor's review of supporting documentation of sufficient sample size to meet the auditor's requirements to achieve the level of confidence determined by the auditor?	
12. Confirm your understanding that results from an independent random claims sample will determine compliance with processing guarantees.	
13. Confirm your understanding that non-processing performance guarantees may be validated through an independent audit with such results determining the amount of any penalty due and if performance guarantees cannot be validated because of insufficient documentation, you will be considered non-compliant with the performance guarantee.	
Member Services	
14. 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. (Answer Yes or No)	

GENERAL INFORMATION	
	OFFEROR RESPONSE
<p>15. Indicate the ways in which your organization is able to accommodate the special needs of enrollees. (List all that apply)</p> <ul style="list-style-type: none"> a) No special accommodations b) Have a TDD (Telecommunications Device for the Deaf) or other voice capability for the hearing impaired c) Contract with an independent translation company to accommodate non-English special enrollees d) Maintain customer service staff with the ability to translate multiple languages. If so, which languages? 	
<p>16. Do you offer a 24-hour telephone Nurse Triage or Live Medical Services (physician or nurse advice/demand management) telephone and/or video program for enrollees? (Choose only one)</p> <ul style="list-style-type: none"> a) Yes, staffed by live health professionals, at no additional charge b) Yes, staffed by live health professionals, at an additional charge of \$ _____ c) No, not offered d) Other 	
<p>17. 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 for sample 834 file. (Answer Yes or No)</p>	
<p>18. Which of the following Member Functions by Website do you provide? (List all that apply)</p> <ul style="list-style-type: none"> a) Provider Profiles b) Health Information c) Claim Status d) Lab Results e) Submission of Referrals f) Request for Prior Authorization g) Submission of Rx h) Other (List) 	
<p>19. Do your provider directories include the following: (List all that apply)</p> <ul style="list-style-type: none"> a) Physician office address and phone number b) Specialty designation (e.g., cardiology, pediatrics, urgent care) c) Doctor accepting new patients d) Office hours e) Languages spoken in office f) List of hospital with admitting privileges 	

GENERAL INFORMATION	
	OFFEROR RESPONSE
20. Do you agree to notify members at no additional cost if an HMO network physician terminates their contract during the plan year? (Answer Yes or 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 (IBNR) reserve?	
3. Indicate the factors used to set the rates for the proposal. a) Annual Trend Factor ___% of expected claims b) Reserve Factor ___% of expected claims c) Margin ___% of expected claims d) Retention as a fixed cost PEPM or PRPM	
4. Explain any other required reserves other than for IBNR. Indicate amounts, reason for reserve, whether interest is credited, and whether reserves are refunded to the client upon policy termination.	
5. Detail any underwriting provisions/rules you will impose on the EUTF.	
D. DISEASE MANAGEMENT and INTEGRATED HEALTH MANAGEMENT (DM/IHM)	
1. Do you perform these services? If yes, describe the DM/IHM services in detail that are covered by your basic fee. For each program service include: program name, a description of the program, condition(s) managed, stratification levels, member identification process, program goals, interventions, and performance metrics.	
2. Do you have a minimum of three years of experience in performing these services? Provide years of experience for each program listed in No. 1 above.	
3. Are you currently providing DM/IHM services to a group of at least 100,000 covered members?	
4. Do you have the ability and are you willing to customize your DM/IHM services to meet the needs/desires of the EUTF? Describe limitations if any.	
5. Do you have the capability to identify specific members targeted for these DM/IHM services (e.g. retirees vs. actives)?	

GENERAL INFORMATION	
	OFFEROR RESPONSE
6. Do you agree to provide EUTF specific data reports of DM/IHM activity at least quarterly (within 45 days of the close of the quarter) and an annual ROI within 3 months of the close of the prior year?	
7. Do you agree (that after the award of this contract and during the implementation phase of your services) you will mine the EUTF medical claims and prescription drug data and identify those individuals appropriate for your DM/IHM services AND provide the EUTF (prior to the start date of the contract) with a report that outlines what you found in their data, including but not limited to the following elements:	
a) The total number of members identified with one or more chronic diseases you will manage in the initial data analysis by specific DM/IHM program service	
b) The number of members you identified in each of your risk classes/level	
c) The costs associated with the above groups	
d) The percent of clinical goals/objectives the population is NOT adhering to in the baseline data search	
e) A comparison of the EUTF's performance to HEDIS 90th percentile benchmark and "book of business" outcomes for similar sized clients of the same or similar industry	
8. Which of your DM/IHM program(s) focus on helping members identify and lessen the following disease conditions and risk factors: a) Obesity b) Smoking c) High cholesterol d) Lack of activity/exercise e) Stress Management f) Diabetes g) Asthma h) Chronic obstructive pulmonary disease i) High blood pressure j) Ischemic heart disease k) Congestive heart failure	
9. Are your DM/IHM services available to be used by participants who live in any of the 50 states?	
10. Describe in detail your methods and strategies to engage members, both retirees and actives, to participate in DM/IHM programs.	

GENERAL INFORMATION	
	OFFEROR RESPONSE
11. How do you recommend that a client communicate and encourage the use of these services among retirees and active members.	
12. Describe your expected participation rates in DM/IHM programs.	
13. Based on data, what DM/IHM programs have been the most effective to improve the health condition of members with chronic conditions?	
14. Explain how your staff introduces themselves to members for the first time for DM/IHM programs (e.g. phone call, letter)?	
15. What DM/IHM programs are available at an additional cost? Explain in detail and include the additional cost.	
E. WELLNESS PROGRAMS and INTEGRATED HEALTH MANAGEMENT (IHM)	
1. Describe your wellness program. List all components of your wellness program (e.g. health risk survey, health coaching, health education classes). For each component describe: a) The intervention b) Risk factors the program addresses (e.g. obesity, poor nutrition, lack of physical activity, smoking, high blood pressure, high blood cholesterol, medication adherence) c) Program goals d) Format offered (face-to-face, telephonic, online, etc.) e) Setting (e.g. worksite, other) f) Target member population (retirees and/or actives) g) How you measure the effectiveness of the program and its individual components.	
2. Do you have a minimum of three years of experience in delivering wellness program services? Provide years of experience for each program component listed in No. 1 above.	
3. Describe strategies and methods you plan to implement to engage participation in the wellness program components described above for the active and retiree population.	
4. For each service listed and/or requested, provide expected participation (based on a percent of total eligible members).	
5. Describe factors to improve participation for both active and retiree members.	
6. Describe factors that will reduce participation?	

GENERAL INFORMATION	
	OFFEROR RESPONSE
7. Based on the demographics list the wellness program components 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	
8. Describe your capacity to report wellness program activity by member type (retiree and/or active) and by employer.	
9. Do you agree to provide EUTF specific data reports of wellness program/IHM utilization activity at least quarterly (within 45 days of the close of the quarter) and an annual ROI within three months of the close of the prior year?	
10. Based on your prior experience with wellness programs, for the program components 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	
11. What is the method used in the derivation of savings estimate provided in No. 10 above.	
12. For each program implemented what is the expected ratio of savings to program expenses in the first 12 months, 24 months and 36 months?	
13. What is done to assess plan participant satisfaction with the program? Are management reports available? If so, please include a sample(s).	
14. Explain in detail each wellness program component included in your quote. What wellness programs are available at an additional cost? Explain in detail and include additional cost.	
15. Provide a full explanation of how your company reimburses providers in order to control cost and manage utilization, other than fee for service arrangements.	
16. Explain what programs you have implemented that address progress toward achieving patient centered outcome measurement and reimbursement to providers that improve these outcomes.	
17. Performance Improvement Projects (PIPs) a) Describe current PIP with providers.	

GENERAL INFORMATION	
	OFFEROR RESPONSE
<p>b) If no response is provided in A above, 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>c) Are all of the services included in your base quote? If not, indicate the changes on a per capita basis.</p>	
<p>18. Describe methods to identify members with pre-diabetes and programs to address this member population.</p>	
F. CLAIM COSTS	
Provider Reimbursement and Discount Worksheets	
<p>1. Indicate non-network equivalent Reasonable & Customary Percentile used for non-network reimbursement.</p>	
<p>2. Indicate source of non-network Reasonable & Customary Allowances (Ingenix, Medicare, ADP, Other).</p>	
<p>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?</p>	
Hospital and Outpatient Facility Charges	

GENERAL INFORMATION						
	OFFEROR RESPONSE					
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 List Number by Island	Oahu	Maui	Hawaii	Kauai	Lanai	Molokai
Acute Hospitals						
Urgent Care Facilities						
Outpatient Surgical Centers						
Clinics						
General/Family Practice Physicians						
OBGYN Specialists						
Other Specialists						
6. a) How are network outpatient facilities such as surgicenters, imaging centers and laboratories reimbursed (on a discounted fee arrangement, percent of Medicare APCs, or 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?						
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 any 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?						

GENERAL INFORMATION	
	OFFEROR RESPONSE
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: _____	
c) Annual Claim Volume: _	
d) Provide number of: <ul style="list-style-type: none"> • Processors • Supervisors • Managers 	
e) Average years of claims administration experience for: <ul style="list-style-type: none"> • Processors • Supervisors • Managers 	
f) Annual turnover percent (%): <ul style="list-style-type: none"> • Processors • Supervisors • Managers 	
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: (Please answer all parts of this question)	
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?	

GENERAL INFORMATION	
	OFFEROR RESPONSE
13. Have you been penalized by any state for failing to meet state average claim turnaround requirements? a) Yes. List state(s) where you were sanctioned in the last 12 months. b) No.	
14. For the claim office proposed, please provide the following data for the latest 12-month period:	
a) Financial accuracy as a percent of total claims dollars paid (include over/underpayments)	
b) 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? (Choose only one) <ul style="list-style-type: none"> • Yes, 100% of recovery • Yes, less ___ recovery collection fee • No, do not agree 	
16. a) Explain your COB procedures.	
b) Do you pursue COB prospectively or retrospectively to payments?	
c) How often are records updated for new information on other coverage?	
d) What is the average COB savings as a percent of total plan cost for: <ul style="list-style-type: none"> • Active/Early retiree • Medicare Eligible 	
e) Will you guarantee COB savings for: (Answer Yes or No) <ul style="list-style-type: none"> • Active/Early retiree • Medicare Eligible 	
17. Please provide at a minimum a description of any fraud detection programs, whether there is a formal written program, and the total number of events per 1,000 covered lives for the following: <ul style="list-style-type: none"> a) Ineligible Claimants b) Errors in service billed vs. actually rendered c) Over billings d) If there is a formal written program, please include a full description of the program and the total number of cases of fraud per 1,000 covered lives. 	
18. a) Do you retain medical consultants for the review of any unusual claims or charges? (Answer Yes or No)	

GENERAL INFORMATION	
	OFFEROR RESPONSE
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 first and subsequent procedures? (Answer Yes or No)	
20. What programs do you offer to address potential drug abuse?	

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

1A. 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					

1B. 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					

1C. 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					

1D. 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
G. 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? (Answer Yes or No)	
3. Do you compare individual network provider practice patterns against Best practices or averages on any of the following: (List all that apply) a) Referral rates to specialists b) Frequency and quality of prescription drug dispensing c) Rates of diagnostic procedures ordered (lab/imaging) d) Rates of surgical procedure relative to peers e) Repeat procedures within given timeframes f) Hospital readmission rates g) 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?	
H. COVERAGE AND CONTRACT ISSUES	
General Contract Provisions	
1. Will you agree to be bound by the terms of the RFP and your proposal until a final contract is executed? (Answer Yes or No)	
Termination Clauses	
2. 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? (Answer Yes or No)	
I. HIPAA QUESTIONS	
1. a) Do you have a formal HIPAA compliance plan in place? (Answer Yes or No)	
b) If yes, attach a copy to your proposal.	
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	

GENERAL INFORMATION	
	OFFEROR RESPONSE
enrollee? At what cost if any?	

MEDICAL NETWORK ANALYSIS

1. DISRUPTION ANALYSIS

As part of the proposal process Segal will also be conducting a network disruption analysis. Network data will be provided upon receipt of a signed confidentiality agreement. The utilized provider listing will be provided by physician, inpatient hospital, and outpatient hospital to assess the alignment between your provider networks and participant utilization patterns.

Please confirm whether the individual provider is currently a contracted network provider in each of your proposed networks. If, after award of the contract, the actual disruption proves to be greater than that identified in your response, the successful bidder must provide accommodations to address the deviation.

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:

Acceptable Media Types

CD ROM or Flash Drive

Acceptable File Format

Microsoft Access or Microsoft Excel

Required Fields (please include file layout)

National Provider ID (MUST BE PROVIDED)

Provider TIN

Provider last name

Provider first name

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.

2. **SCOPE OF NETWORK** – Include a list of all states where your PPO network exists.
3. **GEO ACCESS** – Provide a separate geo access report for each proposed network broken out by island in Hawaii and one report for all non-Hawaii residences, based upon the residential zip codes of the census file included with this RFP. Please make sure that the Geo Access reports match the total participant counts provided below of the current census data.

Standard for Definition of Access to Network Provider

- Physicians 2 in 8 miles
- Hospitals 1 in 15 miles

Enrollment by Island

Island	Actives	Retirees
Oahu	35,377	29,545
Hawaii	8,853	6,450
Maui	5,035	3,873
Kauai	2,970	2,524
Molokai	425	311
Lanai	120	91
Non-Hawaii	92	4,097
Total	52,872	46,891

SECTION IX

PHARMACY BENEFIT

To be completed for fully insured and self-insured benefit integrated or not integrated with medical.

SERVICES TO BE PROVIDED

A number of factors which are listed in Section III will be considered in the selection process.

All OFFERORS are required, at a minimum, to duplicate the plan features and level of coverage presently offered to EUTF's covered member population. Please refer to the plan design information in Exhibit E. No PBM Services are required for the Supplemental or Closed Panel HMO.

OFFERORS should also provide pricing on their standard formulary with exclusions. However, OFFERORS will only be evaluated on the current EUTF formulary. Proposals contingent on the OFFEROR's standard formulary with exclusions will be rejected.

Prospective OFFERORS are to offer comprehensive PBM services including but not limited to the following:

- Claims adjudication and coordination of benefits with non-EUTF plans at point of sale

- EGWP with a Commercial Wrap Contract for Medicare Eligible Retirees in PPO

- Ability to integrate PBM services with medical vendors, as applicable

- Electronic eligibility maintenance

- Patient and provider education, including notification of formulary and/or copay changes to impacted members

- Systematic prospective, concurrent, and retrospective drug utilization review

- Network pharmacy management

- Formulary management and rebate sharing

- Data reporting

- Distribution of pharmacy directories and other materials for enrollees

- Specialty pharmacy program

- Complete availability of IT services, including online/real time availability to EUTF and/or its designee(s)

- Pricing administration

- Customer services: Walk-in customer service office, telephone call center, and mail order fulfillment center located in Hawaii

- Ad hoc reporting

- Website with enrollee portal

- Clinical programs

- Disease management: MTM (Medication Therapy Management Program)

COBRA Administration

Daily sharing of out of pocket information with medical provider to comply with PPACA. Medical provider will also share on a daily basis, out of pocket information with PBM to comply with PPACA.

Adherence to CMS EGWP Guidelines

1.1 Core Requirements

The following are the EUTF's core requirements. Please include your responses within this form. Indicate "yes" or "no" as to your organization's ability and willingness to comply. **OFFEROR's compliance with these requirements is mandatory. However, OFFERORS may also provide pricing on their standard formulary with exclusions. Proposals which only include an "Exclusionary Formulary" will not be accepted. An "Exclusionary Formulary" is one that does not permit the reimbursement of medications from the plan that are not on the preferred formulary listing of the Contractor. The Contractor must also agree to a 90-day adoption of the current contractor's formulary during the first 90 days of the plan year, with no impact on rebate guarantees.**

- a. The OFFEROR agrees to all of the contractual requirements of this RFP as required by the State. All exceptions must be separately noted in Attachment 5, *Exceptions*.
Yes/No.
- b. Provide a copy of your most recent external rating from either: Standard & Poor's, Moody's, or AM Best. If your company is not rated by any of these agencies, submit documentation of a similar nature which attests to your financial stability.
- c. The OFFEROR agrees to the contract terms contained in Section IV, *Scope of Work*.
Yes/No.
- d. The OFFEROR agrees to provide a walk-in customer service office, telephone call center, and mail order fulfillment center located in Hawaii.
Yes/No.

1.2 Term/Termination

1.2.1 The EUTF will have the right to terminate the contract with cause at any time with 30 days' notice without penalty if an effective remedy is not provided to the satisfaction of the EUTF. The financial guarantees for any partial contractual year that results from an early termination will still be guaranteed, reconciled and the PBM will still make payments for any shortfalls for those resulting partial contractual years with less than 12 months.
Yes/No.

1.2.2 The EUTF will have the right to terminate the contract without cause given a 90-day notice period without penalty to the EUTF. The financial guarantees for any partial contractual year that results from an early termination will still be guaranteed, reconciled and the PBM will still make payments for any shortfalls for those resulting partial contractual years with less than 12 months.
Yes/No.

1.2.3 The PBM agrees to a mid-contract term market check, that may start as soon as the second quarter of the second contract year, conducted by an independent third party to ensure the EUTF is receiving appropriate current pricing terms competitive within the industry based on its volume and membership, and will improve pricing in the event that the EUTF's contract terms are less than current. The PBM will review the financial terms of the EUTF compared to financial offering

presented to similar employers in the marketplace as deemed appropriate as part of this process and offer improved pricing to the EUTF. The EUTF will have the right to terminate the contract without penalty if EUTF does not agree with the revised pricing terms.

Yes/No.

1.2.4 Confirm that the improved pricing terms will become effective on the first day of the third year of the contract.

Yes/No.

1.2.5 The PBM contract will not include automatic renewal language unless requested by the EUTF.

Yes/No.

1.2.6 Confirm all rebate revenue earned by the EUTF under the contract will be paid to the EUTF regardless of their termination status as a client. Lag rebates on claims incurred prior to the termination date will continue to be paid to the EUTF after termination until 100% of earned rebates are paid.

Yes/No.

2.1 Financial Definitions

2.1.1 Confirm you agree to the following contract definitions:

	Response (Yes/No)	Comments
<p>a. Brand Drug(s) – The term “Brand Drug(s)” shall mean the following: The Multisource Code field in Medi-Span contains an “M” (co-branded product), or an “N” (single source brand), or an “O” (originator brand) (except where the Claim is submitted with a DAW Code of “3”, “4”, “5” or “6”, in which case it shall be considered a Generic Drug). Claims with a Multisource Code of “O” and with a DAW Code of “0”, “1”, “2”, “7”, “8” or “9” shall be considered a Brand Drug. The Parties agree that when a drug is identified as a Brand Drug, it shall be considered a Brand Drug for all purposes by OFFEROR, including but not limited to adjudicating the Claim, reimbursing the relevant pharmacy, invoicing the EUTF, determining the copayment or coinsurance to be paid by the Plan Beneficiary, calculating the satisfaction of guarantees as described in 6.1 of this Section, and calculating the satisfaction of generic dispensing guarantees as described in 6.7 of this Section.</p>		

	Response (Yes/No)	Comments
<p>b. Generic Drug(s) – The term “Generic Drug(s)” shall mean the following: The Multisource Code field in Medi-Span contains a “Y” (generic). Claims submitted with a Multisource Code field in MediSpan containing the value of “O” and also submitted with a DAW Code of “3”, “4”, “5” or “6” shall also be considered a Generic Drug. OFFEROR agrees that when a drug is identified as a Generic Drug, it shall be considered a Generic Drug for all purposes, including but not limited to adjudicating the Claim, reimbursing the relevant pharmacy, invoicing the EUTF, determining the copayment or coinsurance to be paid by the Plan Beneficiary, calculating the satisfaction of guarantees as described in 6.1 of this Section, and calculating the satisfaction of generic dispensing guarantees as described in 6.7 of this Section.</p>		
<p>c. “Pass Through” and “Transparent” – PBM contractor agrees to pass-through 100% of negotiated discounts with network pharmacies at the point-of-service, and with no pricing spread between what is paid to the pharmacy and invoiced to the EUTF. PBM agrees to provide auditing protocol, enabling tracking of individual claims back to original pharmacy network contract documents. The PBM agrees to pass through 100% of ALL rebate revenue earned and will not charge an administrative fee for this arrangement. The PBM also agrees to disclose details of all other programs and services generating financial remuneration from outside entities, including manufacturers and retailers.</p>		
<p>d. Confirm the PBM will pass through 100% of Manufacturer Administrative Fees paid by manufacturers to the PBM in relation to the EUTF’s utilization.</p>		
<p>e. Confirm the PBM will pass through 100% of Inflation Protection Payments paid by pharmaceutical manufacturers to the PBM in relation to the EUTF’s utilization.</p>		

	Response (Yes/No)	Comments
g. Rebates - Compensation or remuneration of any kind received or recovered from a pharmaceutical manufacturer attributable to the purchase or utilization of covered drugs by eligible persons, including, but not limited to, incentive rebates categorized as mail order purchase discounts; credits; rebates, regardless of how categorized; market share incentives; promotional allowances; commissions; educational grants; market share of utilization; drug pull-through programs; implementation allowances; clinical detailing; rebate submission fees; and administrative or management fees. Rebates also include any fees that PBM receives from a pharmaceutical manufacturer for administrative costs, formulary placement, and/or access.		
h. AWP (Average Wholesale Price) is based on the actual date sensitive, 11-digit NDC (national drug code) for the strength and form of the drug being dispensed as supplied by a nationally-recognized pricing source (i.e., Medi-Span) for retail, mail order, and specialty adjudicated claims (subject to outstanding litigation).		
i. Member Copay – Members will pay the lowest of the following: plan copay/coinsurance, plan-negotiated discounted ingredient cost plus dispensing fee, usual and customary charges (if at retail), MAC (maximum allowable cost) or cash price at retail, mail and specialty pharmacies.		
j. Members – All eligible employees, retired employees, and their eligible dependents enrolled under the EUTF’s prescription benefit program.		
k. Paid Claims – Defined as all transactions made on eligible members that result in a payment to pharmacies or members from the EUTF or the EUTF member copays. (Does not include reversals, rejected claims and adjustments.) Each unique prescription that results in payment shall be calculated separately as a paid claim.		
l. Confirm the PBM will only charge a fee (e.g., administrative fee or dispensing fee) for Paid Claims and will not charge a fee for reversals, rejected claims, adjustments or reprocessed claims.		

	Response (Yes/No)	Comments
m. Client eligibility and claim data – All eligibility and claims records are the sole property of the EUTF and must be made available upon request to the EUTF and its representatives. Selling or providing of the EUTF’s data to ANY outside entities must be approved in advance, reported on a monthly basis and all income derived must be disclosed and shared per agreement with the EUTF. Even if PBM has not "sold" the data, it is NOT free to use the data for analyses that they publish or provide to outside industries.		

3.1 Financial Assumptions and Calculations

3.1.1 Confirm the pricing listed in this proposal reflects the following:

Assumptions	Response (Yes/No)	Comments
a. All guarantees are calculated using the date sensitive AWP based on the 11-digit NDC of the actual product and actual package size that is dispensed.		
b. All-in generic guarantee inclusive of single-source generics		
c. Drugs with an “Insufficient Supply” are included in the guarantees		
d. Select, sole source or authorized generics from at least one FDA-approved generic manufacturer with exclusivity, limited supply, limited availability, or limited competition will be included in the generic pricing guarantees and excluded from the brand pricing guarantees.		
e. No single-source generic or generic drug will be included in the brand drug component for the annual discount guarantee reconciliation.		
f. Confirm “House Generics”/ Brand claims with a DAW 5 will be included in the generic guarantee financial reconciliation calculations and GDR (generic dispensing rate) guarantee calculations.		
g. Confirm how the PBM will calculate the “House Generics” or DAW 5 claims AWP that will be used in the generic guarantee financial reconciliation calculations and GDR guarantee calculations.		

Assumptions	Response (Yes/No)	Comments
h. Confirm “House Generics”/ Brand Claims with DAW 5 will be included as brands in the minimum rebate guarantee calculations.		
i. Confirm any rebates derived from “House Generics” or DAW 5 claims will be passed through at 100% to the EUTF.		
j. Confirm the EUTF will not pay more for any “House Generics” or DAW 5 claims compared to the respective generic equivalent before the application of rebates.		
k. Confirm members will pay the generic copay for any “House Generics” or DAW 5 claims.		
l. Confirm all “House Generics” or Brand Claims with DAW 5 will adjudicate at the generic member copay regardless of whether the doctor checks off a DAW on the script.		
m. Confirm brands with a DAW code (DAW 1 or DAW 2) requiring the substitution of a brand product over a generic product will be included in the brand discount guarantees, dispensing fees, and minimum rebate guarantees.		
n. Confirm brands with a DAW code of 0, 1, 2, 7, 8, and 9 will be included in the brand discount guarantees, dispensing fees, and minimum rebate guarantee calculations.		
o. Confirm any formulary excluded brand products that were adjudicated as a result of an exception process such as for medical necessity will be included in the discount, dispensing fee, minimum rebate guarantees and any rebates associated with such drugs will be passed through at 100% to the EUTF.		
p. Confirm any penalty amounts paid by the member as a result of the DAW 1 or 2 penalty program will not be used by the PBM in discount guarantee reconciliations.		
q. Confirm diabetic strips are included in rebate guarantees.		
r. Confirm all brand claims are included in the rebate guarantees.		
s. Confirm all multi-source brand claims are included in the minimum rebate guarantee calculations.		

Assumptions	Response (Yes/No)	Comments
t. Member Cost Share at the point-of-sale (for retail and mail) is based on the lowest of the plan copay/coinsurance, usual and customary charges, negotiated discounted ingredient cost plus dispensing fee or retail cash price.		
u. All guarantees are calculated before the application of member cost share.		
v. Confirm all of the proposed dispensing fee guarantees are on a maximum guaranteed basis.		
w. Confirm all applicable claims from all 50 states and the District of Columbia will be included in the discount, dispensing fee and rebate guarantee calculations.		

3.1.2 Please confirm your proposed drug type designation or classification (e.g. brand, generic) source (i.e. First DataBank, Medi-Span, Redbook, Other). If other, please specify.

3.1.3 How do you guarantee that members will always pay the lowest price (member cost share, discounted ingredient cost plus dispensing fee, MAC, U&C)? What procedures are established to ensure that the pharmacy is in compliance with this provision? Confirm the EUTF's members will never pay a full co-payment in instances where the plan co-pay is greater than the discounted cost plus dispensing fee plus any sales taxes.

3.1.4 Provide a list, with NDCs, of any non-specialty drug products that are excluded from your drug pricing guarantees (discounts, dispensing fees, and/or rebates).

3.1.5 Using the EUTF's detailed claim-by-claim prescription drug data, provide an exhibit with NDCs identifying the EUTF's applicable claims that are excluded from your non-specialty drug pricing guarantees (discount, dispensing fee, and/or rebate). **Provide separately for Non-Specialty Drugs Dispensed at Participating Retail 30 Pharmacies, Non-Specialty Drugs Dispensed at Participating Retail 90 Pharmacies, and Non-Specialty Drugs Dispensed at the PBM's Mail Order Pharmacy. (Provide name of attachment(s).)**

3.1.6 Provide a list with NDCs of any specialty drug products (whether found in the claims data or not) that are excluded from your specialty drug pricing guarantees (Overall Effective Discount, Dispensing Fee, and/or Rebate). **Provide separately for Specialty Drugs Dispensed at Participating Retail 30 Pharmacies, Specialty Drugs Dispensed at Participating Retail 90 Pharmacies, and Specialty Drugs Dispensed at the PBM's Specialty Pharmacy. (Provide name of attachment(s).)**

3.1.7 Using the EUTF's detailed claim-by-claim prescription drug data, provide an exhibit with NDCs identifying the EUTF's applicable specialty drug claims that are excluded from your specialty drug pricing guarantees. **Provide separately for Specialty Drugs Dispensed at Participating Retail 30 Pharmacies, Specialty Drugs Dispensed at Participating Retail 90 Pharmacies, and Specialty Drugs Dispensed at the PBM's Specialty Pharmacy. (Provide name of attachment(s).)**

3.1.8 Brand and Generic Discount Guarantee Calculations:

	Response	Comments
a. Minimum Brand and Minimum Generic Discount Guarantees for retail, mail and specialty shall be defined and calculated as follows: (1-Aggregate Ingredient Cost/Aggregate AWP)		
b. Aggregate Ingredient Cost prior to the application of the plan specific co-payments (including member paid penalties) will be the basis of the calculation.		
c. All guarantee measurements will be calculated prior to the application of member cost share (including member paid penalties).		
d. Aggregate AWP will be from a single, nationally recognized price source for all claims. Please indicate source.		
e. Dispensing Fees are not included in the Aggregate Ingredient Cost.		
f. Zero balance due claims or zero amount claims will be included in the guaranteed measurement for AWP, ingredient cost, achieved discounts or dispensing fee calculations at the discounted cost before copay.		
g. Both the Aggregate Ingredient Cost and Aggregate AWP from the actual date of claim adjudication will be used.		
h. Aggregate AWP will be the date sensitive, 11-digit NDC of the actual product dispensed.		
i. Both non-MAC, MAC, single-source and multiple source generic products are to be included in the generic guarantee measurement.		
j. The guarantee measurement must exclude the savings impact from DUR (drug utilization review) programs, formulary programs, utilization management programs, and/or other therapeutic interventions.		
k. Confirm all the proposed discount guarantees are on a minimum guaranteed basis (i.e., not a flat, fixed or locked basis) and any discount achieved beyond the minimum guarantee will be passed on to the EUTF.		

3.1.9 Indicate if the following products are included or excluded from your proposed discount and dispensing fee guarantees:

List of Products	Response	Comments
a. Compounds		
b. 340b Pharmacy Claims		
c. Out of Network Claims		
d. Paper Submitted Claims		
e. Secondary Payor Claims (COB or Subrogation)		
f. Vaccines		
g. Non Blood Glucose/ Diabetic Test Strip Over the Counter (OTC) Products		
h. Blood Glucose/ Diabetic Test Strips		
i. Lipid Disorder – PCSK9 Products		
j. Long Term Care (LTC)		
k. Home Infusion		
l. Indian Health Services and Tribal Claims		
m. Over the Counter (OTC) Claims		

3.1.10 Indicate if the following products are included or excluded from your proposed rebate guarantees:

List of Products	Response	Comments
a. Compounds		
b. 340b Pharmacy Claims		
c. Out of Network Claims		
d. Paper Submitted Claims		
e. Secondary Payor Claims (COB or Subrogation)		
f. Vaccines		
g. Non Blood Glucose/ Diabetic Test Strip Over the Counter (OTC) Products		
h. Blood Glucose/ Diabetic Test Strips		
i. Lipid Disorder – PCSK9 Products		
j. Long Term Care (LTC)		
k. Home Infusion		
l. Indian Health Services and Tribal Claims		

m. Ancillary Supplies		
n. Over the Counter (OTC) Claims		

3.1.11 Confirm the PBM agrees to provide upon request any proprietary algorithms, hierarchy or other logic employed to define a prescription drug as generic or brand.

Yes/No.

3.1.12 Confirm the PBM will agree to the Medispan MONY multisource indicators:

- Generics are indicated as “Y”
- Brands are indicated as either “O”, “M” or “N”

Yes/No.

4.1 Financial

4.1.1 Each distinct non-rebate pricing guarantee (including discounts and dispensing fees) will be measured and reconciled on a component (e.g. retail 30 brand, retail 30 generic, retail 90 brand, retail 90 generic, mail order brand, mail order generic, specialty drugs at participating retail pharmacies, and specialty drugs at the PBM's Specialty Pharmacy) basis only and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls recouped by the EUTF. **Surpluses in one component (including rebates) may not be utilized to offset deficits in another component.**

Yes/No.

4.1.2 Each distinct rebate guarantee will be measured and reconciled on a component (e.g. retail 30 brand, retail 90 brand, mail order brand, specialty drugs at participating retail pharmacies, and specialty drugs at the PBM's Specialty Pharmacy) basis only and guaranteed on a dollar-for-dollar basis with 100% of any shortfalls recouped by the EUTF. Surpluses in one component may not be utilized to offset deficits in another component. **Rebates surpluses will not be utilized to offset deficits in any other non-rebate guaranteed component.**

Yes/No.

4.1.3 The PBM will provide a financial reconciliation report within 90 days after the end of each contractual year, and the report will include the contractual and actual discounts and dispensing fees for each component (e.g. retail 30 brand, retail 30 generic, retail 90 brand, retail 90 generic, mail order brand, mail order generic, specialty drugs at participating retail pharmacies, and specialty drugs at the PBM's Specialty Pharmacy).

Yes/No.

4.1.4 Confirm retail 30 network guarantees for prescriptions with up to 83 days' supply and retail 90 network guarantees for prescriptions with 84 to 90 days' supply are measured and reconciled on a separate component basis given that they have separate guaranteed rates. A surplus for either of these guarantees will not be used to offset a shortfall for one of the other retail components or any other component guarantees.

Yes/No.

4.1.5 The PBM agrees that any shortfall between the actual result and the guarantee will be paid, dollar-for-dollar, to the EUTF within 90 days of the end of each contractual year.

Yes/No.

4.1.6 The PBM agrees that any shortfall amount between the actual result and the guarantee that is not paid, dollar-for-dollar, to the EUTF within the agreed upon time frame after the end of each contractual year will accrue a pro-rated 2% monthly late fee.

Yes/No.

4.1.7 The PBM's financial reconciliation that occurs after the end of the contract year will use the lower of the AWP pricing at the point of adjudication or the retroactive AWP pricing, if the pricing source the PBM uses issues retroactive AWP pricing for that annual reconciliation time period.

Yes/No.

4.1.8 All pricing submitted will **NOT** be contingent on participation in any proposed clinical management programs, group medical or behavioral health programs proposed by the PBM or any other vendor other than programs that are requested by the EUTF. Further, the pricing guaranteed in the Financial Section of this RFP reflects a) the PBM's broad national retail 30 network that includes all national retail chains similar to what is currently in place, b) a retail 90 network at one retail chain (or multiple) similar to what is currently in place, and c) the PBM's broadest formulary or preferred drug listing, without any drug coverage exclusions.

Yes/No.

4.1.9 Confirm the PBM will, at a minimum, duplicate the plan features and levels of coverage presently offered by the EUTF without impacting the proposed pricing.

Yes/No.

4.1.10 Confirm that mail order and specialty drug dispensing fees will remain constant throughout the contract term and will not be increased for any increases in postage charges (i.e., U.S. mail and/or applicable commercial courier services).

Yes/No.

4.1.11 Mail order pricing and rebates will apply to all claims that adjudicate at mail regardless of days' supply.

Yes/No.

4.1.12 Confirm retail 90 pricing and rebates will apply to all claims that adjudicate at the retail 90 network with greater than 83 days' supply.

Yes/No.

4.1.13 Confirm retail 30 pricing and rebates will apply to all claims that adjudicate at the retail 30 network with 1 - 83 days' supply.

Yes/No.

4.1.14 Confirm specialty pricing and rebates will apply to all claims that adjudicate at the retail pharmacies and the PBM's specialty pharmacy, respectively, regardless of days' supply.

Yes/No.

4.1.15 Guaranteed rebates will apply to all brand prescriptions dispensed (i.e., not only on formulary prescriptions dispensed and not limited to products that should be eligible to receive a rebate based on products from which the PBM receives a rebate).

Yes/No.

4.1.16 Confirm all rebates are guaranteed on a minimum (i.e., not fixed or flat) basis, and the PBM will pass through 100% of the rebates, including non-specialty and specialty, it has received to the EUTF.

Yes/No.

4.1.17 Confirm that quarterly rebate payments will be based on the minimum rebate guarantees (i.e., not limited to the amount collected).

Yes/No.

4.1.18 Confirm that within ninety (90) days after the end of each quarter, the PBM will pay to the EUTF the minimum rebate guarantees and provide detailed reports listing the number of brand drugs per delivery channel, rebate amount per brand drug at each delivery channel, and the resulting minimum guaranteed rebate payment per delivery channel owed to the EUTF as well as the rebates received by the PBM from manufacturers for the EUTF's utilization without a request being made by the EUTF.

Yes/No.

4.1.19 The PBM will provide the annual rebate reconciliation report within 90 days of the end of each contract year. Confirm any shortfall between the rebates paid and the greater of the minimum rebate payments or the rebates invoiced by the PBM for the EUTF's utilization will be paid, dollar-for-dollar, to the EUTF within 90 days of the end of the contract year.

Yes/No.

4.1.20 Confirm that lag rebates will continue to be paid to the EUTF throughout the term of the contract until 100% of all earned rebates are paid even after all of the minimum rebate guarantees have been paid.

Yes/No.

4.1.21 Confirm rebates will be paid based on the proposed pricing while the contract is finalized.

Yes/No.

4.1.22 The EUTF will be notified of any switch to the source of the aggregate AWP with at least a 180-day notice. Any switch must be based on a book of business decision and apply to similarly situated clients like the EUTF. In the event that a switch is made, it must be price neutral and acceptable to the EUTF.

Yes/No.

4.1.23 The PBM will be responsible for collecting any outstanding member cost shares for prescriptions dispensed through the mail order facility. The PBM will not invoice the EUTF for any uncollected member cost shares even if there is a debit threshold in place.

Yes/No.

4.1.24 The PBM will invoice the EUTF twice monthly for claims and the EUTF will pay the PBM once monthly for the administrative services based on EUTF enrollment counts.

Yes/No.

4.1.25 The EUTF will pay all undisputed claim invoice amounts to the PBM within twenty (20) business days after the EUTF receives such invoice from the PBM.

Yes/No.

4.1.26 Confirm that if the EUTF disputes all or a portion of any invoice, the EUTF will pay the undisputed amount timely and notify the PBM in writing, of the specific reason and amount of any dispute before the due date of the invoice. The PBM and the EUTF will work together, in good faith, to resolve any dispute. Upon resolution, the EUTF or the PBM will remit the amount owed to the other party, if any, within ten (10) business days as the parties agree based on the resolution.

Yes/No.

4.1.27 Confirm the PBM will provide a paid claims data file that corresponds to the invoices at no additional cost to the EUTF.

Yes/No.

4.1.28 There are NO additional fees (beyond those outlined in the Financial Section) required to administer the services outlined in this RFP. Any mandatory fees, including clinical and formulary program fees, must be clearly outlined in the Financial Section.

Yes/No.

4.1.29 All applicable fees include the cost of claims incurred/filled during the effective dates of this contract regardless of when they are actually processed and paid (run-out).

Yes/No.

4.1.30 Confirm the PBM will provide run-out claims processing for the EUTF after contract termination.

Yes/No.

4.1.31 Confirm all pricing will be effective and guaranteed for the term of the agreement and will not include adjustments for claims volume changes or claims volume shifts amongst the various provider channels (e.g., mail utilization rates decline or 90-day retail utilization increases).

Yes/No.

4.1.32 Confirm all pricing will be effective and guaranteed for the term of the agreement.

Yes/No.

4.1.33 Confirm all pricing will be effective and guaranteed for the term of the agreement and will not be modified or amended if the EUTF expands its current 75/25 PPO and other consumer-driven health plan option.

Yes/No.

4.1.34 The PBM mail order service must notify the individual member, the EUTF or its designee prior to substituting products that will result in a higher member co-pay.

Yes/No.

4.1.35 The PBM will NOT implement, administer, or allow any program that results in the conversion from lower discounted ingredient cost drug products to higher ingredient cost drug products or increases the member's cost share without the prior written consent of the EUTF or its designee.

Yes/No.

4.1.36 Confirm the PBM guarantees that any preferred drug or program the PBM recommends the EUTF to implement will result in a lower ingredient cost before the application of rebates on the promoted drug to both the member and the EUTF.

Yes/No.

4.1.37 Confirm products subject to patent actions are not excluded from the financial discount, dispensing fee and rebate guarantees.

Yes/No.

4.1.38 Confirm the PBM agrees to produce a date-sensitive comparison report showing unit costs charged to the EUTF at a GCN-level, and reimburse the EUTF on a dollar-for-dollar basis for all instances where mail order unit costs exceed retail unit costs. Report and reconciliation will be provided on a quarterly basis, without a request being made by the EUTF.

Yes/No.

4.1.39 Confirm the PBM will guarantee Retail/Mail Order unit cost equalization meaning that Mail Order unit costs prior to member cost sharing, dispensing fees, and sales taxes charged will be no greater than the unit cost for the same NDC-11 adjusted for quantity and days' supply at Retail.

Yes/No.

4.1.40 Confirm the PBM guarantees that the cost of a drug at mail will be equal to or less than the cost of the identical drug at retail on the same day, inclusive of U&C pricing. In the case that the EUTF identifies any situation in which the EUTF paid more for a prescription at mail than he/she would have paid at retail on the same day, including U&C pricing, the PBM will reimburse the EUTF on a dollar-for-dollar basis.

Yes/No.

4.1.41 In order to ensure the PBM is managing the MAC list appropriately and its impact on member cost, confirm the PBM will limit the impact of MAC price increases on member copays to not exceed 25% from one quarter to the next quarter.

Yes/No.

4.1.42 Provide the discounts, dispensing fees and logic associated with the compounds the PBM administers when it is clinically appropriate.

Yes/No.

4.1.43 Confirm there are no additional fees to coordinate the deductible and the maximum out-of-pocket with the medical carrier.

Yes/No.

4.1.44 Confirm the PBM agrees to remove any retiree drug only data from the claims file that is shared with the medical carrier at no additional cost.

Yes/No.

4.1.45 The PBM will credit the EUTF the cost difference for any claims in which the EUTF was considered “primary” for the claim, but the claim should have been considered “secondary” for the EUTF (e.g., workers' compensation claim).

Yes/No.

4.1.46 Confirm that the PBM will not bill for medical supplies and services in the dispensing/usage of specialty medications not covered by the EUTF's prescription drug plan.

Yes/No.

5.1 Administrative Fees: EUTF and HSTA VB Active and Non Medicare Eligible Retiree Plans (Excluding EGWP Plan):

5.1.1 Complete the following Administrative Fee Table:

(PASS THROUGH) TRANSPARENT				
Broad Retail 30 Network with all retail chains/ Retail 90 Network at one retail chain (or multiple)/ Open Specialty/ 100% Rebate Pass Through	Contract Term 1	Contract Term 2	Contract Term 3	Contract Term 4
PROPOSAL ADMINISTRATIVE SERVICES	Yes/No	Yes/No	Yes/No	Yes/No
Retail/Mail Administrative Fee per employee/retiree per month (Self-insured bid)				
Retail/Mail Administrative Fee per employee/retiree per month ((Fully-insured bid)				
Indicate which of these services are included at no additional cost:				
<i>Toll Free Phone Lines</i>				
<i>Monthly Data Feeds to the EUTF or Designee(s); including daily exchange of out-of-pocket information with medical vendor</i>				
<i>Prospective /Concurrent/Retro DUR</i>				
<i>Standard Reports</i>				
<i>Ad Hoc Reports</i>				
<i>COB Program</i>				
<i>Mail Program</i>				
<i>Dose Optimization Program</i>				

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(PASS THROUGH) TRANSPARENT Broad Retail 30 Network with all retail chains/ Retail 90 Network at one retail chain (or multiple)/ Open Specialty/ 100% Rebate Pass Through PROPOSAL ADMINISTRATIVE SERVICES	Contract Term 1 Yes/No	Contract Term 2 Yes/No	Contract Term 3 Yes/No	Contract Term 4 Yes/No
<i>Prior Authorization Program</i>				
<i>Step Therapy Program</i>				
<i>Quantity Limitations</i>				
<i>Custom System Overrides</i>				
<i>Annual EOB Statements</i>				
<i>Retro Termination Letters</i>				
<i>Group Coding</i>				
<i>Drug Notification Letters</i>				
<i>Formulary Administration/Management</i>				
<i>ID Cards</i>				
<i>Pharmacy Directories and other member materials</i>				
<i>Standard 1st level appeals processing</i>				
<i>Standard 2nd level appeals processing</i>				
<i>Urgent appeals processing</i>				
<i>Overrides</i>				
<i>Audit Recovery Fees</i>				
<i>Compound Drug Management</i>				
<i>Retrospective DUR</i>				
<i>ePrescribing Fees</i>				
<i>Opioid Management Fees</i>				
<i>Utilization Management Fee</i>				
<i>Urgent Appeal Service for utilization management, formulary, and benefit reviews</i>				
Services above that have additional costs (i.e., services marked “N” above) (show fees separately):				

(PASS THROUGH) TRANSPARENT Broad Retail 30 Network with all retail chains/ Retail 90 Network at one retail chain (or multiple)/ Open Specialty/ 100% Rebate Pass Through PROPOSAL ADMINISTRATIVE SERVICES	Contract Term 1 Yes/No	Contract Term 2 Yes/No	Contract Term 3 Yes/No	Contract Term 4 Yes/No

5.1.2 Detail all services and supplies to be provided under your basic fees that are not included in your response to the chart above.

5.1.3 Detail all data related services included under the base administrative fees including ad hoc reporting, electronic claims files, plan design options, custom mailings, etc. In addition, detail any data-related service fees not included in the base administrative fees.

5.1.4 Do you offer a Vaccine Program? If so, what is the cost for Influenza and Other Vaccines at Participating Pharmacies? Please ensure to include the Ingredient Cost, Dispensing Fee, Professional Service Fee, Program Fee and any other cost/fee in your description below.

5.1.5 How will your system ensure retail pharmacies will only charge members \$0 for ACA vaccines?

5.1.6 Confirm that postage is included in all mail order prescriptions and any mailings.

5.1.7 Confirm that quoted fees include postage paid mail order envelopes for member prescription submission.

5.1.8 Will there be any additional charges if plans/benefits are restructured or new classes of eligible members are added? If so, how are these charges determined and state amount of charges?

5.1.9 Do you have edits or programs in place designed to detect fraud and/or abuse, address potential drug fraud and/or abuse, and notify the EUTF? If yes, (1) explain and include a listing of the specific drugs targeted by this program, (2) describe the enrollee outreach after fraud or abuse is identified, and (3) detail the controls put into place after fraud or abuse is identified. (Provide name of attachment(s).)

5.2 Administrative Fees: EUTF and HSTA VB EGWP Plan:

5.2.1 Complete the following Administrative Fee Table:

(PASS THROUGH) TRANSPARENT PROPOSAL ADMINISTRATIVE SERVICES	Contract Term 1 Yes/No	Contract Term 2 Yes/No	Contract Term 3 Yes/No	Contract Term 4 Yes/No
Retail/Mail Administrative Fee per employee/retiree per month (Self-insured bid)				
Retail/Mail Administrative Fee per employee/retiree per month (Fully-insured bid)				

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(PASS THROUGH) TRANSPARENT PROPOSAL ADMINISTRATIVE SERVICES	Contract Term 1 Yes/No	Contract Term 2 Yes/No	Contract Term 3 Yes/No	Contract Term 4 Yes/No
Indicate which of these services are included for no additional cost:				
<i>Toll Free Phone Lines</i>				
<i>Monthly Data Feeds to the EUTF or Designee(s); including daily exchange of out-of-pocket information with medical vendor</i>				
<i>Prospective /Concurrent/Retro DUR</i>				
<i>Standard Reports</i>				
<i>Ad Hoc Reports</i>				
<i>COB Program</i>				
<i>Mail Program</i>				
<i>Dose Optimization Program</i>				
<i>Prior Authorization Program</i>				
<i>Step Therapy Program</i>				
<i>Quantity Limitations</i>				
<i>Custom System Overrides</i>				
<i>Annual EOB Statements</i>				
<i>Retro Termination Letters</i>				
<i>Group Coding</i>				
<i>Drug Notification Letters</i>				
<i>Formulary Administration/Management</i>				
<i>ID Cards</i>				
<i>Pharmacy Directories and other member materials</i>				
<i>Standard 1st level appeals processing</i>				
<i>Standard 2nd level appeals processing</i>				
<i>Urgent appeals processing</i>				
<i>Overrides</i>				
<i>Audit Recovery Fees</i>				
<i>Compound Drug Management</i>				
<i>Retrospective DUR</i>				

(PASS THROUGH) TRANSPARENT PROPOSAL ADMINISTRATIVE SERVICES	Contract Term 1 Yes/No	Contract Term 2 Yes/No	Contract Term 3 Yes/No	Contract Term 4 Yes/No
<i>ePrescribing Fees</i>				
<i>Opioid Management Fees</i> <i>Utilization Management Fee</i>				
<i>Urgent Appeal Service for utilization management, formulary, and benefit reviews</i> Services above that have additional costs (i.e., services marked “N” above) (show fees separately):				

5.2.2 Detail all services and supplies to be provided under your basic fees that are not included in your response to the chart above.

5.2.3 Detail all data related services included under the base administrative fees including ad hoc reporting, electronic claims files, plan design options, custom mailings, etc. In addition, detail any data-related service fees not included in the base administrative fees.

5.2.4 Do you offer a Vaccine Program? If so, what is the cost for Influenza and Other Vaccines at Participating Pharmacies? Please ensure to include the Ingredient Cost, Dispensing Fee, Professional Service Fee, Program Fee and any other cost/fee in your description below.

5.2.5 How will your system ensure retail pharmacies will only charge members \$0 for Medicare Part D vaccines?

5.2.6 Confirm that postage is included in all mail order prescriptions and any mailings.

5.2.7 Confirm that quoted fees include postage paid mail order envelopes for member prescription submission.

5.2.8 Will there be any additional charges if plans/benefits are restructured or new classes of eligible members are added? If so, how are these charges determined and state amount of charges?

5.2.9 Do you have edits or programs in place designed to detect fraud and/or abuse, address potential drug fraud and/or abuse, and notify the EUTF? If yes, (1) explain and include a listing of the specific drugs targeted by this program, (2) describe the enrollee outreach after fraud or abuse is identified, and (3) detail the controls put into place after fraud or abuse is identified. (Provide name of attachment(s).)

6.1 Prescription Drug Pricing: EUTF and HSTA VB Active and Non-Medicare Retiree Plans Excluding EGWP Plan (Self-Insured)

AWP Reimbursement Basis - Complete the following tables using the drug reimbursement that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract. Columns marked "AWP Discount" are to be completed using a discount from 100% AWP and dispensing fee logic. If alternative pricing is proposed, explain in detail. All guarantees must be based on the AWP unit cost dispensed at the point of sale, and post September 26, 2009 AWP rollback.

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Notes:

- (1). Including both single source and multi-source brands.
- (2). Post September 26, 2009 AWP rollback
- (3). Including single-source generics.

6.1.1 Contract Term 1

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.1.2 Contract Term 2

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.1.3 Contract Term 3

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.1.4 Contract Term 4

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.2 Prescription Drug Pricing: EUTF and HSTA VB Active and Non-Medicare Retiree Plans Excluding EGWP Plan (Fully-Insured)

AWP Reimbursement Basis - Complete the following tables using the drug reimbursement that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract. Columns marked "AWP Discount" are to be completed using a discount from 100% AWP and dispensing fee logic. If alternative pricing is proposed, explain in detail. All guarantees must be based on the AWP unit cost dispensed at the point of sale, and post September 26, 2009 AWP rollback.

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Notes:

- (1). Including both single source and multi-source brands.
- (2). Post September 26, 2009 AWP rollback
- (3). Including single-source generics.

6.2.1 Contract Term 1

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.2.2 Contract Term 2

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.2.3 Contract Term 3

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.2.4 Contract Term 4

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.3 EUTF and HSTA VB (Self-Insured) EGWP Plan Pricing

AWP Reimbursement Basis - Complete the following tables using the drug reimbursement that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract for a self-insured EGWP plan. Columns marked "AWP Discount" are to be completed using a discount from 100% AWP and dispensing fee logic. Any applicable administrative fees are requested on a per-Retiree-per-month (RPM) basis and dispensing fees are requested on a per-prescription paid basis and must be based on prescriptions dispensed (not adjustments, errors, or redos). If alternative pricing is proposed, explain in detail. No fees may be proposed on a per-member, per month basis. All guarantees must be based on the AWP unit cost dispensed at the point of sale, and post September 26, 2009 AWP rollback.

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Notes:

1. Including both single source and multi-source brands.
2. Post September 26, 2009 AWP rollback
3. Including single-source generics.

6.3.1 Contract Term 1

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.3.2 Contract Term 2

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.3.3 Contract Term 3

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.3.4 Contract Term 4

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.4 EUTF and HSTA VB (Fully-Insured) EGWP Plan Pricing

AWP Reimbursement Basis - Complete the following tables using the drug reimbursement that your organization is willing to guarantee on a dollar-for-dollar basis for each year of the contract for a fully insured EGWP plan. Columns marked "AWP Discount" are to be completed using a discount from 100% AWP and dispensing fee logic. Any applicable administrative fees are requested on a per-Retiree-per-month (RPM) basis and dispensing fees are requested on a per-prescription paid basis and must be based on prescriptions dispensed (not adjustments, errors, or redos). If alternative pricing is proposed, explain in detail. No fees may be proposed on a per-member, per month basis. All guarantees must be based on the AWP unit cost dispensed at the point of sale, and post September 26, 2009 AWP rollback.

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Notes:

1. Including both single source and multi-source brands.
2. Post September 26, 2009 AWP rollback
3. Including single-source generics.

6.4.1 Contract Term 1

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.4.2 Contract Term 2

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.4.3 Contract Term 3

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.4.4 Contract Term 4

Broadest Retail Network (List any Major Retail Chains Excluded)	AWP Discount Retail Supply Up to 30 days	AWP Discount Retail Supply 31-90 days	AWP Discount Mail Supply 1-90 days
Brand Drugs [1]			
Discount from AWP[2] for all brands			
Dispensing Fee Per Rx			
Generic Drugs [3]			
Discount from AWP[2] for all generics (composite discount of MAC and Non-MAC prices, discounted AWP, or usual and customary retail price)			
Dispensing Fee Per Rx			
Rebates			
Three Tier Plan – Per Rx (brand & generic)			

6.5 Specialty Pharmacy Program Pricing

6.5.1 Please confirm your agreement to the following definition and qualification criteria of a “specialty drug product”:

The term “Specialty Drug(s)” shall mean each drug identified on Exhibit K of this Agreement. The term “Specialty Drug” shall also include any new-to-market specialty drug that the EUTF approves the dispensing of, in writing. The EUTF shall have the right to select which Specialty Drugs on Exhibit K shall (or shall not) be dispensed to its Plan Beneficiaries.

6.5.2 Provide an AWP-based pricing list **in Excel** of all specialty pharmaceuticals, including Limited Distribution Drugs, that your company dispenses and distributes to providers and patients for your proposed specialty pharmacy program. Your pricing must include adequate supplies of ancillaries such as needles, swabs, syringes, and containers. The following items must be included in your list:

- a. Product Name
- b. Therapeutic Group/Therapeutic Category
- c. NDC
- d. Guaranteed Minimum AWP Discount and Dispensing Fee for all specialty pharmacy program prescriptions for the specialty arrangement.
- e. Limited Drug Designation

6.5.3 Confirm you provided the most recent Limited Distribution Drug Indicator and Exclusive Distribution Indicator in the attachment for the previous question. If not, please provide your proposed Limited Distribution Drug List and Exclusive Distribution List with NDC in an Excel File that will be in place.

6.5.4 How often does your organization evaluate specialty drug classifications? What is the process that your organization uses to move drugs from a specialty drug classification to a non-specialty drug classification and vice versa? Confirm you allow the EUTF the ability to reject any changes in such classification.

6.5.5 Confirm the PBM agrees to notify the EUTF and its members at least 60 days prior to changing the classification of a drug from non-specialty drug classification to a specialty drug classification and at least 60 days prior to the change in classification of a drug from a specialty drug classification to a non-specialty drug classification, previously approved by the EUTF.

6.5.6 Complete the following table:

Specialty Drugs Dispensed at Participating Retail 30 Pharmacies under the Open Specialty Pharmacy Program (30-day supply)	Contract Term 1	Contract Term 2	Contract Term 3	Contract Term 4
Overall Effective Discount (OED) Guarantee for Specialty Brand Drugs	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Overall Effective Discount (OED) Guarantee for Specialty Generic Drugs (including biosimilars)	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Confirm Limited Distribution and Exclusive Distribution Specialty Drugs will be included in the above OED guarantees				
If Limited Distribution Specialty Drugs are not included in the above OED guarantees, then please indicate the Limited Distribution and Exclusive Distribution Drug Guarantee	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Confirm Biosimilars will be included in the above OED guarantee for Specialty Generic Drugs				
If not, then please indicate the Biosimilars Discount Guarantee	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Confirm New to Market Specialty Drugs, New to Market Limited Distribution Drugs and New to Market biosimilars will be included in the above OED guarantees				
If not, then please indicate the New to Market Specialty Drug Discount Guarantee	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
If not, then please indicate the New to Market Limited Distribution Drug Discount Guarantee	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
If not, then please indicate the New to Market Biosimilars Discount Guarantee	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Dispensing Fee Guarantee - Per Prescription	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>
Administrative Fee Guarantee - Per Prescription	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION IX

Specialty Drugs Dispensed at Participating Retail 30 Pharmacies under the Open Specialty Pharmacy Program (30-day supply)	Contract Term 1	Contract Term 2	Contract Term 3	Contract Term 4
Minimum Rebate Guarantee – Per Brand Prescription <i>(Passed Through at 100%)</i>	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>
Confirm covered Biosimilar Products will be included in the above Biosimilars Ingredient Cost and Specialty Drug Dispensing Fee guarantee and although Biosimilar Products will not be included in the Rebate Guarantees, the EUTF will receive 100% of all rebates related to Biosimilar Products, if any.				
Confirm any Exclusions from Minimum Rebate Guarantees. List Drugs and provide Separate Guarantees.				

6.5.7 Complete the following table:

Specialty Drugs Dispensed at the PBM’s Specialty Pharmacy under the Open Specialty Pharmacy Program	Contract Term 1	Contract Term 2	Contract Term 3	Contract Term 4
Overall Effective Discount (OED) Guarantee for Specialty Brand Drugs	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Overall Effective Discount (OED) Guarantee for Specialty Generic Drugs (including biosimilars)	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Confirm Limited Distribution and Exclusive Distribution Specialty Drugs will be included in the above OED guarantees				
If Limited Distribution Specialty Drugs are not included in the above OED guarantees, then please indicate the Limited Distribution and Exclusive Distribution Drug Guarantee	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Confirm Biosimilars will be included in the above OED guarantee for Specialty Generic Drugs				
If not, then please indicate the Biosimilars Discount Guarantee	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Confirm New to Market Specialty Drugs, New to Market Limited Distribution Drugs and New to Market biosimilars will be included in the above OED guarantees				
If not, then please indicate the New to Market Specialty Drug Discount Guarantee	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>

Specialty Drugs Dispensed at the PBM’s Specialty Pharmacy under the Open Specialty Pharmacy Program	Contract Term 1	Contract Term 2	Contract Term 3	Contract Term 4
If not, then please indicate the New to Market Limited Distribution Drug Discount Guarantee	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
If not, then please indicate the New to Market Biosimilars Discount Guarantee	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Dispensing Fee Guarantee - Per Prescription	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>
Administrative Fee Guarantee - Per Prescription	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>
Minimum Rebate Guarantee – Per Brand Prescription <i>(Passed Through at 100%.)</i>	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>	<i>Dollars.</i>
Confirm covered Biosimilar Products will be included in the above Biosimilars Ingredient Cost and Specialty Drug Dispensing Fee guarantees, and although Biosimilar Products will not be included in the Rebate Guarantees, the EUTF will receive 100% of all rebates related to Biosimilar Products, if any.				
Confirm any Exclusions from Minimum Rebate Guarantees. List Drugs and provide Separate Guarantees.				

6.5.8 Confirm the EUTF will have the ability to renegotiate and/or “carve-out” specialty drug pricing and service terms without penalty or changes to the financial guarantees.

6.5.9 Confirm your proposed guarantees for your retail/mail program are not contingent upon the EUTF's purchase of your specialty drug program?

6.5.10 Indicate how long a drug would be considered “New to Market” and the process to move a drug from the New to Market pricing to being discounted under the OED guarantee.

6.5.11 Provide examples of success with managing specialty costs for other clients.

6.6 Allowances

6.6.1 Please complete the following table:

Allowance	Description	Response
General Pharmacy Program Management	Place the \$ (dollar) Per Member amount or the flat dollar (\$) amount you are offering the EUTF for general expenses related to the management of the pharmacy benefits program such as communication expenses, clinical programs, consulting fees or be used as a credit against claim invoices. Credit excludes pharmacy claim and rebate audit amounts.	<i>Dollars.</i>

6.6.2 Confirm the PBM will allow the EUTF to rollover any unused allowances to the next contract year or contract if the proposed allowances are on a contract year basis and/or contract term basis.

6.6.3 If the Allowances described above are offered on a per “Member” basis, describe how the “member” counts will be determined for the allowance calculations described above (i.e., membership at the start of the year, membership over a certain period in time). The actual member counts at a point in time will be based on EUTF enrollment records.

6.6.4 Confirm the EUTF will be able to use the Implementation Credit or the General Administrative Credit for a Pre-Implementation Audit and/or a Post-Implementation Audit.

6.6.5 Confirm the EUTF may use the General Pharmacy Program Management Allowance for services related to managing the pharmacy benefit such as pharmacy audits and pharmacy benefit consulting services.

6.6.6 Confirm the EUTF does not have to repay either the full or a pro-rated share of any of the Allowances if the EUTF terminates the contract early with or without cause.

6.7 Generic Drugs—Dispensing Rate Guarantees

6.7.1 Complete the table below for Contract Years 1, 2, 3, and 4. Note that generic dispensing rate includes only true instances of generic dispensing (i.e., exclude multi-source brand drugs dispensed under member-pay-difference plan designs).

Guaranteed GDR	Retail 30	Retail 90	Mail Order
Contract Term 1	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Contract Term 2	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Contract Term 3	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Contract Term 4	<i>Percent</i>	<i>Percent</i>	<i>Percent</i>

6.7.2 What dollar amount are you prepared to put at risk for failure to meet your GDR guarantee?

6.7.3 Confirm the PBM's Generic Dispensing Rate Guarantee will be measured and reconciled on a component basis and a shortfall in one delivery channel will not be used to offset a shortfall in another delivery channel or any other financial component guarantee.

6.7.4 Confirm the PBM's Generic Dispensing Rate Guarantee does not include copays or rebates into the calculation.

6.8 Trend Guarantees

6.8.1 Confirm the PBM will provide the EUTF with an annual 4% Non-Specialty Gross Drug Spend per Member per Year Trend Guarantee.

6.8.2 Please describe any price inflation guarantee you are putting forth for specialty drugs.

6.8.3 The PBM guarantees that the percentage increase in the Generic Drug Ingredient Cost compared on a Contract Year basis with the immediately prior Contract Year will be no greater than 2% throughout the term of the contract.

7 Technical Services Requirements Questionnaire

7.1 Formulary Management

7.1.1 Provide the name of the non-specialty Formulary (i.e. for preferred and non-preferred status) you are proposing to the EUTF. Provide Information and Names of Attachments.

7.1.2 Provide the name of the Specialty Formulary you are proposing to the EUTF. (Provide names of any attachments.) The current EUTF Specialty Formulary excludes certain brands. See attached Exhibit K.

7.1.3 Provide a description of one alternative formulary option for the EUTF. Please provide revised pricing.

7.1.4 Confirm the PBM will allow members to obtain non-formulary drugs with a prior authorization for medical necessity without impacting the rebate guarantees.

7.1.5 The PBM agrees to remove drugs from coverage under specialty formulary (other than FDA recalls and other safety reasons) at most quarterly and no greater than two percent (2%) of members will be disrupted by any specialty formulary deletions on a quarterly basis.

7.1.6 The PBM agrees to seek EUTF or its designee approval 90 days in advance of when a drug is targeted to be moved to/from the non-specialty and specialty preferred drug list. The PBM must provide a detailed disruption and financial impact analysis at the same time. No greater than two percent (2%) of members will be disrupted by any non-specialty and specialty formulary deletions or all deletions in total on an annual basis.

7.1.7 The PBM agrees to notify the EUTF or its designee 90 days in advance of when a drug is targeted to change tiers or be moved to or from a preferred or non-preferred non-specialty/ specialty formulary tier. The PBM must provide a detailed disruption and financial impact analysis at the same time.

7.1.8 The PBM agrees to notify members 30 calendar days in advance of when a member's utilized drug is targeted to be moved to a higher cost tier. The PBM must provide at least one notification to the member with the formulary alternative. This includes a change in the member's cost share due to a service warranty.

7.1.9 Provide a description of the PBM's process on how impacted members will be communicated regarding formulary drug shifts from a Preferred to a Non-Preferred Tier.

7.1.10 Does the PBM use an external rebate aggregator? If so, which one?

7.1.11 Confirm the PBM will be able to provide a list of the non-preferred brand drugs that are covered by the EUTF upon request at any time during the term.

7.1.12 Confirm the PBM agrees to grandfather the EUTF's current formulary for up to 90 days following the contract effective date, with no impact on rebate guarantees.

7.1.13 As a reminder, all bidders must complete and submit a formulary disruption based on your proposed formulary and on the claims data that will be provided upon the submission of the “Confidentiality Form”. Results to be included are the number of members that will require a change as well as the number of prescriptions associated with the formulary change. An Excel file that lists the specific drugs that will be negatively impacted (higher-cost tier) along with the total number of scripts and members impacted for each of these drugs should also be provided. Please provide a summary of your formulary disruption analysis using the table below:

Type of Change	Member Impact	% of Total Members	Number of Scripts Impacted	% of Total Scripts (including all brands and generics)
No Change	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Positive (higher-cost tier to lower tier)	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Negative (lower tier to higher-cost tier)	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Moving from covered to not covered	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>
Total	<i>Integer.</i>	<i>Percent.</i>	<i>Integer.</i>	<i>Percent.</i>

7.1.14 Please complete the following table.

	#1 Top Drug that is Moving from Preferred to Non-Preferred based on impacted Members: [Indicate Member and Script Impact.]	#2 Top Drug that is Moving from Preferred to Non-Preferred based on impacted Members: [Indicate Member and Script Impact.]	#3 Top Drug that is Moving from Preferred to Non-Preferred based on impacted Members: [Indicate Member and Script Impact.]
Name of Drug	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>
Member Impact	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>
% of Total Members	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>
Number of Scripts Impacted	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>
% of Total Scripts (including all brands and generics)	<i>Percent.</i>	<i>Percent.</i>	<i>Percent.</i>

7.2 Clinical Programs

7.2.1 Provide descriptions of the PBM's capabilities regarding compounds and ability to only administer them when it is clinically appropriate based on the EUTF's guidance.

7.2.2 Describe your home infusion capabilities. Provide the contractual discounts, dispensing fees, administrative fees and rebates you are proposing to the EUTF for home infusion claims.

7.2.3 Provide descriptions of the PBM's capabilities to use medical claims data and prescription claims data to identify safety and health risks.

7.2.4 Provide descriptions of the PBM's online capabilities to allow members to view actionable items and enhance the care for patients with chronic and complex conditions.

7.2.5 Provide descriptions of the PBM's Prior Authorization, Drug Quantity Management, Step Therapy capabilities for non-specialty and specialty drugs.

7.2.6 Confirm the PBM will not charge more than once for a Prior Authorization fee for a single prescription (e.g., the PBM won't charge multiple times if they have to reach out to the doctor multiple times for a single prescription). Confirm the PBM will guarantee to charge the lowest of the Prior Authorization fee or the EUTF's Net Cost (before rebates).

7.2.7 Provide descriptions of the PBM's programs to better manage the high cost of Hepatitis C, PCSK9 inhibitors and Oncology drugs.

7.2.8 Provide a description on how the PBM will manage Non-FDA approved drugs.

7.2.9 Provide a description on how the PBM will manage DESI drugs.

7.2.10 Provide descriptions of the PBM's process to better manage drug inflation.

7.2.11 Provide a description of how the PBM will manage 510k products based on the EUTF's benefits coverage.

7.2.12 Provide descriptions of the PBM's programs to better manage high cost non-specialty generics and brands as well as hyperinflation drugs. Does the PBM guarantee to refund the EUTF for every non-specialty drug over \$1,000 that adjudicates that was not properly reviewed by the PBM?

7.2.13 Provide descriptions of PBM's process to introduce new clinical programs to the EUTF that would take into consideration what is currently in place, what is needed and what is no longer needed. Describe how you will provide adequate time to inform the EUTF about the program, provide the EUTF with member and financial specific information and allow the EUTF sufficient time to come up with a decision on the program.

7.2.14 Provide information on how prior authorizations and step therapies will work for those members that have already gone through the process prior to the implementation date assuming you'll receive a claims history file, open mail refill file and a prior authorization file for only the past 12 months. Provide information how these members will be impacted at a retail pharmacy (assuming the member is paying the higher copay for maintenance drug refills at retail) and via mail order.

7.2.15 Provide a complete list of your clinical programs with pricing associated with each program and highlight those programs recommended for the EUTF. Describe the type of impact members will face for each of these programs.

7.2.16 Not used

7.2.17 Do you require two generic products in order for a brand drug with a DAW 1 or 2 code to get the DAW penalty? Does the DAW penalty process apply to just DAW 1 and 2 or all DAW codes? Describe any additional details on how your organization's DAW penalty process works. Does your process allow an appeals process that allows a member's doctor to provide information showing that the brand name drug is medically necessary? If so, how does that process work? Would the regular brand discount, fee, rebate and member copay apply to that drug?

7.3 Retail Network Management

7.3.1 Provide a description of the program you are proposing that will allow a member to fill a maintenance medication at one retail chain (or network) at the mail order copay and mail order pricing to the EUTF. Confirm the proposed offer will remain the same if the EUTF participates in this program assuming the current plan design stays in place.

7.3.2 Provide the names of the retail chain(s) that are part of your proposed retail 90 Network that allows members to pay the mail order copay and the EUTF obtain the mail order pricing. (Provide names and name of attachment(s), if any.)

7.3.3 The PBM agrees that it will not remove any participating network pharmacies that impact greater than 2% of the EUTF's prescriptions without communicating to the EUTF at least sixty (60) days in advance of the scheduled change. The current guarantees will be honored if the EUTF opts

out of the network changes. If the change is not agreeable to the EUTF, the EUTF will have the right to terminate the agreement without penalty with 30 days' notice.

7.3.4 The PBM agrees that it offers a performance guarantee that will guarantee that at least 95% of members will have access to a network pharmacy within a five-mile radius of their residence.

7.3.5 The PBM agrees to offer improved pricing terms to the EUTF if greater than 2% of utilizing members are impacted by proposed changes to the participating retail 30 and retail 90 pharmacy network.

7.3.6 Confirm the EUTF reserves the right to remove any retail pharmacy from its retail pharmacy network.

7.3.7 Confirm the PBM will not withhold any financial recoveries from audits performed on the contracted pharmacy network including mail order and specialty pharmacies. Any recoveries will be disclosed and credited to the EUTF.

7.3.8 Confirm the PBM will not charge the EUTF or offset any costs from a retail pharmacy audit recovery even if the PBM has to pursue additional collection action to recover retail pharmacy audit discrepancies.

7.3.9 Confirm the PBM will maintain the retail pharmacy audit recovery fee paid to the PBM at 0% of the collections throughout the life of the contract.

7.3.10 Provide a description of the escalation process for urgent drug claim issues in which a claim is rejecting at the pharmacy and members need immediate assistance and resolution.

7.3.11 As a reminder, all bidders must complete and submit a retail network disruption based on your proposed retail 30 and the retail 90 network and on the claims data that will be provided upon the submission of the “Intent to Propose” Form. Results to be included are the number of members that will be required to change the utilized retail pharmacy as well as the number of prescriptions associated with the retail pharmacy change. An Excel file that lists the specific retail pharmacies that will be negatively impacted (will be considered out of network for the proposed retail 30 and/or the retail 90 network) along with the total number of scripts and members impacted for each of these retail pharmacies should also be provided. Please provide a summary of your retail network disruption analysis using the tables below:

Type of Change	Retail 90 Network
Number of Currently Utilized Retail Pharmacies that are Not Part of Proposed Network and are Eligible to Solicit	<i>Integer.</i>
Number of Members that are Using Those Retail Pharmacies that are Not Part of Proposed Network and are Eligible to Solicit	<i>Integer.</i>
Number of Prescriptions that Adjudicated via Those Retail Pharmacies that are Not Part of Proposed Network and are Eligible to Solicit	<i>Integer.</i>
Number of Currently Utilized Retail Pharmacies that are Part of Proposed Network	<i>Integer.</i>
Number of Members that are Using Those Retail Pharmacies that are Part of Proposed Network	<i>Integer.</i>
Number of Prescriptions that Adjudicated via Those Retail Pharmacies that are Part of Proposed Network	<i>Integer.</i>

7.3.12 Top 3 Currently Utilized Retail Pharmacies that are Not Part of Proposed Network based on impacted number of members, Location of Pharmacies, Number of members that use each of those pharmacies and Number of prescriptions that use each of those pharmacies.

	Out-of-Network Retail Pharmacy #1	Out-of-Network Retail Pharmacy #2	Out-of-Network Retail Pharmacy #3
State of Hawaii	<i>Unlimited.</i>	<i>Unlimited.</i>	<i>Unlimited.</i>
# of Members	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>
# of Scripts	<i>Integer.</i>	<i>Integer.</i>	<i>Integer.</i>

7.4 Audit Rights

7.4.1 The EUTF or an independent auditor retained by EUTF, may review 100% of the claims and rebates. Any independent auditor retained by EUTF must meet the following criteria: (a) is a public accounting firm that is a member of the American Institute of Certified Public Accountants (AICPA), or (ii) a reputable consulting firm with a pharmacy benefit consulting practice that

operates nationally and adheres to generally accepted accounting and actuarial principles, provided that, with respect to any audits of pharmaceutical manufacturer rebate contracts or retail network pharmacy contracts, such consulting firm maintains an information “fire wall” between its consulting and auditing divisions; (b) has not previously breached a confidentiality agreement with CONTRACTOR; (c) does not currently provide audit or consulting services or advice to any person, company or other entity in connection with any lawsuit, investigation or other proceeding is unrelated to EUTF; and (d) enters into a confidentiality agreement with CONTRACTOR that is reasonably acceptable to CONTRACTOR and EUTF prior to commencing any audit activities and carries insurance for professional malpractice of at least two million dollars (\$2,000,000)

7.4.2 The EUTF or its designee will have the right to audit annually, (for both claims and rebate audits), with full cooperation of the selected PBM, the claims, services and pricing and/or rebates, including the manufacturer rebate contracts held by the PBM, to verify compliance with all program requirements and contractual guarantees with no additional charge from the PBM.

7.4.3 The EUTF or its designee will have the right to audit up to the last four complete contractual years (48 months) of claims at no additional charge from the PBM as long as the audit period has not been previously audited. Confirm all audits will not be limited to information relating to the plan year in which the audit is conducted or the immediately preceding plan year.

7.4.4 The EUTF or its designee will have the right to conduct an audit at any time during the year, at any point during the contract term, and the selected PBM will provide all documentation necessary to perform the audit. Confirm the EUTF may conduct such audit every year regardless of when the prior audit was conducted as long as the audit period has not been previously audited.

7.4.5 The EUTF will not be held responsible for time or miscellaneous costs incurred by the PBM in association with any audit process including, all costs associated with provision of data, audit finding response reports, or systems access, provided to the EUTF or its designee by the PBM during the life of the contract and period after the contract equal to the term of the contract including extensions. Note: This includes any data required to transfer the business to another vendor and money collected from lawsuits and internal audits.

7.4.6 The PBM will provide complete claim files and documentation (i.e., full claim files, financial reconciliation reports, inclusion files, and plan documentation) to the auditor within 30 days of receipt of the audit data request as long as a non-disclosure agreement is in place between the auditor and the PBM.

7.4.7 The PBM will not set a maximum number of claim samples per audit. The EUTF or the auditor, on behalf of the EUTF, will be able to provide all claims in question (e.g., claim samples separately without limit) during an audit for each contract year that is being audited regardless of whether the scope of the audit is for one year or multiple contractual years.

7.4.8 The PBM agrees to a 30-day turnaround time to provide the full responses to all of the sample claims and claims audit findings, including suspected errors, regardless of the number of claim samples sent to the PBM or the number of years that encompass the scope of the audit.

7.4.9 The EUTF or its designee will have the right to audit to the greater of 12 pharmaceutical manufacturer contracts or the pharmaceutical manufacturer rebate contracts that account for 70% of the total rebate payments during the selected audit period during an on-site rebate audit.

7.4.10 Confirm the PBM will correct any errors that the EUTF, or its representative, brings up to the PBM's attention whether identified by an audit or otherwise. Describe the process that the PBM will undergo to correct the error and make the appropriate payments to the member and/or the EUTF, if applicable.

7.4.11 Confirm the audit provision shall survive the termination of the agreement between the parties for a period of equal to the term of the contract including extensions after the termination of the contract at no additional cost to the EUTF.

7.4.12 Confirm only the EUTF, or the auditor on behalf of the EUTF, is able to formally close an audit initiated by the EUTF or the auditor on behalf of the EUTF.

7.4.13 Confirm the EUTF is able to initiate a new audit even if all parties have not agreed that the prior audit is closed.

7.4.14 Confirm how the PBM will be able to proactively provide analytical reports throughout the contract year indicating the actual performance versus the financial guarantees without a formal audit. This is in addition to the annual reconciliation reports that the PBM is expected to proactively provide to the EUTF.

7.4.15 Confirm the PBM will provide the response to the suspected errors within 45 calendar days from the PBM's receipt of such findings during an audit.

7.4.16 Confirm the EUTF will have the ability to fully inspect the contracts between participating pharmacies and the PBM for up to 80% of retail pharmacy claims under the pass through pricing arrangement.

7.5 Implementation

7.5.1 The PBM agrees to provide an Implementation Credit to the EUTF on a Per Member basis.
Yes/No. If Yes, provide the amount.

7.5.2 The PBM agrees to provide a fund for a Pre or Post-Implementation Audit of at least \$30,000 to be conducted at least 60 days prior to the start of claims adjudication. The PBM will work with the auditor to run test claims in a test environment utilizing the EUTF's actual plan parameters. The PBM contractor will be selected by the EUTF in accordance with 7.4.1.
Yes/No.

7.5.3 The PBM agrees to load all current prior authorizations, open mail order refills, specialty transfer files, claim history files, and accumulator files that exist for current members from the existing PBM at NO charge to the EUTF (with no charges being deducted from the implementation allowance for file loading or IT) even if the EUTF terminates the contract with or without cause at any point of the contractual term.
Yes/No.

7.5.4 The PBM agrees to send at least the most current 12 months of claims history data, all current prior authorizations, open mail order refills, specialty transfer files, and accumulator files that exist for the EUTF members to the next/successor PBM at NO charge even if the EUTF terminates the contract with or without cause at any point of the contractual term.
Yes/No.

7.5.5 Not used.

7.5.6 The PBM agrees to waive any charges to the EUTF or the EUTF's medical plan claims administrators such as a set-up fee, a programming fee, or a monthly fee, for establishing a connection with a Third Party Administrator/Claims processor for real-time, bidirectional data integration, including non-standard data integration formats.

Yes/No.

7.5.7 The PBM agrees to absorb any programming or other administrative costs to meet any existing or future requirements of the Affordable Care Act.

Yes/No.

7.5.8 The PBM will provide draft SPD/benefits booklet language for any clinical programs that are to be implemented upon the EUTF's request.

Yes/No.

7.5.9 The PBM will have the EUTF's specific 800-telephone number available to all plan members prior to the go-live date.

Yes/No.

7.6 Member Service and Account Management

7.6.1 The PBM agrees to service the EUTF from its national accounts service unit.

7.6.2 The PBM agrees to provide dedicated account resources including, but not limited to, a local overall account manager, senior account manager (supervisor of account manager), enrollment manager, IT manager, clinical pharmacist, and implementation manager (if necessary). Please include biographies in attachments. Please provide the following information regarding the proposed account team:

	Name of Team Member	Years of PBM Experience	Number of Assigned Accounts	Location
Local Overall Account Manager				
Senior Account Manager (supervisor of above)				
Enrollment Manager				
IT Manager				
Clinical Pharmacist				
Implementation Manager (if necessary)				

7.6.3 The PBM agrees to obtain the EUTF's approval for all member communication materials before distribution to members. The PBM will not automatically enroll the EUTF in any programs that involve any type of communications with members or alterations of members' medications, without express written consent from the EUTF.

7.6.4 The EUTF reserves the right to review, edit, or customize any communication from the PBM to its membership, unless restricted by federal law.

7.6.5 Indicate how the PBM will personalize member communications based on the EUTF's various demographics (e.g., age, new hires) and type of enrolled plan.

7.6.6 Confirm that postage is included when mailing ID cards and duplicate cards.

7.6.7 The PBM will be able to print out the full name of the primary member and dependents on the ID Card at no additional charge to the EUTF.

7.6.8 Describe how the PBM will ensure that the PBM does not create unnecessary duplicate ID cards that will be incorrectly charged to the EUTF when receiving and loading eligibility files.

7.6.9 All member service call recordings and notes between the PBM and the EUTF's members will be the EUTF's property.

7.6.10 The PBM agrees to document 100% of the EUTF's member service calls through call recordings and call notes. The PBM will forward written transcripts of calls at the EUTF's request within two business days of the request being made.

7.6.11 The EUTF reserves the right to access all call recordings or call notes from member service calls with its members. The PBM agrees to allow the EUTF the right to request call recordings and/or notes at any time. The PBM agrees to allow the EUTF to listen to any recorded calls within 24 hours of the EUTF's request.

7.6.12 All customer service operations requiring verbal communication with the EUTF and the EUTF's members will be performed in the United States (i.e., will not be performed offshore).

7.6.13 The PBM agrees to allow the EUTF to access its member website with a dummy login prior to the go-live date.

7.6.14 The PBM will provide the EUTF with a virtual tour of its CSR system and any custom messaging system.

7.6.15 The PBM agrees to monthly meetings to review member service issues. The PBM agrees to allow the EUTF to review member service quality issues to the resolution endpoint.

7.6.16 The PBM agrees to a minimum of one annual meeting with call center executives to discuss services regarding enrollment and member issues.

7.6.17 The PBM agrees to provide different levels of access to each of the EUTF's designees to the online, real time, claim system so that not all of the EUTF's designees are able to see all details related to member claims in the system.

7.6.18 The PBM agrees that all future edits required because of plan design changes implemented by the EUTF shall be completed, after testing, by the PBM within 45 days of request/advisory by the EUTF.

7.6.19 The PBM agrees to provide weekly and/or monthly data transmissions (may include feeds to data warehouses) to at least 10 chosen vendors at no charge and two full, annual electronic claims files, in NCPDP format, at no charge as needed. The PBM will also interact/exchange data with all vendors as needed at no additional charge.

7.6.20 Provide information on programs your organization offers that would allow members to contact the same Care Representative.

7.6.21 Confirm that multi-language communication phone line support is included in the base administrative fee. List the languages available to the EUTF members speaking to your customer service representatives.

7.6.22 How do you track member complaints? List the top 5 member complaints related to retail, mail order, and the specialty pharmacy program. What processes/remedies have been put into effect to resolve these complaints?

7.6.23 How are disabled (e.g., hearing-impaired) member calls facilitated through your member services area?

7.6.24 Describe what portion of the EUTF's business with your organization will be serviced by a subcontractor or through leased services/networks.

7.6.25 List all functions you currently outsource to any third party and subcontractor name(s) for the following functions:

	Outsource to third party? Yes/No	Provide subcontractor name
Claim processing system		
Formulary Management		
Appeals		
Clinical programs		
Pharmacy and Therapeutics Committee		
Customer service		
Rebate contracting		
Network contracting		
Mail order		
Specialty Pharmacy		
Data Reporting		

7.6.25.a Describe what portion of the EUTF's business with your organization will be serviced by a subcontractor or through leased services / networks.

7.6.26 Please provide the following information regarding your organization:

	CY 2018
Total Number of Covered Lives	
Total Number of Scripts Dispensed	
Total AWP Dollars Processed	
Total Number of Pharmacy Benefit Client Accounts	
Total Number of Pharmacy Benefit Client Accounts with over 30,000 covered lives	
Major Owners of the Organization	

7.6.27 Please provide the following information regarding the proposed call center:

	CY 2018
Location	
Days of Operation	
Hours of Operation	

Percent of Calls Abandoned	
Average Number of Seconds to Reach Representative	

7.6.28 Please provide the following information regarding the proposed mail order facility:

	CY 2018
Location	
Days of Operation	
Hours of Operation	
Total Scripts Filled	
Utilization as Percent of Capacity	
Average Turnaround (No Intervention)	
Average Turnaround (Intervention Required)	
Average Generic Dispensing Rate	
Average Generic Substitution Rate	

7.6.29 Not used.

7.6.30 Please provide the PBM's Book-of-Business Turnover Rate for the following divisions:

	CY 2018
Overall Book-of-Business	<i>Percent.</i>
Call Center Representatives	<i>Percent.</i>
Strategic Account Executives	<i>Percent.</i>
Account Managers	<i>Percent.</i>
Client-Facing Clinical Pharmacists	<i>Percent.</i>

7.6.31 Please provide three references with over 50,000 covered lives each that the EUTF may contact.

- a. One would be a current client that has been with the PBM for three years.
- b. The second would be a new client that went through the implementation process within the past 6-12 months.
- c. The third would be a client that terminated the PBM.

7.7 Legal Responsibilities

7.7.1 The PBM shall indemnify, defend and hold harmless the EUTF, its Trustees, officers, directors, employees and agents from and against any and all claims, actions, demands, costs, and expenses, including reasonable attorney fees and disbursements, as a result of a breach by the PBM of any of its obligations under the contract or arising out of the negligent act or omission or willful misconduct of the PBM or its employees or agents.

Yes/No.

7.7.2 The indemnification set forth above shall cover a breach of protected health information.

Yes/No.

7.7.3 The PBM acknowledges that it is compliant with the Electronic Data Interchange (“EDI”), Privacy and Security Rules of the HIPAA, and will execute a BAA. PBM also agrees that in the event of a privacy violation or data breach, that the PBM will notify the EUTF and the impacted members to a breach and provide any required remedies.

Yes/No.

7.7.4 Confirm the PBM agrees to hold the EUTF harmless for any HIPAA Violations made by the PBM or its Network Pharmacies.

Yes/No.

7.7.5 The PBM will agree to be claims fiduciary for clinical based determinations.

Yes/No.

7.7.6 The PBM agrees that these Agreements or any of the functions to be performed hereunder shall not be assigned by either party to another party, absent advance notice to the other party, and written consent to said assignment, which consent shall not be unreasonably withheld. In the event either party shall not agree to an assignment by the other party, then this agreement shall terminate upon the effective date of said assignment.

Yes/No.

7.7.7 The PBM must agree that in the event of a dispute between the parties, about the payment or entitlement to receive payment, or any administrative fees hereunder, the PBM and the EUTF shall endeavor to meet and negotiate a reasonable outcome of said dispute. In NO event shall the PBM undertake unilateral offset against any monies due and owed the EUTF, whether from manufacturer rebates, credit adjustment or otherwise.

Yes/No.

7.7.8 The PBM agrees to provide the PBM's alternative mediation or appeal options for conflict resolution to help the EUTF resolve disputes. This appeal option should provide a simple, efficient and fair method of providing resolutions to member and plan sponsor issues.

Yes/No.

7.7.9 What general and professional errors and omissions liability coverage does the PBM currently have in place? Include name of insurer, per occurrence \$ limits and total policy coverage limits.

7.7.10 Confirm the EUTF will have the option of choosing legal counsel to defend claims litigation based on decisions made by the PBM to deny coverage for clinical reasons, and that the PBM will be fully involved in said defense, the cost of which shall be borne by the PBM to the extent the PBM is found to have been negligent or at fault in the denial decision.

Yes/No.

7.7.11 Confirm the PBM will respond to and timely incorporate future Health Care Reform changes in full compliance with the law and at no additional cost to the EUTF.

Yes/No.

7.7.12 The PBM agrees to handle claims/appeals processing in accordance with the minimum requirements of the PPACA.

Yes/No.

7.7.13 The PBM agrees to be responsible for selecting and contracting the external review organizations sufficient to allow the EUTF to comply with the PPACA.

Yes/No.

7.7.14 Confirm any disputes between the PBM and the EUTF shall be governed by laws of the State of Hawaii and the exclusive jurisdiction for any judicial suit, action or proceeding relating to the agreements shall be the courts in the State of Hawaii.

Yes/No.

7.8 General

7.8.1 Complete the following tables as per the Proposal Instructions:

Organization Name:	
Date Founded	
Contact Person's Name	
Title	
Address	
City/State	
Phone Number	
E-mail Address	
Fax Number	

7.8.2 Not used.

7.8.3 Not used

7.9 Organizational Stability & Experience

7.9.1 Provide the latest annual report, financial statement, SAS 70 type II, and other financial reports that indicate the financial position of your organization. Including:

- a. Current ratio
- b. Days cash on hand
- c. Debt to equity ratio

7.9.2 Complete the following table:

	Response
a. Parent Company	
b. Year PBM Established	
c. Membership count (total covered lives)	
Current (2019)	
1 year prior (2018)	
2 years prior (2017)	
% of total potential lives from the EUTF (current)	
% from MCO/HMO plans (current)	
d. Number of Group Plans In Force (current)	
Total	
Under 10,000 lives	
Over 100,000 lives	
Number of Health Plans	
e. AWP dollars processed (calendar year 2016)	
Retail	
Mail Order	
f. Number of Group Plans Added:	
Past 12 months	
Past 24 months	
g. Number of Group Plans Terminated:	
Past 12 months	
Past 24 months	

7.9.3 Have you acquired or sold any organizations in the last 24 months? If so, explain.

7.9.4 Have you relocated staff, changed computer or telephone systems in the last 12 months? Do you anticipate any major changes to your organization or structure in the next 12-24 months? If so, elaborate.

7.9.5 Indicate the number of any outstanding legal actions pending against your organization and/or owners. Explain the nature and status of the action(s). Can you assure the EUTF these actions will not disrupt business operations? 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? Explain the nature and status of the action(s).

7.9.6 Provide a disclosure of all potential conflicts of interest (e.g. brand manufacturer payments, programs that shift prescriptions to drugs that are more expensive, etc.)

7.10 Not used

7.11 Drug Utilization Review

7.11.1 It is expected that all network pharmacies will have real-time online edits. If this is not the case indicate the deviation. For the following section, please indicate in your response if there are discrepancies between the retail pharmacy network and mail order capabilities.

DRUG UTILIZATION REVIEW	Real Time Edit Criterion	% of Network Pharmacies that Satisfy Criterion	% of Network Pharmacies with real time, Online edits	Percent of Total Rx's Denied (Last Calendar Year)
Eligible Member/Dependent				
Eligible Drug				
Contract Price of Drug				
Drug Interactions				
Coordination of Benefits (COB)				
Duplicate Prescription				

Refill too Soon				
Proper Dosage				
Proper Days' Supply				
Generic Availability				
Patient Copayments				
Other (List)				

7.11.2 What edits occur prospectively at point of sale (POS)? Concurrently? Retroactively?

7.11.3 What Drug Utilization Review features, capabilities, and/or processes differentiate your organization from your competitors?

7.11.4 Provide most recent quarterly book of business savings for the following programs:

	Percent
Concurrent DUR _____% of Total Ingredient Costs	
Retrospective DUR _____% of Total Ingredient Costs	
Prior Authorization _____% of Total Ingredient Costs	

7.11.5 Are reported savings based on an EUTF specific claim-by-claim analysis? If no, describe the savings calculation process in detail for each of the claim edit services you offer.

7.11.6 Not used

7.11.7 Provide a sample of DUR reports you produce and monitor. Are these reports made available to the EUTF at no additional cost?

7.11.8 What criteria and methodologies are used to identify and monitor high cost claimants? What programs does your company have to reduce any costs of these claims, and include a detailed explanation of the programs and any additional costs that may be associated with these programs. How will the contractor coordinate with the EUTF's medical benefits provider?

7.11.9 Describe your pre-authorization protocols available to the EUTF. Include information on step therapies and other clinical management programs along with any additional costs for such services and credentials of the staff performing pre-authorization. What drugs or class of drugs do you recommend be pre-authorized?

7.11.10 How will you communicate innovative programs such as genetic testing or therapy-specific management centers to the EUTF?

7.11.11 Explain any financial incentives established for providers to comply with utilization management protocols or treatment benchmarks. (Include withholds, bonuses, or other arrangements.)

7.11.12 How do you guard against the filling of separate prescriptions for the same or similar drugs at different pharmacies on the same day or within 48 hours?

7.11.13 Do you evaluate the appropriateness of the prescribing physician/practitioner credentials?

7.11.14 What clinical programs do you offer that incentivize adherence? Do you have the system capabilities to offer lower cost shares for more adherent members? (e.g., if prescription is consistently filled when 75% to 100% of the prescription has been depleted, the copay is cut in half or a lower co-insurance is applied.)

7.11.15 Do you have the system capabilities for a “starter dose” program where the first few weeks of therapy do not incur a member cost share?

7.11.16 Identify which of the following edits are performed at the point-of-sale:

	Performed at the Point of Sale (Yes or No)
Ineligible participant	
COB	
Benefit maximums for certain drug types	
Drug is inappropriate for the patient due to age	
Drug is inappropriate for the patient due to gender	
Quantity versus Time	
Allergy	
Incorrect AWP or formula price	
UCR input	
Duplicate Rx	
Refill too soon	
Incorrect dosage	

	Performed at the Point of Sale (Yes or No)
Rx splitting	
Drug interactions	
Over utilization	
Under utilization	
Aggregate Benefit Maximums	
Possible Narcotic Abuse	
Other POS Edits (provide list)	

7.12 Administrative, Member & Claim Paying Services

7.12.1 Will you agree to monthly face-to-face meetings with the EUTF, if requested, to discuss plan performance, present financial results, etc.? What information would be shared at these meetings?

7.12.2 Will dedicated customer service representatives be assigned to this account? If so how many at the call center and at the walk-in customer service center?

7.12.3 Do customer service reps have online access to real time claim processing information?

7.12.4 For the customer service call center proposed for the EUTF provide the following for 2016:

	Response
Percent of calls abandoned	
Percent of calls handled by live representative within 20 seconds	
Average number of seconds to reach a live customer service representative	
Inquiries made to service office	

7.12.5 Do you offer the EUTF online access to information and services via the Internet? Explain which types of information and services.

7.12.6 Can your organization send recovery letters to members who continue to use their drug card after their termination? If yes, at what cost? What do you do to respond to members who do not respond?

7.12.7 Will you survey the EUTF members annually regarding program administration satisfaction? If yes, provide an example.

7.12.8 Will one toll-free number provide coverage for the retail, mail order, and specialty program?

7.12.9 What type of automated services are available 24/7 to EUTF staff, and to EUTF members? If automated services are available, describe the type of services that are available to members and to EUTF staff.

7.12.10 How do you service members travelling internationally? What if international stay is for an extended period (visiting semester, etc.)? Does your answer differ between Active and Non-Medicare eligible participants from Medicare eligible participants?

7.12.11 Can you provide early refills for traveling members?

7.12.12 Describe service available to the Deaf, Hard of Hearing, and Blind.

7.12.13 How do you track member complaints?

7.12.14 List the top five member complaints related to each of the retail, mail order, and the specialty pharmacy program.

7.12.15 Do you currently perform membership satisfaction surveys? What percent of members indicated that they were “satisfied or very satisfied” with the overall program? What percent of members indicated that they were dissatisfied or very dissatisfied with the overall program?

7.12.16 Do you provide member support services for selecting and/or locating network pharmacies and formulary look-ups?

7.12.17 How are members notified of the following events? (Indicate for each below: Phone, Written Document, or Other (specify). Are these services included in the administrative fee?

	Response	Comments
Plan Change		
New Drug Additions/Formulary Changes		
Change in Pharmacy Network Panel		
Ineligible, Banned, or Recalled Drug		
Generic Substitution		
Change in medical/clinical management rules		

7.12.18 How do you remind members regarding refills and adherence? Indicate methods and frequency of interventions.

- a. At mail
- b. At retail

7.12.19 How often are network pharmacy directories updated. Do you distribute these to members on a regular basis or make them available on-line?

7.12.20 What services are available to members via the Internet? Do you have a website for members? Provide details regarding capabilities (e.g., clinical resources, drug cost estimators, etc.).

7.12.21 Does your member website include network pharmacies' usual and customary (U&C) and/or contracted discounted pricing information? If so, please indicate if the pricing is real-time or how often it is updated?

7.12.22 Describe security systems and protocols in place to protect confidential patient records in storage and in transit. Is the site VIPPS certified and licensed in every state?

7.12.23 Do you have programs specifically designed for members, which will increase formulary compliance? Are these programs included in the administrative fee? Explain and include any sample member materials.

7.12.24 Can your organization produce "EOB" type statements for the members? (Should include YTD payments, deductible balances, total paid by plan costs, total paid by enrollee, etc.)

7.12.25 Describe what reporting you will provide to the EUTF regarding formulary use and member satisfaction.

7.12.26 How many sub-group levels can be captured in your claims and billing systems?

7.12.27 Do you administer medical necessity appeals? Please describe the process in detail you are proposing for EUTF. Would the appeal process be included in the proposed administrative fee?

7.12.28 How are out-of-network claims processed?

7.12.29 Does your system have the ability to identify claims for which a manufacturer copay coupon was used? If so, can your system restrict these coupons from being used?

7.12.30 Describe any reports either clinical or financial in nature that would be provided to the EUTF in order to help manage benefit costs.

7.12.31 Confirm that you agree to EUTF payment procedures as described in Section IV, *Payment to Contractor*. Please confirm that the Contractor agrees that the EUTF has twenty (20) days after receipt of invoice to pay the Contractor. What methods of payment are available (e.g., ACH, Direct Deposit, SurePay, Checks)? What exceptions are there to the standard payment terms?

7.12.32 Please confirm and describe your organization's ability to implement and report outcomes for its core clinical programs and non-core (buy-up) programs. Please confirm and describe this reporting availability for the client's account hierarchy structure.

7.12.33 Please confirm that the EUTF will have the ability to access your internal and external national benchmark data (e.g. IMS) and support inquiries from the EUTF regarding benchmark information (e.g. quarterly IMS market shares for select drug classes, IMS generic dispensing rates, etc.).

7.12.34 Please confirm your organization can provide comprehensive plan sponsor benefit description set-up documents upon request or on an ongoing basis to the EUTF. Please provide the guaranteed turn-around time for providing such requested documents. (Evidence of coverage)

7.12.35 Please provide the normal scheduled maintenance hours for the PBM's claims system.

7.13 Reporting Capabilities

7.13.1 Please indicate for each report noted below whether you can provide such a report. If you can provide the requested report, please indicate the price or if the cost is included in the basic administration fee. Please indicate for each report noted below if a report can be separated by bargaining units (BU) as reported to you by the EUTF.

Report Type	Yes/No	Cost	Frequency	Available by Sub-Group	Available in total	Separated by Bargaining Unit
Eligibility Report which shows accuracy of updates and changes						
Paid Claims Summary (Ingredient cost, day supply, dispensing fees, taxes, copay totals by month)						
Detail Claim Listing (Utilization and ingredient cost by individual claimant, listing the drug name and dosage, quantity, day supply, submitted charge, allowable charge, paid)						
Cost Sharing Report (Amounts determined to be ineligible, amounts applied to copays and coinsurance, and amounts adjusted for COB)						
Detailed Utilization Report (# of prescriptions submitted by single source brand, multi-source brand and generic drugs, including average AWP, Ingredient cost per Rx, Dispensing fee, and average days supply)						
Top Drug Report (detail of cost and utilization by top drug products)						
High Amount Claimant report						
Therapeutic Interchange Report detailing success rates and cost impacts of PBM initiated interchanges % if % or drug utilization review						

Report Type	Yes/No	Cost	Frequency	Available by Sub-Group	Available in total	Separated by Bargaining Unit
Drug Utilization Review activity and Savings Report by type of edit)						
Formulary Savings and Rebate report						
Paid Claims Summary showing total number of claims, eligible charges and claim payments for each category						
Prior Authorization and other clinical program reporting						
Pharmacy cost and utilization reporting (includes number of patients, scripts, dollar volume)						
Transcripts of customer service call recordings and detailed call notes upon request (please indicate how soon the report will be available after the call has occurred)						
Other Reports						

7.14 Prescription Reimbursement Issues

7.14.1 What is your proposed source for AWP data?

- 1: first data
- 2: Medi-Span,
- 3: Redbook,
- 4: Other

7.14.2 How often are AWP prices updated in your adjudication system?

- 1: Monthly,
- 2: Quarterly,
- 3: Semi-annually,
- 4: Annually,
- 5: Other

7.14.3 What percent of your network pharmacy contracts include the “lesser of retail price, MAC price, or discounted price” provision?

- 1: 0 – 20%,
- 2: 21 - 40%,
- 3: 41 - 60%,
- 4: 61 – 80%,
- 5: 81 – 100%

7.14.4 How do you guarantee that members always receive this lowest price? What procedures are established to ensure that the pharmacy is in compliance with this provision?

7.14.5 Not used.

7.14.6 Explain in detail how network pharmacies’ U&C prices are captured and reported.

7.14.7 Describe the retail network pharmacy reimbursement process in detail.

7.14.8 Are there financial incentives to network pharmacies, physicians and other providers that are tied to utilization rates, compliance goals, quality of care outcomes, or other performance results? If so, explain and include any incentive-based dispensing fees, bonuses, withholds, retroactive capitations, etc.

7.14.9 Do you maintain multiple contracts with individual pharmacies at varying reimbursement rates? If yes, explain.

7.14.10 Describe any financial or other incentives you are willing to offer the EUTF based on increased Internet utilization for mail order claim submission in recognition of the inherent cost savings.

7.14.11 Do your MAC price lists vary contractually between network pharmacies? If yes, why?

7.14.12 Will the retailers provide the lower of the discounted plan cost plus dispensing fee, member cost, U&C, or retail price for plan adjudication?

7.14.13 Explain in detail the process you propose regarding the EUTF verification of drug manufacturer revenue transparency.

7.14.14 Define your electronic process for determining a product's brand or generic status for both retail and mail order claims using First DataBank and/or Medi-Span definitions.

7.14.15 How often are your retail network provider contracts renegotiated?

- 1: Annually,
- 2: Every two years,
- 3: Every 3 to 5 years,
- 4: Other

7.14.16 Is it possible for a retail pharmacy to submit NDC numbers for adjudication that contain AWP prices designed to maximize their discounted ingredient costs?

7.14.17 How do you ensure that submitted NDCs at retail are indicative of pharmacy drug purchasing patterns?

7.14.18 Does your organization share in any financial remuneration that retail pharmacies receive from drug manufacturers or other sources?

7.14.19 Specify if you are able to readily provide a detailed listing of all of the various ingredients that are included in multi-ingredient compound claims and confirm multi-ingredient compounds can take a specified cost-share.

7.14.20 Do you have the capabilities to capture and support cost share tiers based on diagnosis codes (ICDs) as well as associated claims reporting.

7.14.21 Complete the following table indicating the amount that would be collected from the participant for each prescription claim scenario (copays are illustrative).

Rx Cost	Scenario 1 (Retail)	Scenario 2 (Retail)	Scenario 3 (Mail Order)	Scenario 4 (Mail Order)
Ing. Cost plus Disp. Fee plus Sales Tax	\$9.00	\$9.00	\$22.00	\$22.00
Copay/Coinsurance	\$10.00	\$5.00	\$35.00	\$5.00
U&C	\$25.00	\$25.00	\$55.00	\$55.00
Amount Collected from Participant				
Amount Charged to the EUTF				

7.14.22 Confirm you will be able to provide integration assistance to EUTF to help track PPACA required copayments for member out-of-pocket maximums and it is included in your proposed administrative fee? If so, is there an additional charge associated with this?

7.15 Network Management & Quality Assessment

7.15.1 Complete the following table. Check off those elements that are included in your pharmacy selection process and provide the percentage of pharmacies that satisfy the following selection criteria elements.

	Standard Selection Criterion	Percent of Pharmacies that Satisfy Criteria	Comments
a. Require unrestricted licensure			
b. Review malpractice coverage and history			
c. Require full disclosure of current litigation and other disciplinary activity			
d. Require signed application/agreement			
e. Require current DEA registration			
f. On-site review of pharmacy location and appearance			
g. Review hours of operation and capacity of network pharmacies to handle the added volume the EUTF would generate			
h. On-site electronic access to patient data			

7.15.2 Describe the general credentialing and re-credentialing process and minimum criteria for selecting a network pharmacy. Include the minimum required malpractice coverage per individual practitioner, or group. If the process differs by type of pharmacy (i.e., independent vs. chains), indicate and describe separately. Provide the number of years that a pharmacy contract is in effect.

7.15.3 Describe any incentives or programs in place with providers designed to increase generic dispensing and formulary compliance. Explain in detail.

7.15.4 Describe the process in place to ensure that the EUTF is credited for prescriptions filled but not obtained (Return to Stock situations).

7.15.5 What procedures are established to ensure that network pharmacies are in compliance with negotiated MAC provisions and prices?

7.15.6 Not used.

7.15.7 Provide the total number of pharmacies included in your proposed pharmacy network.

7.15.8 Summarize the quality assurance programs your organization presently has in place and list the most important actions these programs have taken in the past year to improve performance.

7.15.9 Do you monitor individual physician prescribing patterns? If so, what action is taken with prescribers who have a high degree of non-compliance or outlier prescribing? Will you agree to exchange this data with the medical carriers at no cost to the EUTF.

7.15.10 If you provide mail order benefits through a third party, explain any audit procedures in place to ensure proper dispensing and pricing practice adherence.

7.15.11 What safeguards exist for preventing breaches in patient confidentiality with regard to pharmacy/medical claims information?

7.15.12 Will you guarantee that the EUTF will be charged the generic price and the enrollee is charged the generic copay if a generic is out of stock?

7.15.13 How do you capture pharmacy errors? List the top 5 reasons for errors (e.g., wrong dosage).

7.15.14 Will your company agree to sign the BAA attached as Exhibit F to this RFP?

7.15.15 Are the retail and mail order network contracts solely owned and operated by your organization?

7.15.16 Does your organization own any network pharmacies, including mail and/or specialty?

7.15.17 Will the EUTF receive an 180 day notice, when possible, of any event or negotiation that may cause a disruption in the retail pharmacy network access?

7.15.18 Please provide network disruption analysis and indicate number of pharmacies and prescriptions disrupted.

7.15.19 Complete the following table, listing the total number of network dispensing facility locations by Island. Only include network dispensing facilities.

Island List Number by Island	Oahu	Maui	Hawaii	Kauai	Lanai	Molokai
Network Dispensing Facilities						

7.15.20 Do you currently have a mail order fulfillment center located in the State? If you do not have a fulfillment center located in the State, do you agree to establish such a facility, to be fully operational by January 1, 2018?

7.16 Formulary Management & Rebates

7.16.1 Do you receive formulary rebates from manufacturers of generic drugs? If yes, confirm that these will be paid to the EUTF?

7.16.2 If you require a formulary management fee, indicate amount or percentage proposed. Other than these fees, do you guarantee that 100% of all rebates collected be passed through to the EUTF?

7.16.3 Describe how your preferred drug list is established. Include how specific drugs are selected and how often your P&T Committee meets.

7.16.4 Are any P&T Committee enrollees employed by or under contract with any drug manufacturers? Are any P&T enrollees directly employed by your organization?

7.16.5 Can you support custom changes to the preferred drug list at the request of the EUTF?

7.16.6 How many different standard preferred drug lists do you presently support? What is the average size of groups with custom preferred drug lists? What is the total enrollment count with custom preferred drug lists?

7.16.7 How many custom preferred drug lists do you presently support?

7.16.8 Will you guarantee that any preferred drug lists switches which are not economically advantageous to the EUTF on an ingredient cost basis will be reported and reimbursed to the EUTF on a dollar-for-dollar basis using the least expensive, therapeutically equivalent alternative drug as the basis for reimbursement?

7.16.9 Can the EUTF be given the ability to authorize non-formulary overrides directly?

7.16.10 What percent of all available brand drugs are excluded from your formulary and/or preferred drug listing (based on total number of Rx dispensed for plans with an open formulary)?

7.16.11 Are any generic drugs considered “non-preferred” on your proposed formulary (i.e., subject to the “non-preferred” copay)? If yes, please describe in detail and provide examples.

7.16.12 Please provide the percentage of non-formulary brand drugs that have a generic equivalent.

7.16.13 What percent of all available brand drugs are non-preferred (not on your preferred drug list)?

7.16.14 Do you have a Formulary Grievance Process in place to address member concerns regarding preferred drug list alternatives? If yes, explain this process in detail.

7.16.15 Do you have the capabilities to have a specified cost-share for Multi-Source Brand drugs regardless of formulary status? (e.g., 75% co-insurance for all multi-source brands). Specify if there are system limitations where formulary coding supersedes any specific cost share coding specified for multi-source brands.

7.16.16 Do you have the capabilities to support a turn-key value-based benefit design or evidence-based benefit design? Specify the therapeutic classes that would be targeted.

7.16.17 How do you adjudicate vaccine claims with or without the associated administration charges from the pharmacy? Specify if there are any limitations (e.g., specific vaccines, need for supplemental pharmacy network, etc.).

7.16.18 For the EUTF’s top 100 retail brand prescriptions by cost during January 1, 2018 through July 31, 2019, please indicate whether each brand drug will be considered “preferred” or “non-preferred.”

Please make sure that you answer "Yes" for only those situations where the exact drug listed is considered “preferred.” For example, if Flonase is listed and is not considered “preferred” on your proposed formulary, then you should answer "No", even though the generic equivalent may be considered “preferred”. You should only answer "Yes" if the brand Flonase is considered “preferred”.

7.16.19 For the EUTF’s top 100 mail brand prescriptions by cost during January 1, 2018 through July 31, 2019, please indicate whether each brand drug will be considered “preferred” or “non-preferred.”

Please make sure that you answer "Yes" for only those situations where the exact drug listed is considered “preferred.” For example, if Flonase is listed and is not considered “preferred” on your proposed formulary, then you should answer "No", even though the generic equivalent may be considered “preferred”. You should only answer "Yes" if the brand Flonase is considered “preferred”.

7.16.20 Based on the EUTF's detailed claim-by-claim prescription drug data during January 1, 2018 through July 31, 2019, please indicate what percent of retail and mail generic and brand prescriptions are currently considered “preferred” on your proposed formulary:

	Retail	Mail
Preferred Generics as a Percent of all Generics:		
Preferred Brands as a Percent of all Brands:		

7.17 Mail Order Program

7.17.1 Not used.

7.17.2 Does your organization own the mail service facility? If this is a subcontractor, please indicate the subcontractor name.

7.17.3 Describe the process for ordering prescriptions by mail and include a sample envelope.

7.17.4 Describe your process for ordering refills by mail, phone, fax, and the Internet. What percentages of refills are currently received by mail, phone, fax, and Internet?

	Response
Mail	
Phone	
Fax	
Internet	

7.17.5 How far in advance may participants order a refill on a 90-day supply prescription?

- 1: 90 days in advance
- 2: 60-89 days in advance
- 3: 30-59 days in advance
- 4: less than 30 days in advance
- 5: Other

7.17.6 Describe your process of filling/ordering prescriptions, refills, and split-prescriptions. Do you have an automatic refill process with a standard refill-too-soon threshold? Are you able to send email reminders for refills? Include an explanation of how you fulfill prescriptions for drugs that need refrigeration particularly with respect to residents that may be in rural communities in the State.

7.17.7 Will you agree that all mail order discount guarantees will be based on lowest listed NDC level AWP cost? If not, state your suggested pricing basis.

7.17.8 Will mail order pricing apply to all Rx's dispensed through mail order facilities?

7.17.9 How many calendar days advanced notice must a member provide in order to guarantee that their supply is received before the existing supply is depleted?

- 1: Less than 7 days
- 2: 7-9 days
- 3: 10-14 days
- 4: Greater than 14 days

7.17.10 What is the average time in calendar days between receipt of claim and delivery to patient (include delivery time)? When a Hawaii facility is used? When a non-Hawaii facility is used?

7.17.11 Can you provide a system edit to facilitate physician outreach in order to avoid partial fills? Explain.

7.17.12 Will the EUTF not be charged for uncollected mail order cost share amounts?

7.17.13 Does your organization, or your associated facilities, repackage drug products for use in filling mail order prescriptions? If yes, does the AWP for repackaged drugs match the AWP of the same package size of the source labeler? If not, describe how you establish the AWP for your repackaged NDCs.

7.17.14 Describe your policy on too-early refills and emergency supplies. Outline your process for prescriptions which are ordered prior to the first available refill date.

7.17.15 Using the table below, provide the mail order performance statistics, over the past three years, for the facility being proposed:

	2016	2017	2018
a. Mail Facility Name			
b. Total number of prescriptions dispensed			
c. Utilization as a percent (%) of capacity			
d. Average turn-around time (no intervention required)			
e. Average turn-around time (intervention required)			
f. Average Generic Dispensing Rate for all clients utilizing facility			
g. Average Generic Substitution Rate for all clients utilizing facility			

7.17.16 Explain the process for providing members with a short-term retail prescription supply in the case of delayed delivery of their mail order prescription.

7.17.17 How are members notified when a mail order prescription is delayed due to the following circumstances?

	Response
A prescription requiring clarification from the physician or physician’s agent (e.g., missing quantity, illegible drug name).	
A clean prescription where the delay is due to operational, capacity, or drug supply issues.	
A clean prescription where the delay is a result of a therapeutic switch intervention.	
Weather or natural disaster	

Other	
-------	--

7.17.18 Describe your quality controls to ensure accurate dispensing of prescriptions. How many levels of review take place and who conducts the reviews?

7.17.19 Describe online integration, if any, with retail pharmacies to ensure non-duplication and to identify potential adverse interaction.

7.17.20 What are your contingency plans and procedures for providing backup service in the event of strike, natural disaster, or backlog?

7.17.21 How often do you switch generic manufacturers for particular products? How are participants notified of the switch?

7.17.22 How often are therapeutic interchanges performed at mail order, if at all? If so, please explain applicable drug products and rationale.

7.17.23 Are on-site audits performed at your mail service pharmacies? Describe the frequency and types of audits performed and by whom.

7.17.24 Describe the process for notifying members of prescriptions not on the formulary.

7.17.25 Describe the process for notifying members of the expiration date of their prescription.

7.17.26 Describe the process for notifying members of their next refill date and the number of refills remaining.

7.17.27 Describe your system of providing patient-advisory information with prescriptions filled.

7.17.28 What percentage of prescriptions receives a patient-information supplement?

- 1: 0 to 20%,
- 2: 21 to 40%,
- 3: 41 to 60%,
- 4: 61 to 80%,
- 5: 81 to 100%

7.17.29 When do you bill the patient?

- 1: Before the prescription is filled,
- 2: After the prescription is filled

7.17.30 How do you provide notification of a product recall (such as Vioxx) to the EUTF and members?

7.17.31 How do you handle the following situations?

	Response
a. No co-pay included in envelope	
b. Bounced check from patient	
c. Terminated/not authorized credit card	

7.17.32 Please indicate your mail order pharmacies' usage, if any, of DAW 5 for processing claims. Which drug products are assigned DAW 5 codes? Please describe your DAW 5 processing protocol and rationale.

7.17.33 Please describe any additional service or value benefits provided by your mail order service pharmacies.

7.17.34 Please indicate what payment method options exist for members at your mail order facility. (Please specify: Visa, MasterCard, Check, American Express, Debit Cards, Cash, etc.)

7.17.35 Will you agree to hold EUTF harmless for any claims resulting from dispensing errors from mail order fulfillment?

7.17.36 Will you agree to the Point of Sale coordination with other pharmacy benefit plans such that members' out of pocket cost is the net result of the coordination of benefit plans?

7.17.37 Please describe how contactor will mail refrigerated medications.

7.18 Specialty Pharmacy Program

7.18.1 Explain any programs offered by your organization designed to encourage appropriate utilization of specialty drug products.

7.18.2 Not used.

7.18.3 Detail any disease and therapy management programs you offer (include steps and costs). Indicate whether these are included in your base administrative fee.

7.18.4 Identify how many members you currently manage as well as the total number of Rx's dispensed for the same disease states noted in 3 above.

7.18.5 Explain the formulary decision and drug selection process as it pertains to specialty drugs.

7.18.6 Please confirm your organization can support a specialty cost share tier for select plan designs.

7.18.7 Will a member incur any additional costs for the delivery of specialty drugs? If so, outline all billing/payment methods and all associated costs.

7.18.8 Confirm that members will continue to be able to receive specialty Rx's dispensed at retail pharmacies.

7.18.9 Please describe your organization's ability to limit specialty medication utilization to 30 days' supply per month.

7.18.10 What differentiates your company and capabilities from other specialty drug vendors in a very competitive industry?

7.18.11 Explain your side-effect counseling process. To which drugs and conditions does this process apply?

7.18.12 Does your organization currently engage in outcomes reporting? Explain.

7.18.13 Do you currently have a specialty/biotech drug P&T Committee? If yes, explain the role, function, and structure and how it differs from your traditional P&T Committee.

7.18.14 Do you agree to include a contract provision enabling the EUTF to "carve-out" specialty drug services annually without impact to non-specialty contractual provisions, terms, and pricing?

7.18.15 EUTF's **medical** plan currently pays for specialty drugs administered in a hospital setting, including outpatient hospital clinics, and EUTF's **prescription drug** plan pays for specialty drugs administered in a home setting or physician's office. Confirm that you are able to accommodate this arrangement. Please consider in your answer full compliance with Act 226, SLH 2013 and the prohibition of exclusive specialty drug dispensing.

7.18.16 Provide the customer and enrollee service operation hours of your specialty pharmacy program.

7.18.17 Please describe any additional service or value benefits provided by your specialty drug pharmacies (e.g. sharps disposal units at no cost upon request for injectable drug users, research of financial assistance options that may be available for members who request it, etc.)

7.18.18 Please indicate what payment method options exist for members at your specialty facility. (Please specify: Visa, MasterCard, Check, American Express, Debit Cards, Cash, etc.)

7.19 Medicare Part D - Employer Group Waiver Plan (EGWP)

The objective of the EGWP portion of this RFP is to solicit competitive proposals from qualified bidders that will offer high quality, cost effective prescription drug benefits programs for EGWP with Wrap to the EUTF's Medicare-eligible members. The EUTF requires matching the existing plan design and incurring minimal disruption to the current drug formulary and pharmacy network.

7.19.1 Do you maintain a Center for Medicare and Medicaid Services (CMS) approved prescription drug Medicare Part D plan in the form of an Employer Group Waiver Plan (EGWP)? Bidders must describe all of the following:

7.19.2 Verify that you are able to duplicate the current retiree plan design. Please describe any exceptions.

7.19.3 Describe your capabilities to provide a secondary commercial wrap benefit to the EGWP in order to maximize the pharmaceutical manufacturers coverage gap discount program (CGDP).

7.19.4 Verify that your P&T Committee meets CMS' requirements for objectivity and validity.

7.19.5 Please provide an NDC-level, copy of your Medicare Part D formulary in a Microsoft Excel format that includes formulary indicators.

7.19.6 Confirm that you will provide all CMS required filings related to formulary, medication therapy management (MTM), and other clinical programs on a timely basis.

7.19.7 How many group EGWP contracts do you presently insure or administer? Please provide the number of lives covered for each of the top 10 largest clients.

7.19.8 Confirm that you will provide all CMS required filings related to certification of compliance to all waste, fraud, and abuse requirements.

7.19.9 Confirm you provide a pharmacy network per CMS requirements by providing a GeoAccess report.

7.19.10 Confirm you will coordinate benefits with Medicare at point-of-sale to ensure members receive benefits seamlessly. Confirm you will also coordinate benefits non-EUTF plans for active employees and non-Medicare retirees at point-of-sale to ensure members receive benefits seamlessly.

7.19.11 Confirm you will apply the required brand and generic Pharma discount for Part D applicable drugs at point-of-sale.

7.19.12 Confirm that you will provide all CMS-required member communications and that this is included in your base administrative fee.

7.19.13 Confirm that the EUTF will have the ability to customize member communications at no additional charge when permitted by CMS, unless restricted by federal law.

7.19.14 Not used.

7.19.15 Describe the transition process you will utilize for members who are currently using non-formulary prescription drugs, drugs requiring prior authorization, step therapy, and quantity level limits.

7.19.16 Describe the enrollment/disenrollment process and include detail regarding the timing of when enrollment/disenrollment changes go into effect. The EUTF rules for termination are contained in the EUTF Administrative Rules, Exhibit C, of the plan. The EUTF allows for the retroactive termination of enrollment even though CMS only permits prospective termination.

Note: EUTF does not normally cancel/terminate Medicare retirees prospectively. How do you handle the CMS required “opt hold” period such that there is the least amount of benefit disruption to the member if the EUTF notifies you retroactively within 30days of Medicare enrollment?

7.19.17 Confirm that you will provide separate reporting and billing for the EGWP group.

7.19.18 Confirm that you will mirror the current retiree plan design as closely as possible consistent with CMS regulation. Please provide a description of any deviations from the current plan design.

7.19.19 Not used.

7.19.20 Describe how you will handle the following scenario so that the retiree has no disruption in coverage: On 1/7/21, EUTF notifies you, via an 834 file, that a non-Medicare retiree became Medicare Part B eligible on 1/1/21 (retiree will need to be moved from the non-Medicare commercial plan to the EGWP plan).

7.19.21 Describe how you will handle the following: The EGWP 834 file shows that on 1/1/21 a new Medicare retiree enrolls in plans with a non-Medicare spouse. Does your system have the capability to cover the Medicare retiree in the EGWP plan and the non-Medicare spouse in the commercial plan (even though the non-Medicare spouse does not show up on the Commercial 834 file)? Note: The EUTF benefits administration system always reports the dependent with the retiree.

7.19.22 Confirm you will process low-income premium subsidy refunds to members and the EUTF as well as low-income cost sharing refund requests to the members.

7.19.23 Are there any charges for CMS required services that are not included in the EGWP base administrative fee? Please list each service and associated charge separately.

7.19.24 Please provide the current CMS Star Rating for your EGWP plan.

7.19.25 Please provide the CMS Star Ratings for your EGWP plan for each of the past 3 years.

7.19.26 Describe any corrective action you have incorporated in the past 3 years to improve CMS Star Ratings.

7.19.27 Please complete the table below.

EMPLOYER GROUP WAIVER PLAN	VENDOR RESPONSE
1. Do you agree to provide the following services under the EGWP Plan? Are the services included in your base administrative fee?	
➤ Collect and validate Medicare HICN	
➤ Research and resolve enrollment errors	

EMPLOYER GROUP WAIVER PLAN	VENDOR RESPONSE
➤ Medication Therapy Management (MTM) Program	
➤ Monitor and track all changes made by CMS	
➤ Enrollment modifications resulting in Low-Income assistance as granted or removed by CMS	
➤ Benefit Consultation and Actuarial Equivalence validation	
➤ Fraud, Waste and Abuse Program	
➤ Grievance, Appeals, and coverage determination – investigate and resolve complaints from the CMS Complaint Tracking Module	
➤ Full enrollment reports (accepted, rejected, or CMS changes)	
➤ Evidence of Coverage (EOC)/ID Card/Abridged Formulary/Pharmacy Directory	
➤ Annual Notices of Changes/EOC	
➤ Low-Income Subsidy (LIS) Rider	
➤ LIS premium refunds directly to low-income retirees	
➤ Transition Letters	
➤ Explanation of Benefits (Monthly)	
➤ Receive and reconcile CMS Direct Subsidy (paid – 45 days after receipt), LIS, LICS, (Paid at time of reconciliation) and Catastrophic Payments (paid at time of reconciliation)	
➤ Reconcile LIS eligibility with CMS on a monthly basis	
➤ Manage TrOOP	
➤ Collect late enrollment penalties and remit to CMS.	

7.19.28 How will the EUTF members be notified of the following events? (phone, written document, other)

Event	
Plan change	
New Drug Additions/Formulary changes	
Change in Pharmacy Network	
Ineligible, Banned, or Recalled Drug	
Approaching True Out of Pocket Limit	
Generic substitution	

ATTACHMENTS AND EXHIBITS

- ATTACHMENT 1: OFFER FORM, OF-1
- ATTACHMENT 2: INTENT TO BID FORM
- ATTACHMENT 3: CONFIDENTIALITY AGREEMENT
- ATTACHMENT 4: CONFIDENTIAL INFORMATION
- ATTACHMENT 5: EXCEPTIONS
- ATTACHMENT 6: PERFORMANCE GUARANTEES
- EXHIBIT A: CLAIMS EXPERIENCE
- EXHIBIT B: PREMIUM RATES
- EXHIBIT C: EUTF ADMINISTRATIVE RULES
- EXHIBIT D: CONTRACT FORM AND GENERAL CONDITIONS
- EXHIBIT E: EVIDENCE OF COVERAGE DOCUMENTS
- EXHIBIT F: BUSINESS ASSOCIATE AGREEMENT
- EXHIBIT G: SAMPLE 834 FILES FOR EUTF ELIGIBILITY
TRANSACTIONS
- EXHIBIT H: ENROLLMENT COUNTS
- EXHIBIT I: CENSUS AND NETWORK DATA
- EXHIBIT J: ACT 226, SLH 2013
- EXHIBIT K: SPECIALTY DRUGS

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 NO. 20-003

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	Authorized (Original) Signature
_____	_____
Telephone No.	Name and Title (Please Type or Print)
_____	_____
Fax No.	**Exact Legal Name of Company (Offeror)

E-mail Address	

**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: _____

ATTACHMENT 2

INTENT TO BID FORM

RFP No. 20-003, Medical Benefits and Pharmacy Benefit Management Services

Email or fax this registration form by **January 14, 2020** to:

Mr. Derek M. Mizuno
 Hawaii Employer-Union Health Benefits Trust Fund
 Fax: (808) 586-2320
 Email: eutf.rfp@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
ACTIVES	
<input type="checkbox"/> EUTF 90/10 PPO - Fully Insured (FI) Medical, Rx, and Chiro	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF 90/10 PPO - Self-Insured (SI) Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF 90/10 PPO - Minimum Premium Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF 80/20 PPO - FI Medical, Rx, and Chiro	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF 80/20 PPO - SI Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF 80/20 PPO - Minimum Premium Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF 75/25 PPO - FI Medical, Rx, and Chiro	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF 75/25 PPO - SI Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF 75/25 PPO - Minimum Premium Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF 75/25 PPO (Part-Time) - FI Medical and Rx (no chiro)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF HMO - FI Medical, Rx, and Chiro	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF HMO - SI Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF HMO - Minimum Premium Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF Closed Panel Comprehensive HMO - FI Medical, Rx, and Chiro	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF Closed Panel Standard HMO - FI Medical, Rx, and Chiro	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF Closed Panel Standard HMO (Part-Time) - FI Medical and Rx (no chiro)	<input type="checkbox"/> Yes <input type="checkbox"/> No

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

<input type="checkbox"/> EUTF Supplemental Copay - FI Medical and Rx (no chiro)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB 90/10 PPO - FI Medical, Rx, and Chiro	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB 90/10 PPO - SI Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB 90/10 PPO - Minimum Premium Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB 80/20 PPO - FI Medical, Rx, and Chiro	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB 80/20 PPO - SI Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB 80/20 PPO - Minimum Premium Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB Closed Panel Comprehensive HMO - FI Medical, Rx, and Chiro	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF PPO - SI Rx only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF HMO - SI Rx only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB PPO - SI Rx only	<input type="checkbox"/> Yes <input type="checkbox"/> No
RETIREEES	
<input type="checkbox"/> EUTF 90/10 PPO - FI Medical and Rx (no chiro)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF 90/10 PPO - SI Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF 90/10 PPO - Minimum Premium Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF Comprehensive HMO - FI Medical and Rx (no chiro)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF Medicare Advantage PPO - FI Medical and Rx (no chiro)	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB 90/10 PPO - FI Medical, Rx, and Chiro	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB 90/10 PPO - SI Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB 90/10 PPO - Minimum Premium Medical only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB Comprehensive HMO - FI Medical, Rx, and Chiro	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF PPO - SI Rx only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> EUTF EGWP - SI Rx only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB PPO - SI Rx only	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> HSTA VB EGWP - SI Rx only	<input type="checkbox"/> Yes <input type="checkbox"/> No

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.**

CONFIDENTIALITY AGREEMENT

THIS CONFIDENTIALITY AND NON-DISCLOSURE AGREEMENT is between **The Segal Group, Inc.**, on behalf itself and its operating subsidiaries and affiliates, including Segal Consulting, (“Segal”) and _____

_____, on behalf of itself and all of its subsidiaries and affiliates, (“Bidder”) and is executed in connection with various bids, proposals or other replies (each a “Bid”) that Bidder intends to submit to Segal in response to various Request For Proposals/Requests for Information (each an “RFP”) issued by Segal on behalf of one or more of Segal’s clients (each a “Client”).

WHEREAS, in order to prepare its Bid, Bidder needs to receive certain plan information and data, which may include individually identifiable health information pertaining to a Client health plan participants and beneficiaries, (“Client Health Plan Information”) and certain Segal proprietary information consisting of the RFP questionnaire and specifications and any associated financial spreadsheets (the Client Health Plan Information, together with the other Segal proprietary information are collectively referred to as “Segal’s Proprietary Information”). For the avoidance of doubt, the term “individually identifiable health information” refers to any health information, including demographic information, that is not “de-identified,” as defined in 45 C.F.R. Section 164.514(b)(2);

WHEREAS, in order to evaluate Bidder’s Bid, Segal and Client may need to receive certain proprietary information from Bidder which may include, but not be limited to, provider-specific network allowances and reimbursement arrangements and other information designated by Bidder in writing as confidential and proprietary information of Bidder (“Bidder’s Proprietary Information”); and

WHEREAS, Segal’s Proprietary Information and Bidder’s Proprietary Information are collectively referred to as “Proprietary Information.”

NOW THEREFORE, in order to exchange Proprietary Information in connection with the RFP, the parties agree as follows:

1. Bidder will use Segal’s Proprietary Information only for the purpose of preparing its Bid and as otherwise permitted by paragraph 5 of this Agreement. Segal will use Bidder’s Proprietary Information only for the purpose of evaluating Bidder’s Bid and as otherwise permitted by paragraph 5 of this Agreement.
2. Bidder and Segal agree that only those individuals employed by them who have a need to know Proprietary Information to prepare or evaluate the Bid and have been made aware of the terms of this Agreement and agreed to abide by its terms will have access to Proprietary Information of the other party (“Bidder’s Representatives” and “Segal’s Representatives”).
3. Neither Bidder nor any Bidder Representatives will disclose Segal’s Proprietary Information to any person or entity outside of Bidder, unless such a disclosure is: (a) necessary to prepare the Bid and the recipient first executes a confidentiality agreement with provisions no less stringent than this one; or (b) required by law. Neither Segal nor any Segal Representatives will disclose Bidder’s Proprietary Information to any person or entity outside of Segal (other than Client), unless such a disclosure is: (a) necessary to evaluate the Bid and the recipient first executes a confidentiality agreement with provisions equivalent to this one; or (b) required by law.
4. Bidder and Segal agree to use commercially reasonable efforts to maintain the security of the Proprietary Information of the other party.

5. Each party will return the other party's Proprietary Information to the other party or destroy it upon completion of the RFP process if such return or destruction is feasible, except that Segal may retain an archival copy of Bidder's Proprietary Information for its file. If Bidder determines that return or destruction of some or all of Segal's Proprietary Information is not feasible, Bidder agrees to: (a) inform Segal, in writing, 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 Bidder retains it; and (c) limit further uses or disclosures to those that make the return or destruction infeasible.
6. Bidder will report to Segal, in writing, any use and/or disclosure of individually identifiable health information that is not permitted by this Agreement.
7. Each party shall regard and preserve as confidential all of the other party's Proprietary Information that has been or may be obtained by such party during the course of the RFP, whether Bidder or Segal has such information in memory, or in writing or in other physical form. Neither party shall, without written authority from the other party, use for such party's benefit or purposes, either during the RFP process or thereafter, any Proprietary Information of the other party, except as necessary to respond to the RFP or evaluate the RFP response.
8. With respect to the RFP and the Proprietary Information exchanged in connection therewith, the obligations assumed by the parties in this Agreement shall continue beyond completion of the RFP process.
9. In certain instances, Segal may conduct the RFP process electronically through the use of a third party hosted Website. The host Website being used is owned by Proposal Technologies Network, Inc. ("Proposal Tech"). Proposal Tech and Segal have entered into a confidentiality agreement that protects the confidentiality of Segal's and Bidder's Proprietary Information, as well as Client's confidential information.
10. Bidder shall and does hereby agree to indemnify, defend and hold harmless Segal, Client and their respective officers, directors, employees and shareholders from and against any and all claims, demands, losses, costs, expenses, obligations, liabilities, damages, recoveries, and deficiencies, including interest, penalties, and reasonable attorney fees and costs, that the other may incur or suffer and that result from, or are related to, any breach or failure of Bidder or Bidder's Representatives to perform any of the representations, warranties and agreements contained in this Agreement that pertain to individually identifiable health information.
11. Each party recognizes that any breach of the covenants contained in this Agreement would irreparably injure the other party and/or Client. Accordingly, the non-breaching party 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.
12. 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.
13. This Agreement shall be binding upon Segal and Bidder and their respective successors, assigns, heirs, executors and administrators.
14. 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.

- 15. 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.
- 16. The written notices required by paragraphs 5 and 6 of this Agreement shall be sent by certified mail, return receipt requested, postage prepaid or by overnight air express mail service to: General Counsel, The Segal Group, Inc., 333 West 34th Street, New York, New York 10001.

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

THE SEGAL GROUP, INC.

BIDDER

Signed: _____

Signed: _____

Name: _____

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.

ATTACHMENT 6

PERFORMANCE GUARANTEES

Hawaii Employer-Union Health Benefits Trust Fund

All Medical Plans

Performance Guarantee Reporting

Performance Guarantees are not negotiable. Payments are calculated and paid quarterly based on the average enrollment of employees/retirees in the plan for the period in which the Performance Guarantee applies multiplied by the dollar amount per employee/per retiree (PE/PR) in each category, except where an annual measurement is indicated in which the average enrollment for the entire year would be used and payments are calculated and paid annually. Payments related to DM/IHM amounts measured and paid quarterly will be “trued-up” at year end. Performance Guarantees are subject to audit by the EUTF and are based on the combined performance under all contracts issued to the OFFEROR if more than one contract is issued to an OFFEROR.

The Contractor must document compliance with the Performance Guarantees in a sufficient manner for the EUTF’s third party auditor (or EUTF staff or the benefits consultant, if no audit is contracted for the time period) to determine Contractor compliance with the Performance Guarantees. If the EUTF’s third party auditor (or EUTF staff or the benefits consultant, if no audit is contracted for the time period) is unable to determine Contractor compliance because the documentation is insufficient, the Contractor will be deemed to have not complied with the Performance Guarantee for the applicable period.

Sampling or using non-EUTF specific data (e.g. utilizing Hawaii Regional data or National data) is not permitted in determining the measurements unless otherwise specified. Rounding of measurements is not permitted for any Performance Guarantee in any situation.

The following is an example of how the penalties are assessed:

Average enrollment during the period (e.g. quarter) is 10,000
 Penalty for the category is \$1.25 PE and PR
 Contractor does not comply for 4 quarters

Penalty is \$50,000 = 10,000 * \$1.25 * 4 quarters

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
<i>Call Response Center</i>				
1) 93.00% of calls answered within 20 seconds or 2) 100.00% of calls answered within an average of 20 seconds (not including calls answered by an automated voice response system). The Contractor must select option 1 or 2 prior to commencement of the contract. This selection will remain in effect for the entire contract period.	Option 1: Number of calls answered within 20 seconds / total number of calls received Option 2: Total aggregate time from 1 st ring to answer or abandonment /	Yes	Quarterly	\$1.00

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
	total number of calls received			
<u>PPO, Open Panel HMO, and Supplemental:</u> 98.00% of telephone inquiries/issues resolved at the first point of contact, as long as the Contractor's customer service representative has the information available at the time of the call. For inquiries requiring additional information or research, callers will be informed of the actions needed by the customer service representative and when the caller can expect resolution. <u>Closed Panel HMO:</u> 98.00% of telephone inquiries/issues resolved at the first point of contact.	The number of telephone inquiries/issues completely resolved at the first point of contact / (the total number of telephone inquiries/issues [for PPO, Open Panel HMO and Supplemental, less telephone inquiries/issues requiring additional information or research])	Yes	Quarterly	\$1.00
Achieve call abandonment rate below 3.00%	Number of calls abandoned (callers hang up or are lost by the system) / total number of calls received	Yes	Quarterly	\$1.00
<i>Claims Processing and Claims Service</i>				
Achieve 99.00% financial accuracy on claim payments. Random sampling is permitted with an error rate of 3.00% or less at a 95.00% confidence level.	Number of claims paid (in the sample) with the correct eligible charge less the correct member coinsurance / total number of claims for the quarter (in the sample)	Either	Quarterly	\$1.00
Achieve 99.00% of claims coded accurately. Random sampling is permitted with an error rate of 3.00% or less at a 95.00% confidence level.	Number of claims (in the random sample) coded accurately / total number of claims for the quarter (in the random sample)	Either	Quarterly	\$1.00
Process 99.00% of claims within 30 calendar days	Number of claims paid within 30 calendar days of receipt / total number of claims paid	Yes	Quarterly	\$1.00

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
<p>Process 99.00% of appeals within 30 calendar days of receipt of all supporting documentation for pre-service and 60 calendar days of receipt of all supporting documentation for post-service</p>	<p>Number of claims appeals (e.g. written letters that clearly state that it's an appeal and appeals filed under the Member Appeal Rights and Process) adjudicated (letter mailed approving or denying) within 30 calendar days for pre-service and 60 calendar days for post-service / total number of claims appeals.</p> <p>(Within 30 calendar days means if received on Thursday 8/1, letter mailed by Tuesday 9/3 4:30 p.m.)</p>	<p align="center">Yes</p>	<p align="center">Quarterly</p>	<p align="center">\$1.00</p>
<p><i>EUTF Trustee and EUTF Administrative Service</i></p>				
<p>Resolve 98.00% of enrollee issues within 3 business days.</p>	<p>Resolved (i.e. items closed by EUTF) enrollment issues communicated by EUTF staff to Contractor (e.g. Administrator inquiry to the Contractor account team and rush enrollments) within 3 business days / total enrollment issues communicated by EUTF staff to Contractor</p> <p>(Within 3 business days means if communicated on Monday 7/29 resolved by Thursday 8/1 4:30 p.m.)</p>	<p align="center">Yes</p>	<p align="center">Quarterly</p>	<p align="center">\$1.00</p>

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Achieve a level 4 or higher (on a scale of 1 to 5) on Contractor service levels to the EUTF as rated by the EUTF on an annual basis.	EUTF to determine who will rate Contractor and weightings, and the criteria for the evaluation.	Yes	Annual	\$2.00
Provide all reports (excluding Wellness and Total Health Management Reports noted below) as described in this RFP plus any additional reports requested by the EUTF within time periods determined by the EUTF staff.	Penalty will be prorated based on the number of missed report deadlines over the total report deadlines for the time period. (Monthly reports represent three reports for the quarter.) If the report provided on or after the deadline is incomplete (i.e. with missing sections), a penalty will be owed.	Yes	Quarterly	\$2.50
Provide all benefit summaries/guides within time periods determined by the EUTF staff. Includes but is not limited to a summary of benefits and coverage (SBC) for active employee plans as required by ACA.	Penalty will be multiplied by the number of missed deadlines in the quarter.	Yes	Quarterly	\$0.50
Maintain consistent, primary account team throughout the contract term unless a change is requested by the EUTF and mutually agreed to by the Contractor. Measurement of this guarantee will exclude replacement of primary account team members 1) due to termination of employment and 2) in cases of promotion or transfer out-of-state if the outgoing account team member's tenure overlaps with the incoming account team member's tenure for a period of at least one month (the "Transition Period") and the outgoing team member remains directly available to EUTF and the incoming account team member for inquiries and consultation for an additional period of at least one month after the Transition Period ends.	Primary account team members are indicated in the Contractor's response to the RFP and include the Account Manager, Senior Account Manager (supervisor of the Account Manager), Enrollment Manager, and IT Manager. Refer to Section VII of this RFP.	Yes	Quarterly	\$1.25
<i>Plan Administration</i>				

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Load weekly 834 files within 24 hours after delivery by EUTF and process all transactions (e.g. enrollments, terminations, and other life events) including mailing of ID cards within 48 hours	If the 834 file is electronically delivered Monday 7/29 10:00 a.m., all transactions must be loaded by Tuesday 7/30 10:00 a.m. and ID cards must be mailed by Thursday 8/1 10:00 a.m. If the 834 file is delivered Friday 8/2 10:00 a.m., all transactions must be loaded by Monday 8/5 10:00 a.m.	Yes	Quarterly	\$1.00
Process 99.00% of all transactions accurately	Transactions from the 834 file processed accurately / total transactions from the 834 file. If there is a correction, it must occur within 24 hours after the 834 file is delivered by EUTF in order to be considered accurate.	Yes	Quarterly	\$1.00
Achieve 99.00% accuracy on an annual reconciliation between the Contractor's enrollees versus the EUTF's enrollees, excluding enrollment differences due to timing.	Errors (e.g. EUTF has a member enrolled on their file, but the same member is not enrolled by the Contractor and vice versa not due to timing) / total enrolled by EUTF	Yes	Annual	\$1.00
Maintain a geo access percentage of 95.00% or better than the results submitted in the proposal on a per island basis within the State and measured separately by providers, facilities and sources of care and services.	As per the RFP, the Geo Access is based on the residential zip code of those listed in the census files and requires 2 providers in your network within 8 miles of the residential zip code of those in the file. Also the percent with a minimum of two PCP within the 8 mile requirement. For acute hospitals, it is the percent within 15 miles.	Yes	Quarterly	\$2.00

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
	Number of EUTF enrollees that fall within the above geo access parameters / total number of EUTF enrollees			
<i>Participant Service</i>				
Resolve 98.00% of written inquiries (including claims) within 10 business days and 100.00% within 20 business days of receipt	Number of written inquiries resolved within 10 business days (and 20 business days) / total number of written inquiries (Within 10 business days means if received on Monday 7/29 resolved by Monday 8/12 4:30 p.m.)	Yes	Quarterly	\$1.00
Achieve 90.00% satisfaction with the Contractor in an annual survey conducted by the Contractor based on an enrollee satisfaction survey. Contractor shall use random sampling with an error rate of 3.00% or less at a 95.00% confidence level.	Number of surveys completed with overall satisfaction with Contractor (e.g. satisfied, very satisfied or extremely satisfied) / total number of surveys completed	Yes	Annual	\$2.00
Achieve 99.00% accuracy on communication to participants including ID cards. Letters are to be pre-approved by the EUTF prior to mailing.	Number of communication pieces that are accurate and sent to the correct participants (e.g. an individual letter to one EUTF member is one piece and one airing of a radio ad is one piece) / total number of communication pieces	Yes	Quarterly	\$1.00
<i>Wellness and Total Health Management</i>				
Develop and present to EUTF, within 10 months of the commencement of the contract, a comprehensive wellness, disease management, integrated health management plan identifying areas for improvement in program utilization,	Plan due 10/31/21 for retirees and 4/30/22 for actives.	Yes	One-time (Plan)	\$1.35 (Plan) 1% of quarterly

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
lifestyle and health metrics. Include, at a minimum, trend and baseline data, measurable objectives, your strategies and interventions to meet objectives and a timeline for implementation. Monitor the plan and provide EUTF with an annual progress report, within 30 days after the end of each contract period.			Annual (monitoring)	DM/IHM fees (monitoring)
Report on Healthcare Effectiveness Data and Information Set (HEDIS) measures including but limited to cancer screenings, respiratory conditions, cardiovascular conditions and comprehensive diabetes care. Provide a final report annually by August 31, covering the period from January 1 - December 31. Present the final summary of the annual HEDIS report to the Benefits Committee by November 30.	Contact EUTF for a report template outlining data and information to include in the annual report and summary presentation. Data elements will include, but not be limited to, a 3-year trend comparing EUTF rates by member type, and unions to regional averages, industry averages and HEDIS national 90 th percentile in PPT format.	Yes	Annual	2% of annual DM/IHM fees
Report utilization rates and recommendations for improvements for wellness, disease management and integrated health management programs by member type, within 30 days after the end of each quarter.	EUTF to determine content, scope of reports, and due dates.	Yes	Quarterly	2% of quarterly DM/IHM fees
For both the commercial and retiree populations, meet or exceed the national 90 th percentile quality benchmark; or show improvement of 5.00% or better from the prior year in the diabetes test result percentage for A1c levels less than or equal to 8.0	See column 1 for description.	Yes	Annual	2% of annual DM/IHM fees
For both the commercial and retiree populations, meet or exceed the national 90 th percentile quality benchmarks; or show improvement of 5.00% or better from the prior year in hypertension control <140/90.	See column 1 for description	Yes	Annual	2% of annual DM/IHM fees
Report on the burden of disease including prevalence data for lifestyle and chronic conditions; and the contributing cost of	Contact EUTF for a report template outlining data and information to include	Yes	Annual	2% of annual DM/IHM fees

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
chronic conditions. Provide a final report annually, by July 31, covering the period January 1 – December 31.	in the annual report and summary presentation. Data elements will include, but not be limited to, a 3-year trend comparing EUTF rates by member type, and unions to regional averages, industry averages, state book of business in PPT format.			

Hawaii Employer-Union Health Benefits Trust Fund

Standalone Self-Insured Prescription Drug Plan

Performance Guarantee Reporting

Performance Guarantees are not negotiable. Payments are calculated and paid quarterly based on the average enrollment of employee/retirees in the plan for the period in which the Performance Guarantee applies multiplied by the dollar amount per employee/per retiree (PE/PR) in each category, except where an annual measurement is indicated in which the average enrollment for the entire year would be used and payments are calculated and paid annually. Performance Guarantees are subject to audit by the EUTF and are based on the combined performance under all contracts issued to the OFFEROR if more than one contract is issued to an OFFEROR.

The Contractor must document compliance with the Performance Guarantees in a sufficient manner for the EUTF's third party auditor (or EUTF staff or the benefits consultant if no audit is contracted for the time period) to determine Contractor compliance with the Performance Guarantees. If the EUTF's third party auditor (or EUTF staff or the benefits consultant if no audit is contracted for the time period) is unable to determine Contractor compliance because the documentation is insufficient, the Contractor will be deemed to have not complied with the Performance Guarantee for the applicable period.

Sampling is not permitted in determining the measurements unless otherwise specified. Rounding of measurements is not permitted for any Performance Guarantee in any situation.

The following is an example of how the penalties are assessed:

Average enrollment during the period (e.g. quarter) is 10,000
Penalty for the category is \$1.25 PE and PR
Contractor does not comply for 4 quarters

Penalty is \$50,000 = 10,000 * \$1.25 * 4 quarters

PERFORMANCE and IMPLEMENTATION GUARANTEES:

EGWP plan for Retirees

IMPLEMENTATION GUARANTEES

The EUTF will require specific implementation guarantees. The categories/standards below are pass/fail categories/standards, and failure in any part of a category/standard requires the total payment for that category.

Implementation Guarantees	Standard	Annual Per Year Penalty Dollars at Risk
Implementation Team	Implementation team will be assigned and introduced to EUTF at least 6 months in advance of effective date. Implementation team will not change, unless requested by EUTF.	\$150,000.00
Timely and Accurate Installation	Installation of all administrative, clinical and financial parameters for EUTF's program will be completed by November 1, 2020 and will involve no systems errors. ID cards will be delivered within 14 days of receipt of final file from EUTF. EUTF and members have access to all online tools by October 1, 2020.	\$300,000.00
Implementation Satisfaction Scorecard	Assigned Account Executive will work with EUTF prior to the start of implementation to agree on terms of a satisfaction scorecard to be issued to client after implementation is completed. EUTF Administrator will complete scorecard after implementation. Any overall score less than satisfactory will result in full payment for this category.	\$300,000.00

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
Payment Accuracy and System Performance				
<i>Financial Accuracy</i> – Achieve 99.00% financial accuracy on claim payments. Random sampling is permitted with an error rate of 3.00% or less at a 95.00% confidence level.	Number of claims paid (in the random sample) with the correct eligible charge less the correct member coinsurance / total number of claims for the quarter (in the random sample)	Yes	Quarterly	\$0.15
<i>Mail Service Non-Financial Accuracy</i> – 99.00% dispensing accuracy of the mail service pharmacy across all EUTF lines of business (e.g. correct participant name, correct participant address, correct drug, correct dosage form, correct strength).	The number of errors / total number of mail service prescriptions dispensed in the quarter	Yes	Quarterly	\$0.15
<i>System Downtime</i> – 98.50% of the time pharmacies in PBM's network shall have access to its network 24 hours a day, 7 days a week, 365 days a year.	Minutes of downtime including normal scheduled maintenance / total number of minutes in the quarter	No	Quarterly	\$0.10
<i>Eligibility Data</i> – Load weekly clean 834 files within 24 hours after delivery by EUTF and process all transactions (e.g. enrollments, terminations, and other life events). "Clean" is defined as records that contain the mutually agreed upon data elements and the file processes in its entirety and does not suspend. Contractor will mail 100.00% of the ID cards within 4 business days (within 10 business days for the EGWP) after file load completion if the file is loaded electronically.	If the 834 file is electronically delivered Monday 7/29 10:00 a.m., all transactions must be loaded by Tuesday 7/30 10:00 a.m. and ID cards must be mailed by Monday 8/5 4:30 p.m. (Tuesday 8/13 4:30 p.m. for EGWP). If the 834 file is delivered Friday 8/2 10:00 a.m., all transactions must be loaded by Monday 8/5 10:00 a.m.	Yes	Quarterly	\$0.15
<i>Eligibility Data Accuracy</i> – Process 99.00% of all transactions accurately.	Transactions from the 834 file processed accurately / total transactions from the 834 file. If there is a correction, it must occur within 24 hours after the 834 file is delivered by	Yes	Quarterly	\$0.15

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
	EUTF in order to be considered accurate.			
<i>Eligibility Data Error Reporting</i> – Eligibility file error reporting on all electronic eligibility file updates will be provided to the EUTF within 2 business days after delivery of the 834 file by EUTF.	Penalty will be multiplied by the number of error reports not received within 2 business days after delivery of the 834 file during the quarter.	Yes	Quarterly	\$0.15
<i>Invoicing Errors</i> – All invoicing errors (e.g. service warranties) will be credits back to the client within two months of identification of the error.	Penalty will be multiplied by the number of invoicing errors not credited back within 2 months during the quarter. If an error was identified on 3/1 and was not credited back to EUTF by 5/1, a penalty will be owed for the 2 nd quarter. A penalty will be owed for each quarter thereafter until credited back to EUTF.	Yes	Quarterly	\$0.10
<i>Enrollment Accuracy</i> – Achieve 99.00% accuracy on an annual reconciliation between the Contractor’s enrollees versus the EUTF’s enrollees, excluding enrollment differences due to timing.	Errors (e.g. EUTF has a member enrolled on their file, but the same member is not enrolled by the Contractor and vice versa, not due to timing) / total enrolled by EUTF	Yes	Annual	\$0.15
Account Management				
<i>Client Approval of Enrollee Communications</i> – Achieve 99.00% accuracy on communication to participants including ID cards. Letters are to be pre-approved by the EUTF prior to mailing.	Number of communication pieces that are accurate and sent to the correct participants (e.g. an individual letter to one EUTF member is one piece and one airing of a radio ad is one piece) / total number of communication pieces	Yes	Quarterly	\$0.10
<i>Delivery of Reports</i> – Provide all reports as described in this RFP plus any additional	Penalty will be prorated based on the number of missed report deadlines	Yes	Quarterly	\$0.50

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
reports requested by the EUTF within time periods determined by the EUTF staff.	over the total report deadlines for the time period. (Monthly reports represent three reports for the quarter.) If the report provided on or after the deadline is incomplete (i.e. with missing sections), a penalty will be owed.			
<i>Delivery of Benefit Summaries</i> – Provide all benefit summaries within time periods determined by the EUTF staff. Includes but is not limited to a summary of benefits and coverage (SBC) for active employee plans as required by ACA.	Penalty will be multiplied by the number of missed deadlines in the quarter.	Yes	Quarterly	\$0.10
<i>Pharmacy Audit Resolution</i> – Contractor guarantees credits resulting from Pharmacy Desk Top Audits will be applied to the EUTF’s invoice within 45 days of resolution.	Penalty will be multiplied by the number of credits not applied within 45 days of resolution during the quarter.	Yes	Quarterly	\$0.10
<i>Account Team Performance</i> – Achieve a level 4 or higher (on a scale of 1 to 5) on Contractor service levels to the EUTF as rated by the EUTF on an annual basis.	EUTF to determine who will rate the Contractor and weightings, and the criteria for the evaluation.	Yes	Annual	\$1.50
<i>Account Team Turnover</i> – Maintain consistent, primary account team throughout the contract term unless a change is requested by the EUTF and mutually agreed to by the Contractor. Measurement of this guarantee will exclude replacement of primary account team members 1) due to termination of employment and 2) in cases of promotion or transfer out-of-state if the outgoing account team member’s tenure overlaps with the incoming account team member’s tenure for a period of at least one month (the “Transition Period”) and the outgoing team member remains directly available to EUTF and the incoming account team member for inquiries and consultation for a further period of at least one month after the Transition Period ends.	Primary account team members are indicated in the Contractor’s response to the RFP and include the Account Manager, Senior Account Manager (supervisor of Account Manager), Enrollment Manager, IT Manager, and Clinical Pharmacist. Refer to Section IX of this RFP.	Yes	Quarterly	\$0.25

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
<i>Maintenance of Network</i> – Maintain a geo access percentage of 95.00% or better than the results submitted in the proposal on a per island basis within the State.	Number of in-network pharmacies that fall within the above geo access parameters / total number of in-network pharmacies	Yes	Quarterly	\$1.00
Member Services				
<i>Mail Turnaround—Prescriptions not requiring intervention</i> – 98.00% of prescriptions dispensed within 2 business days of receipt and 100.00% within 3 business days of receipt.	Number of prescriptions dispensed within 2 business days (and 3 business days) of receipt / total number of prescriptions dispensed	Yes	Quarterly	\$0.10
<i>Mail Turnaround – Prescriptions requiring intervention</i> – 95.00% of prescriptions requiring intervention dispensed within 4 business days of receipt and 100.00% within 5 business days of receipt.	Number of prescriptions requiring intervention dispensed within 4 business days (and 5 business days) of receipt / total number of prescriptions requiring intervention dispensed	Yes	Quarterly	\$0.10
<i>Mailing Enrollee Materials</i> – 100% of enrollee materials will be mailed at least 10 business days prior to the effective date and will be 100.00% accurate (provided that eligibility file was received at least 30 days prior to the effective date).	Number of communication pieces that are mailed at least 10 business days prior to the effective date and 100% accurate / total number of communication pieces	Yes	Quarterly	\$0.10
<i>Phone Speed of Answer</i> – 1) 93.00% of calls answered within 20 seconds or 2) 100.00% of calls answered within an average of 20 seconds (not including calls answered by an automated voice response system). The Contractor must select option 1 or 2 prior to commencement of the contract. This selection will remain in effect for the entire contract period.	Option 1: Number of calls answered within 20 seconds / total number of calls received Option 2: Total aggregate time from 1 st ring to answer or abandonment / total number of calls received	Yes	Quarterly	\$0.10
<i>Phone Abandonment Rate</i> – Achieve call abandonment rate below 3.00%.	Number of calls abandoned (callers hang up or are lost by the	Yes	Quarterly	\$0.10

HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

SECTION X

Guarantee	Description	EUTF Specific	Frequency	Amount at Risk per Period (PE/PR)
	system) / total number of calls received			
<i>Written Inquiry Answer Time – Resolve 98.00% of written inquiries (including claims) within 10 business days and 100.00% resolved within 20 business days of receipt.</i>	Number of written inquiries resolved within 10 business days (and 20 business days) / total number of written inquiries (Within 10 business days means if received on Monday 7/29 resolved by Monday 8/12 4:30 p.m.)	Yes	Quarterly	\$0.10
<i>Enrollees Satisfaction Survey – Achieve 90.00% satisfaction with the Contractor in an annual survey conducted by the Contractor based on an enrollee satisfaction survey. Contractor shall use random sampling with an error rate of 3% or less at a 95% confidence level.</i>	Number of surveys completed with overall satisfaction with Contractor (e.g. satisfied, very satisfied or extremely satisfied) / total number of surveys completed	Yes	Annual	\$1.00
<i>Issue Resolution: Verbal Inquiries –98.00% of telephone inquiries/issues resolved at the first point of contact.</i>	The number of telephone inquiries/issues completely resolved at the first point of contact / the total number of telephone inquiries/issues	Yes	Quarterly	\$0.10
<i>Issue Resolution – Resolve 98.00% of enrollee issues within 3 business days.</i>	Number of enrollee issues resolved within 3 business days / total number of enrollee issues	Yes	Quarterly	\$0.10

EXHIBIT A

CLAIMS EXPERIENCE

Claims data will be provided upon completion of the Intent to Bid Form (Attachment 2) and signed Confidentiality Agreement (Attachment 3)

EXHIBIT B

PREMIUM RATES

Premium rates are available at the EUTF website:

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

EXHIBIT C

EUTF ADMINISTRATIVE RULES

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

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1.00 GENERAL PROVISIONS

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1.01 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.

“Cancellation Non-Payment Status” means an employee-beneficiary whose plans have been cancelled for the remainder of the plan year due to failure to pay the required semi-monthly or monthly contributions.

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

“Child” means an employee’s, spouse’s or partner’s as defined in these rules, legally adopted child, child placed for adoption, stepchild, foster child, or recognized natural child but excluding a child born or legally adopted more than ten months after the date of death of: (1) an active employee killed in the performance of duty; (2) an active employee who was eligible to retire on the date of death; or (3) a retired employee-beneficiary. For non-excepted benefits, a child may be unmarried or married and does not need to live with or be financially dependent on the employee-beneficiary. For excepted benefits, a child must be unmarried and live with the employee-beneficiary. A child has been placed for adoption when an employee-beneficiary, spouse, or partner 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 and has been awarded legal and physical custody of the child pursuant to a valid court order.

“Civil Union Partner” means an individual who is a party to a civil union established pursuant to Chapter 572B of the Hawaii Revised Statutes.

“Contribution” or “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.

“Eligibility” shall have the meaning as meeting the Fund’s requirements to participate or be qualified to participate in plans offered by the Fund.

“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.

“Excepted Benefits” shall mean benefits not subject to the National Health Care Reform Law (including the Patient Protection and Affordable Care Act [PPACA] of 2010, the Public Health and Safety Act, the Health Care and Education Reconciliation Act [HCERA] of 2010, and all subsequent legislative amendments and guidance). Examples of ‘excepted benefits’ include stand alone dental and vision plans and retiree-only plans.

“Fraud and Intentional Misrepresentation” includes, but is not limited to, intentionally or knowingly keeping an ineligible dependent enrolled in a Fund benefit plan (for example, an ex-spouse, over age or ineligible dependent child, etc.). Other situations of fraud or intentional misrepresentation of fact can include: failure to submit the required proof dependent status documentation or the documentation submitted does not confirm the dependent is eligible as a dependent for coverage in a Fund benefit plan, or filing fraudulent claims as described in Rule 4.12(b). The Fund will provide at least thirty (30) days advance written notice to each participant who will be affected before coverage is rescinded for fraud or intentional misrepresentation. In accordance with the requirements in the Affordable Care Act, the Fund will not retroactively cancel coverage except when premiums and contributions are not timely paid in full, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Fund.

“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.

“Limiting Age” shall mean: (1) for active employees, pertaining to excepted benefits, as defined in this Rule 1.02, the age a child loses

eligibility as a dependent-beneficiary is upon reaching age nineteen, unless the child is a full-time student, as defined in this Rule 1.02, which would extend the limiting age to the child's twenty-fourth birthday; (2) for active employees, pertaining to non-excepted benefits, as defined in this Rule 1.02, the age at which a child loses eligibility as a dependent-beneficiary is upon the end of the month that the dependent reaches age twenty-six; (3) for retirees, surviving spouses and surviving partners, the age a child loses eligibility as a dependent-beneficiary is upon reaching age nineteen, unless the child is a full-time student, as defined in this Rule 1.02, which would extend the limiting age to the child's twenty-fourth birthday; (4) for an unmarried child of (a) an employee who is killed in the performance of the employee's duty or (b) deceased retired employee and does not have a surviving parent who is eligible to be an employee-beneficiary, the age a child loses eligibility is upon reaching age nineteen, unless the child is a full-time student, as defined in this Rule 1.02, which would extend the limiting age to the child's twenty-fourth birthday.

"Non-excepted Benefits" shall mean benefits subject to the National Health Care Reform Law (including the Patient Protection and Affordable Care Act [PPACA] of 2010, the Public Health and Safety Act, the Health Care and Education Reconciliation Act [HCERA] of 2010, and all subsequent legislative amendments and guidance). Examples of non-excepted benefits include medical and prescription drug plans for active employees.

"Month" shall mean thirty (30) days.

"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.

"Partner" or "Partnership" shall mean a domestic partner or civil union partner.

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

“Plan year” shall mean the 12-month period from January 1 through December 31 for retired employees and July 1 through June 30 for active employees.

“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.

“Spouse” means a person who is lawfully married pursuant to Hawaii law”.

“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.

“Termination of civil union partnership” means the civil union partnership terminates in accordance with applicable state laws and rules.

“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 current version 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 and communication committee functions.
 - (3) The Investment Committee will review the reports of the Investment Consultant and report to the Board of Trustees on the Fund's investments.
- (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 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 current version 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 the vote of the board, the board may vote on the same question or resolution at the next two successive meetings of the board. In the event of a deadlock in the vote of the board on the same question or resolution at the 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 (10) 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 (20) 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) of this Rule, 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 (20) copies shall be made available to the public. Twenty (20) 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; and (b) 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 within the times prescribed in these Rules;
 - (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, within the times prescribed by the Fund;
 - (2) Determining that employees are eligible to participate in Fund benefit plans pursuant to the definition of employee-beneficiary found in these rules and section 87A-1 of the Hawaii Revised Statutes;
 - (3) 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;
 - (4) Assisting the Fund in distributing information to and collecting information from the employee-beneficiaries; and
 - (5) 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 (not related to Claim Filing and Appeals Information for Self-Insurance Plan Administered Benefits, which are discussed in Rule 2.06)
- 2.05 Emergency Appeals of Eligibility
- 2.06 Claim Filing and Appeals Information for Self-Insured Plan Administered Benefits

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 (90) 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 (90) 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 (not related to Claim Filing and Appeals Information for Self-Insurance Plan Administered Benefits, which are discussed in Rule 2.06)

- (a) A person aggrieved by one of the following eligibility 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, offered or sponsored by the Fund; or
 - (4) A refusal to reinstate the person's enrollment in or coverage by a benefit plan, 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 one hundred eighty (180) days of the date of the adverse decision with respect to which relief is requested. The written appeal shall be filed in duplicate. Unless otherwise provided by applicable federal or state law, neither the administrator nor the board shall be required to hear any appeal that is filed after the one hundred eighty (180) day period has expired. The written appeal need not be in any particular form but should contain the following information:
- (1) The aggrieved person's name, address, and telephone number;
 - (2) A description of the decision with respect to which relief is requested, including the date of the decision;
 - (3) A statement of the relevant and material facts; and
 - (4) A statement as to why the aggrieved person is appealing the decision, including the reasons that support the aggrieved person's position or contentions.
- (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 thirty (30) 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 within ninety (90) days of the administrator's action. If no action is taken by the administrator within thirty (30) days of the written appeal to the administrator being filed in the Fund's office, then the written appeal to the Board must be filed in duplicate in the Fund's office within one-hundred twenty (120) days of the written appeal to the administrator being filed 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 forty-five (45) days of the date of the postmark of a request for appeal. The board shall not be required to hold a hearing on any appeal unless otherwise required by applicable federal or state law. If required to hold a hearing, or if it decides to voluntarily hold a hearing on an appeal, subject to applicable federal or state law, the board may set such hearing before the board, a special, or standing committee of the board, a hearings officer, or any other person or entity authorized by the board to hear the matter in question. Nothing in 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 of Eligibility

- (a) The Board may appoint a sub-committee made up of two trustees, one from the employer group and one from the employee group, to hear and make final decisions on emergency appeals. The Board Chair shall appoint the sub-committee chair, which shall rotate between employer trustee and employee trustee every six months.

- (b) An employee-beneficiary (“appellant”) who is aggrieved by a plan administrator’s decision denying or limiting eligibility for 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 in the opinion of a physician with knowledge of the medical condition of the employee-beneficiary or dependent-beneficiary:
 - (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) 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.

- (c) Any appellant or designee desiring to make an emergency appeal under this Rule shall contact the Fund administrator and be prepared to provide 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; a statement as to why the appellant is appealing the decision, including all reasons that support the appellant’s position or contentions; and any relevant and material facts;
 - (3) 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 (b) above;
 - (4) Information that supports 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

- (5) If appellant is going to be represented by a designee, proof the designee may act on behalf 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 providing information or documents required in 1 through 5 above.

- (d) The Fund administrator shall expeditiously, but in no event later than two business days, 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 submitting a request to the Fund Administrator. No particular form is required for such a request so long as it can be understood that the appellant is seeking to appeal the Fund administrator's decision to the Board.
- (e) 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 the sub-committee can meet either in person or via phone. The hearing shall be set as soon as possible.
 - (2) Notify the appellant and his or her representative, if any, of the time and date of the hearing;
 - (3) The Fund administrator may request the parties to provide the Fund administrator with copies of any documents, records, written testimony, or other written evidence that they wish the sub-committee to consider at the hearing; and
 - (4) Prior to the hearing, the Fund administrator shall provide each member of the sub-committee with copies of any materials provided by the appellant.
- (f) 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 sub-committee shall hear and consider all relevant testimony and documents;
 - (2) At any time during the hearing, the sub-committee may enter executive session to consult counsel regarding any legal issues involved in the appeal; and
 - (3) Prior to the conclusion of the hearing, the sub-committee shall announce its decision on the appeal to the Fund administrator. The sub-committee shall subsequently issue its decision in writing. A certified copy of the written decision shall be sent by certified mail to the appellant within a reasonable time after the hearing.
- (g) 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.

2.06 Claim Filing and Appeals Information for Self-Insured Plan Administered Benefits

- (a) This section describes the self-insured plans appeals timing and processes if an employee-beneficiary or dependent-beneficiary receives an adverse benefit determination. The process will be in conformance with 29CFR 2560.503 and amendments thereto. The processes are comprised of the following:
- (1) Internal standard appeal;
 - (2) External Appeal using the Independent Review Organization (IRO);
 - (3) Internal expedited appeal for urgent care;
 - (4) External appeal using an IRO for urgent care.
- (b) Definitions pertinent to claims and appeals.
- (1) "Adverse benefit determination", a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Fund benefit. An adverse benefit determination includes a denial, reduction, or termination of, or failure to provide or make payment (in whole or in part) for, a Fund benefit based on the application of a utilization review. An adverse benefit determination also includes a failure to cover a Fund benefit

- because use of the benefit is determined to be experimental, investigative, or not medically necessary or appropriate.
- (2) “Fund Benefit”, when referenced in this Section 2.06, a Fund benefit refers specifically to a self insured plan administered benefit.
 - (3) “Claim”, a request for a Fund benefit that is made in accordance with the Fund’s established procedures for filing benefit claims.
 - (4) “Medically Necessary” (Medical Necessity), medications, health care services or products are considered medically necessary if:
 - i. Use of the medication, service, or product is accepted by the health care profession in the United States as appropriate and effective for the condition being treated;
 - ii. Use of the medication, service, or product is based on recognized standards for the health care specialty involved;
 - iii. Use of the medication, service, or product represents the most appropriate level of care for the individual, based on the seriousness of the condition being treated, the frequency and duration of services, and the place where services are performed; and
 - iv. Use of medication, service or product is not solely for the convenience of the individual, individual’s family, or provider.
 - (5) “Post-Service Claim”, a claim for a Fund benefit that is not a Pre-Service Claim.
 - (6) “Pre-Authorization”, pre-service review of an employee-beneficiary’s or dependent-beneficiary’s initial request for a particular medication, service or product. The self-insured plan administrator will apply a set of pre-defined criteria to determine whether there is need for the requested medication, service, or product.
 - (7) “Pre-Service Claim”, a claim for a medication, service, or product that is conditioned, in whole or in part, on the approval of the benefit in advance of obtaining the requested medical care or service. Pre-service claims include individual requests for pre-authorization.
 - (8) “Urgent Care Claim”, a claim for a medication, service, or product where a delay in processing the claim: (a) could seriously jeopardize the life or health of the employee-beneficiary or dependent-beneficiary, and/or could result in the employee-



beneficiary's failure to regain maximum function, or (b) in the opinion of a physician with knowledge of the employee-beneficiary's condition, would subject the employee-beneficiary or dependent-beneficiary to severe pain that cannot be adequately managed without the requested medication, service, or product.

- (c) Time limit for initial filing of self-insured plan and administered claims.
 - (1) All post-service self-insured plan administered claims must be submitted to the administrator within one year from the date of service. No plan benefit will be paid for any claim not submitted within this period.
 - (2) If a self-insured plan claim is not approved, an employee-beneficiary or dependent-beneficiary may appeal that denial by following the steps in this Claim Filing and Appeal section. The Fund has delegated final claims and appeal authority for self-insured plan administered benefits to the independent self-insured plan administrator. This section discusses the claim appeal process for the following types of claims: Pre-Authorization Claim Review Services, Pre-Service Appeals Review Services, and Post-Service Appeals Review Services.
- (d) The claims and appeals process
 - (1) Pre-authorization review. The self-insured plan administrator will implement the cost containment programs by comparing individual requests for certain medicines, services, or products and/or other benefits against pre-defined lists or formularies before those prescriptions, services, or products are approved. If the self-insured plan administrator determines that the employee-beneficiary or dependent-beneficiary's request for pre-authorization cannot be approved, that determination will constitute an adverse benefit determination.
 - (2) Appeals of adverse benefit determinations of pre-service and urgent care claims. If an adverse benefit determination is rendered on the employee-beneficiary or dependent-beneficiary's self-insured plan administered claim, the employee-beneficiary or dependent-beneficiary may file an appeal of that determination. The individual's appeal of the adverse benefit determination must be made in writing and submitted to the self-insured plan administrator within one hundred eighty (180) days after the

employee-beneficiary or dependent-beneficiary receives notice of the adverse benefit determination.

If the adverse benefit determination is rendered with respect to an urgent care claim, the employee-beneficiary or dependent-beneficiary and/or the employee-beneficiary or dependent-beneficiary's attending physician may submit an appeal by contacting the self-insured plan administrator. The employee-beneficiary or dependent-beneficiary's appeal should include the following information:

- (i) Name of the person the appeal is being filed for;
- (ii) The prescription drug program identification number, service description and/or code, or product name and number;
- (iii) Date of birth;
- (iv) Written statement of the issue(s) being appealed;
- (v) Prescription drug name(s), service(s), or product(s) being requested; and
- (vi) Written comments, documents, records or other information relating to the claim.

The employee-beneficiary or dependent-beneficiary's appeal and supporting documentation should be mailed, emailed, or faxed to the self-insured plan administrator.

If a covered person or their covered dependent does not understand English and has questions about a claim denial, the covered person or covered dependent should contact the appropriate claims administrator to find out if assistance is available.

TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa ang EUTF.

CHINESE (中文): 如果需要中文的帮助, 请拨 EUTF.

- (3) The self-insured plan administered program's review. The self-insured plan administrator will provide the first-level review of appeals of pre-service claims. If the employee-beneficiary or dependent-beneficiary appeals the self-insured plan administrator's

decision, the employee-beneficiary or dependent-beneficiary can request an additional second-level medical necessity review. That review will be conducted by an Independent Review Organization (“IRO”).

- (4) Timing of review.
- (i) Pre-Authorization Review. The self-insured plan administrator will make a decision on a pre-authorization request for a Fund benefit within fifteen (15) days after it receives the request. If the request relates to an urgent care claim, the self-insured plan administrator will make a decision on the claim within seventy-two (72) hours.
 - (ii) Pre-Service Claim Appeal. The self-insured plan administrator will make a decision on a first-level appeal of an adverse benefit determination rendered on a pre-service claim within fifteen (15) days after it receives the employee-beneficiary or dependent-beneficiary’s appeal. If the self-insured plan administrator renders an adverse benefit determination on the first-level appeal of the pre-service claim, the employee-beneficiary or dependent-beneficiary may appeal that decision by providing the information described above. A decision on the employee-beneficiary or dependent-beneficiary’s second-level appeal of the adverse benefit determination will be made (by the IRO) within fifteen (15) days after the new appeal is received. If the employee-beneficiary or dependent-beneficiary is appealing an adverse benefit determination of an urgent care claim, a decision on such appeal will be made not more than seventy-two (72) hours after the request for appeal(s) is received (for both the first-and second-level appeals, combined).
 - (iii) Post-Service Claim Appeal. The self-insured plan administrator will make a decision on an appeal of an adverse benefit determination rendered on a post-service claim within sixty (60) days after it receives the appeal.
- (5) Scope of review. During its pre-authorization review, first-level review of the appeal of a pre-service claim, or review of a post-service claim, the self-insured plan administrator will:

- (i) Take into account all comments, documents, records and other information submitted by the employee-beneficiary or dependent-beneficiary relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination on the claim;
- (ii) Follow reasonable procedures to verify that its benefit determination is made in accordance with the applicable Fund documents;
- (iii) Follow reasonable procedures to ensure that the applicable Fund provisions are applied to the employee-beneficiary or dependent-beneficiary in a manner consistent with how such provisions have been applied to other similarly-situated individuals; and
- (iv) Provide a review that does not afford deference to the initial adverse benefit determination and is conducted by an individual other than the individual who made the initial adverse benefit determination (or a subordinate of such individual).

If an employee-beneficiary or dependent-beneficiary appeals the self-insured plan administrator's denial of a pre-service claim, and requests an additional second-level medical necessity review by an IRO, the IRO shall:

- a) Consult with appropriate health care professionals who were not consulted in connection with the initial adverse benefit determination (nor a subordinate of such individual);
 - b) Identify the health care professional, if any, whose advice was obtained on behalf of the Fund in connection with the adverse benefit determination; and
 - c) Provide for an expedited review process for urgent care claims.
- (6) Notice of adverse benefit determination. Following the review of an employee-beneficiary or dependent-beneficiary's claim, the self-insured plan administrator will notify the employee-beneficiary or dependent-beneficiary of any adverse benefit determination in writing. (Decisions on urgent care claims will be also communicated by telephone or fax.) This notice will include:

- (i) The specific reason or reasons for the adverse benefit determination;
 - (ii) Reference to the pertinent Fund provision on which the adverse benefit determination was based;
 - (iii) A statement that the employee-beneficiary or dependent-beneficiary is entitled to receive, upon written request, free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim;
 - (iv) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse benefit determination, either a copy of the specific rule, guideline, protocol or other similar criterion; or a statement that such rule, guideline, protocol or other similar criterion will be provided free of charge upon written request; and
 - (v) If the adverse benefit determination is based on a medical necessity, either the IRO's explanation of the scientific or clinical judgment for the IRO's determination, applying the terms of the Fund to the employee-beneficiary or dependent-beneficiary's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.
- (7) Authority as claims fiduciary. The self-insured plan administrator has been designated by the Board as the claims fiduciary with respect to all types of claim appeal review of the benefit claims arising under the Fund it administers. The self-insured plan administrator shall have, on behalf of the Fund, sole and complete discretionary authority to determine these claims conclusively for all parties. The self-insured plan administrator is not responsible for the conduct of any second-level medical necessity review performed by an IRO.
- (8) Voluntary external review. The Patient Protection and Affordable Care Act ("ACA") imposes external review requirements on group health plans, including outpatient prescription drug benefits. Under the ACA, an employee-beneficiary or dependent-beneficiary who receives a final internal adverse determination of a "Claim" for benefits under a self-insured administered plan may be permitted to further appeal that denial using the voluntary external

review process. The external review process provides employee-beneficiary or dependent-beneficiary's with another option for protesting the denial of their claim.

- (9) Standard/non-expedited Federal external review process.
 - (i) Request for review. An employee-beneficiary or dependent-beneficiary whose claim for self-insured administered benefits is denied may request, in writing, an external review of his or her claim within four (4) months after receiving notice of the final internal adverse benefit determination. The employee-beneficiary or dependent-beneficiary's request should include their name, contact information including mailing address and daytime phone number, individual ID number, and a copy of the coverage denial. The employee-beneficiary or dependent-beneficiary's request for external review and supporting documentation may be mailed, emailed, or faxed to the self-insured plan administrator at their address, email, or fax.
 - (ii) Preliminary review. Within five (5) days of receiving an employee-beneficiary or dependent-beneficiary's request for external review, the self-insured plan administrator will conduct a "preliminary review" to ensure that the request qualifies for external review. In this preliminary review, the self-insured plan administrator will determine whether:
 - a) The employee-beneficiary or dependent-beneficiary is or was covered under the Fund at the time the benefit at issue was requested, or in the case of a retrospective review, was covered at the time the benefit was provided;
 - b) The adverse benefit determination or final internal adverse benefit determination does not relate to the employee-beneficiary or dependent-beneficiary's failure to meet the Fund's requirements for eligibility (for example, worker classification or similar determinations), as such determinations are not eligible for Federal external review;
 - c) The employee-beneficiary or dependent-beneficiary has exhausted the Fund's internal appeal process

(unless the employee-beneficiary or dependent-beneficiary's Claim is "deemed exhausted" under the ACA); and

- d) The employee-beneficiary or dependent-beneficiary has provided all the information and forms necessary to process the external review.

Within one (1) day after completing this preliminary review, the self-insured plan administrator will notify the employee-beneficiary or dependent-beneficiary, in writing, that: (1) the employee-beneficiary or dependent-beneficiary's request for external review is complete, and may proceed; (2) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (3) the request for external review is complete, but not eligible for review.

- (iii) Referral to IRO. If the employee-beneficiary or dependent-beneficiary's request for external review is complete and the employee-beneficiary or dependent-beneficiary's claim is eligible for external review, the self-insured plan administrator will assign the request to one of the IROs with which the administrator has contracted. The IRO will notify the employee-beneficiary or dependent-beneficiary of its acceptance of the assignment. The employee-beneficiary or dependent-beneficiary will then have ten (10) days to provide the IRO with any additional information the employee-beneficiary or dependent-beneficiary wants the IRO to consider. The IRO will conduct its external review without giving any consideration to any earlier determinations made on behalf of the Fund.

The IRO may consider information beyond the records for the employee-beneficiary or dependent-beneficiary's denied Claim, such as:

- a) The employee-beneficiary or dependent-beneficiary's medical records;
- b) The attending health care professional's recommendations;

- c) Reports from appropriate health care professionals and other documents submitted by the Fund, the employee-beneficiary or dependent-beneficiary, or the employee-beneficiary or dependent-beneficiary's treating physician;
 - d) The terms of the Fund to ensure that the IRO's decision is not contrary to the terms of the plan (unless those terms are inconsistent with applicable law);
 - e) Appropriate practice guidelines, which must include applicable evidence based standards and may include any other practice guidelines developed by the Federal government, national, or professional medicine societies, boards, and associations;
 - f) Any applicable clinical review criteria developed and used on behalf of the Fund (unless the criteria are inconsistent with the terms of the Fund or applicable law); and
 - g) The opinion of the IRO's clinical reviewer(s) after considering all information and documents applicable to the employee-beneficiary or dependent-beneficiary's request for external review, to the extent such information or documents are available and the IRO's clinical reviewer(s) considers it appropriate.
- (iv) Timing of IRO's determination. The IRO will provide the employee-beneficiary or dependent-beneficiary and the self-insured plan administrator (on behalf of the Fund) with written notice of its final external review decision within forty-five (45) days after the IRO receives the request for external review. The IRO's notice will contain:
- a) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if available), the diagnosis code and its meaning, the treatment code and its meaning, and the reasons for the previous denials);

- b) The date the IRO received the external review assignment from the self-insured plan administrator, and the date of the IRO's decision;
 - c) References to the evidence or documentation, including specific coverage provisions and evidence-based standards, the IRO considered in making its determination;
 - d) A discussion of the principal reason(s) for the IRO's decision, including the rationale for the decision, and any evidence-based standards that were relied upon by the IRO in making its decision;
 - e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Fund or to the individual;
 - f) A statement that the employee-beneficiary or dependent-beneficiary may still be eligible to seek judicial review of any adverse external review determination; and
 - g) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsmen available to assist the employee-beneficiary or dependent-beneficiary.
- (10) Reversal of the Fund's prior decision. If the self-insured plan administrator, acting on the Fund's behalf, receives notice from the IRO that it has reversed the prior determination of the employee-beneficiary or dependent-beneficiary's claim, the self-insured plan administrator will immediately provide coverage or payment for the claim.
- (11) Expedited Federal external review process. An employee-beneficiary or dependent-beneficiary may request an expedited external review:
- (i) If the employee-beneficiary or dependent-beneficiary receives an adverse benefit determination related to a claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the employee-

- beneficiary or dependent-beneficiary, and/or could result in the employee-beneficiary or dependent-beneficiary's failure to regain maximum function, and the employee-beneficiary or dependent-beneficiary has filed a request for an expedited internal appeal; or
- (ii) If the employee-beneficiary or dependent-beneficiary receives a final internal adverse benefit determination related to a claim that involves: (a) a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the life or health of the employee-beneficiary or dependent-beneficiary, and/or could result in the employee-beneficiary or dependent-beneficiary's failure to regain maximum function; or (b) an admission, availability of care, continued stay, or a prescription drug benefit for which the employee-beneficiary or dependent-beneficiary has received emergency services, but has not been discharged from a facility.
- (12) Request for review. If the employee-beneficiary or dependent-beneficiary's situation meets the definition of urgent under the law, the external review of the claim will be conducted as expeditiously as possible. In that case, the employee-beneficiary or dependent-beneficiary or the employee-beneficiary or dependent-beneficiary's physician may request an expedited external review by calling the customer care toll-free at the number on their benefit ID card or contacting their benefits office. The request should include the employee-beneficiary or dependent-beneficiary's name, contact information including mailing address and daytime phone number, employee-beneficiary or dependent-beneficiary's ID number, and a description of the coverage denial. Alternatively, a request for expedited external review may be faxed; employee-beneficiary or dependent-beneficiary contact information and coverage denial description, and supporting documentation may be faxed or emailed to the attention the self-insured plan administrator's external review appeals department. All requests for expedited review must be clearly identified as "urgent" at submission.
- (13) Preliminary review. Immediately on receipt of an employee-beneficiary or dependent-beneficiary's request for expedited

external review, the self-insured plan administrator will determine whether the request meets the reviewability requirements described above for standard external review. Immediately upon completing this review, the self-insured plan administrator will notify the employee-beneficiary or dependent-beneficiary that: (i) the employee-beneficiary or dependent-beneficiary's request for external review is complete, and may proceed; (ii) the request is not complete, and additional information is needed (along with a list of the information needed to complete the request); or (iii) the request for external review is complete, but not eligible for review.

- (14) Referral to IRO. Upon determining that an employee-beneficiary or dependent-beneficiary's request is eligible for expedited external review, the self-insured plan administrator will assign an IRO to review the employee-beneficiary or dependent-beneficiary's claim. The self-insured plan administrator will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final adverse benefit determination to the assigned IRO electronically, by telephone, by fax, or by any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information and documents described above. In reaching a decision on an expedited request for external review, the IRO will review the employee-beneficiary or dependent-beneficiary's claim de novo and will not be bound by the decisions or conclusions reached on behalf of the Fund during the internal claims and appeals process.
- (15) Timing of the IRO's determination. The IRO must provide the employee-beneficiary or dependent-beneficiary and the self-insured plan administrator, on behalf of the Fund, with notice of its determination as expeditiously as the employee-beneficiary or dependent-beneficiary's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the employee-beneficiary or dependent-beneficiary's request for external review. If this notice is not provided in writing from the IRO and is provided orally, within forty-eight (48) hours after providing the oral notice, the IRO will provide the employee-beneficiary or dependent-beneficiary and the self-insured plan

administrator, on behalf of the Fund, with written confirmation of its decision.

- (16) Authority for review. The self-insured plan administrator will be responsible only for conducting the preliminary review of an employee-beneficiary or dependent-beneficiary's request for external review, ensuring that the individual is timely notified of the decision as to eligibility for external review, and for assigning the request for external review to an IRO. The actual external review of an employee-beneficiary or dependent-beneficiary's appeal will be conducted by the assigned independent review organization (IRO). The self-insured plan administrator is not responsible for the conduct of the external review performed by an IRO.
- (e) Facility of payment. If the Fund administrator or its designee determines that an employee-beneficiary or dependent-beneficiary cannot submit a claim or prove that an employee-beneficiary or dependent-beneficiary paid any or all of the charges for health care services that are covered by the Fund because an employee-beneficiary or dependent-beneficiary is incompetent, incapacitated or in a coma, the Fund may, at its discretion, pay Fund benefits directly to the health care provider(s) who provided the health care services or supplies, or to any other individual who is providing for an employee-beneficiary or dependent-beneficiary care and support. Any such payment of Fund benefits will completely discharge the Fund's obligations to the extent of that payment. Neither the Fund, administrator, claim administrator nor any other designee of the Fund administrator will be required to see to the application of the money so paid.
- (f) Discretionary authority of Fund administrator and designees. In carrying out their respective responsibilities under the Fund, the Fund administrator or its designee, other plan fiduciaries, and the self-insured plan administrator, have full discretionary authority to interpret the terms of the plan and to determine eligibility and entitlement to Fund benefits in accordance with the terms of the Fund. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

- (g) Elimination of conflict of interest. To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

- (h) Limitation on when a lawsuit may be started. An employee-beneficiary or dependent-beneficiary or any other claimant may not start a lawsuit to obtain Fund benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Fund's claim appeal review procedures described in this document) for every issue deemed relevant by the claimant, or until ninety (90) days have elapsed since an employee-beneficiary or dependent-beneficiary filed a request for appeal review if an employee-beneficiary or dependent-beneficiary have not received a final decision or notice that an additional sixty (60) days will be necessary to reach a final decision. No lawsuit may be started more than three years after the end of the year in which services were provided.

3.00 ELIGIBILITY FOR ENROLLMENT

- 3.01 Health Benefits
- 3.02 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 partner of an employee who is killed in the performance of the employee's duty or of a deceased retired employee, provided the surviving spouse or partner does not remarry or enter into another 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 limiting age, as defined in Rule 1.02 or is an adult disabled child in accordance with Rule 3.01(b)(3) and does not have a surviving parent who is eligible to be an employee-beneficiary; and
- (5) The unmarried child of a deceased retired employee, provided the child is under the limiting age, as defined in Rule 1.02, and does not have a surviving parent who is eligible to be an employee-beneficiary.

With respect to subsection (3) above, a surviving spouse or partner ceases to be an eligible employee-beneficiary once the spouse or partner remarries or enters into another partnership even though the spouse or partner may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of partnership, termination of a civil union or death. A surviving partner shall not cease to be eligible under subsection (3) 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 or civil union partner" in Rule 1.02. With respect to subsection (4) and (5), an unmarried child ceases to be eligible as of midnight of the birthday in which the child reaches the limiting age, as defined in Rule 1.02.

Notwithstanding any other provision in these rules to the contrary, a retired employee-beneficiary who is eligible to enroll in the Medicare Part B medical insurance plan shall not be eligible for medical or prescription drug coverage offered or sponsored by the Fund until the employee-beneficiary's Medicare Part B medical insurance plan is effective and provides satisfactory proof to the Fund of that enrollment as defined by the Fund.

An employee-beneficiary who is in Cancellation Non-Payment Status is not eligible for enrollment in Fund health benefit plans until the plan year following the cancellation. The employee-beneficiary may enroll during the Fund's open enrollment period or upon experiencing a mid-year qualifying event in a plan year following the cancellation.

- (b) Dependent-beneficiaries of active employees. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund for active employees:
- (1) An employee-beneficiary's spouse or partner;
 - (2) An employee-beneficiary's, spouse's or partner's child, provided the child is under the limiting age, as defined in Rule 1.02 for excepted and non-excepted benefits;
 - (3) An employee-beneficiary's, spouse's or 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. A child under this Rule is not required to live with the employee-beneficiary; but, ceases to be an eligible dependent-beneficiary once he/she marries or enters into a partnership even though he/she may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of partnership, termination of civil union or death; and
 - (4) A child for whom an employee-beneficiary must provide health benefit coverage under the terms of a qualified medical child support order provided the child is under the limiting age as defined in Rule 1.02.

With respect to subsection (2) above, an unmarried child ceases to be eligible as of midnight of the child's nineteenth or twenty-fourth birthday for excepted benefits as defined in Rule 1.02, as applicable. For non-excepted benefits, coverages are terminated at the end of the month in

which the child turns twenty-six. With respect to subsections (2) and (3), the child of a spouse or partner ceases to be eligible upon a divorce, the dissolution of the domestic partnership or termination of the civil union partnership. In addition, as a condition of eligibility for any child age nineteen up to twenty-four for excepted benefits as defined in Rule 1.02, 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.

- (c) Dependent-beneficiaries of retired employees. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund for retired employees:
- (1) An employee-beneficiary's spouse or partner;
 - (2) An employee-beneficiary's, spouse's or partner's unmarried child, provided the child is under the limiting age, as defined in Rule 1.02;
 - (3) An employee-beneficiary's, spouse's or 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. A child under this Rule is not required to live with the employee-beneficiary; but, ceases to be an eligible dependent-beneficiary once he/she marries or enters into a partnership even though he/she may subsequently become single again as a result of an annulment, divorce, legal separation, dissolution of partnership, termination of civil union or death; and
 - (4) A child for whom an employee-beneficiary must provide health benefit coverage under the terms of a qualified medical child support order provided the child is under the limiting age as defined in Rule 1.02.

With respect to subsection (2) above, 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 spouse or partner ceases to be eligible upon a divorce, the dissolution of the domestic partnership or termination of the civil union partnership. In addition, as a condition of eligibility for any child age nineteen up to twenty-four, 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 medical or prescription drug coverage under any retiree benefit plan offered or sponsored by the Fund until the dependent-beneficiary's Medicare Part B medical insurance plan is effective and provides satisfactory proof to the Fund of that enrollment as defined by the Fund.

3.02 Group Life Insurance

Employees and retired employees are eligible to enroll for any group life insurance plans offered or sponsored by the Fund.

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 Regular Open and Additional Limited Enrollment Periods
- 4.09 Continuation of Coverage
- 4.10 Contribution Shortage
- 4.10.5 Contribution Refund
- 4.11 Cancellation of Enrollment; Effective Dates of Cancellation
- 4.12 Termination of Enrollment; Effective Dates of Termination
- 4.13 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 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 and thereafter, 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 Fund.
- (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.
- (c) 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.

- (d) 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 as provided by State and Federal law; 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 is ineligible due to outstanding past due contributions or other amounts to the Fund, or is ineligible due to Cancellation Non-Payment Status; 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

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 children be enrolled by more than one employee-beneficiary. The Fund shall cancel such dual coverage enrollments.

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's employer; (2) in the case of a retired employee, surviving spouse or partner under Rule 3.01, and unmarried child under Rule 3.01, the Fund; (3) or others, as specified by the Fund. However, if filed before the time or times prescribed in these rules, an enrollment application, 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 and any required proof documents within forty five (45) days of the specified event that allows the filing of the application except for the following events: (1) termination of employment for which the enrollment application must be filed within thirty (30) days of the termination of employment; (2) newborns for which the enrollment application and required proof documents must be filed within one hundred eighty (180) days of the birth; (3) retirement, and surviving spouse, partner or child who become eligible as an employee-beneficiary under Rule 3.01 for which an enrollment application and required proof documents must be filed within sixty (60) days of the event.

- (b) An employee-beneficiary who fails to file an enrollment application and required proof documents within the time prescribed by subsection (a) above or any otherwise applicable rule shall result in the rejection of the requested enrollment changes and not be permitted to file that application until the next regular open or additional limited 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 partnership status, 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 employee-beneficiary or dependent-beneficiary's enrollment shall be cancelled as set forth in Rule 4.11(c).

4.08 Regular Open and Additional Limited Enrollment Periods

Except as otherwise provided by these rules, an employee-beneficiary may file an enrollment application during a regular open or additional limited enrollment period to make any one or a combination of enrollment changes that have been approved by the board for that regular open or additional limited 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 regular open or additional limited enrollment period.

4.09 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-beneficiary'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 the same public employer within the same pay period or the next consecutive pay period, the employee shall be considered as having transferred employment, such as when the employee terminates employment with the state and is rehired with the state, or when the employee terminates employment with a county and is rehired by the same county. 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. When an employee terminates employment and is rehired by a different public employer within the same pay period or the next consecutive pay period, such as when the employee terminates employment with the state and is hired by a county or terminates one county and is rehired by a different county, the employee shall be allowed to change between plans, including adding or dropping dependents and changing tiers. Notwithstanding the definitions of "employer" and "public employer" set forth and used in these rules, for purposes of this section only, the different public employers are: 1) State, including executive, legislative, and judicial branches, Department of Education, University of Hawaii, Hawaii Health Systems Corporation, Office of Hawaiian Affairs, and all Charter Schools; 2) City and County of Honolulu; 3) County of Hawaii; 4) County of Maui, and 5) County of Kauai. Changes shall become effective at the beginning of the next pay period in which the termination of employment occurred, without a break in coverage.

4.10 Contribution Shortage

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 or 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 (30) days of the date on which the required semi-monthly or monthly contribution payment was due. Cancellation of the employee-beneficiary's enrollment due to any contribution shortage shall be as per Rule 4.11(b), and reinstatement of the employee-beneficiary's enrollment after any such cancellation shall be as per Rule 4.13(b).

4.10.5 Contribution Refund

The Fund may refund employee-beneficiaries or dependent-beneficiaries any amounts deemed owing, provided that at the time of the disbursement of such refunds, no refund need be made where the amount thereof is less than one dollar.

4.11 Cancellation of Enrollment; Effective Dates of Cancellation

- (a) 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 by the Fund 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 by the Fund in writing after the effective date of the enrollment, but at least thirty (30) days in advance, the enrollment may be canceled retroactively (a rescission) to the date the person was ineligible if cancellation is due to Fraud or Intentional Misrepresentation of a material fact, as defined in Rule 1.02 or
 - (3) When the person is notified by the Fund in writing after the effective date of the enrollment, the enrollment will be cancelled prospectively effective the first day of the first pay period following the date that ineligibility is determined by the Fund. Employee-beneficiaries may be liable for the employer portion of

premiums paid for any ineligible person and/or any benefits that were provided as per Rule 4.12(d).

- (b) Cancellation Due to Failure to Pay Contribution Shortage. If an employee-beneficiary does not make full payment of all contributions due within thirty (30) days of the date of the notice of contribution shortage in Rule 4.10, the employee-beneficiary's enrollment in all health benefit plans, and all dependent-beneficiaries' health benefit plans 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 and the employee-beneficiary will be ineligible for fund health benefits. If an employee-beneficiary is currently on a leave of absence covered under the Family Medical Leave Act (FMLA), the employee-beneficiary and dependent beneficiary(s) enrollment in all health benefit plans shall be cancelled thirty (30) days from the date of the notice of contribution shortage. The employee-beneficiary may only apply for a new enrollment as per Rule 4.13(a). However, the enrollment and eligibility for benefits of the employee-beneficiary and his or her dependent-beneficiaries may be reinstated as provided in Rule 4.13(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.
- (c) 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 thirty (30) days advance written 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.
- (d) Cancellation Due to Acquiring Coverage From a Non-Fund Plan. An employee-beneficiary or dependent-beneficiary may cancel enrollment in



a Fund benefit plan upon acquiring coverage from a non-Fund plan or when moving to a country in which they are eligible for publicly provided healthcare or similar, by filing an enrollment application to the employee-beneficiary's employer or, if none, directly with the Fund requesting cancellation. The enrollment application must be filed with the employee-beneficiary's employer, or, if none, directly to the Fund within forty five (45) days of acquiring coverage from the non-Fund plan or moving to another country as noted above. The effective date of cancellation shall be the end of the pay period in which the employee-beneficiary or dependent-beneficiary moves to another country as noted above or acquires coverage from the non-Fund plan, except when the employee-beneficiary or dependent-beneficiary acquires coverage from the non-Fund plan on the first or the sixteenth of the month, in which case coverage ends at the end of the prior pay period.

The Fund shall determine the required proof documents.

- (e) Cancellation When Beginning a Leave of Absence Without Pay. An employee-beneficiary may voluntarily cancel enrollment in all Fund benefit plans when beginning a leave of absence without pay that is expected to last more than one month. An enrollment application must be filed with the employee-beneficiary's employer requesting cancellation of all plans within forty five (45) days of the beginning of the leave of absence without pay. The effective date of the cancellation shall be the end of the pay period during which the leave of absence without pay begins. Employee-beneficiaries who cancel coverage in accordance with this section may re-enroll in the same benefit plans upon return from the leave of absence without pay by completing an enrollment application and submitting it to the employee-beneficiary's employer within forty five (45) days of returning from the leave of absence.

4.12 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, provided the termination is not retroactive. If, by virtue of an administrative error,



coverage continues to be provided by the Fund, and paid for by the employee-beneficiary, the effective date of cancellation shall be the last day of the pay period following the date of issuance of a thirty (30) days written notice. Employers shall submit to the Fund the enrollment application within thirty (30) days of the change in employment status causing termination of enrollment. Employers submitting enrollment applications after thirty (30) days of the change in employment status may be responsible for 100% of the premiums, both employer and employee contributions, until such termination.

- (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 upon thirty (30) days advance written notice 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. 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 within forty five (45) days. All such notices shall be in writing and shall be sent to the Fund.
- (d) Recovery of Benefits. In all situations in which an ineligible person receives benefits under the Fund, or the employee-beneficiary or dependent-beneficiary files fraudulent claims for benefits per Rule 4.12(b), the Fund shall be entitled to seek recovery of any benefits that were provided to any person or seek recovery of the employer contributions paid for any ineligible person after an event that terminated the person's enrollment or that otherwise made that person ineligible for continued enrollment or coverage by the benefit plans offered or sponsored by the Fund. In seeking to recover benefits under this rule and in situations in which the Fund overpays amounts to an employee-beneficiary or dependent-beneficiary, 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 payments to the person whose

enrollment was terminated, who otherwise ceased to be eligible for continued enrollment or coverage in the Fund's benefit plans or who was overpaid.

4.13 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 open enrollment period or upon experiencing a mid-year qualifying event in any plan year following the cancellation. 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 4.11(b), 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 within sixty (60) days from the date of the notice of cancellation in accordance with cancellation of enrollment under Rule 4.11(b) and whose enrollment has not been cancelled under Rule 4.11(b) within twelve (12) months of the date of the notice of cancellation. The reinstatement shall be made so that the employee-beneficiary and his or her dependent-beneficiaries shall suffer no break in coverage. Employee-beneficiaries who are currently on leave of absence covered under the FMLA or Uniform Services Employment and Reemployment Rights Act (USERRA) shall be allowed to re-enroll in coverage as per Rule 5.06(c).

- (c) Reinstatement Upon Return From Lawful Strike. If an employee-beneficiary's enrollment is cancelled for non-payment during a lawful strike, the employee-beneficiary may re-enroll upon return from the lawful

strike without the requirement to pay back premiums and without coverage during the non-payment period under the following conditions:

- (1) The employee-beneficiary files an enrollment application within forty five (45) days of returning from the lawful strike, and
- (2) The employee-beneficiary and any covered dependent-beneficiaries had no covered services during the non-payment period.
- (3) The employee-beneficiary enrolls in the same plans and at the same tier the employee-beneficiary was enrolled in prior to the lawful strike.

The effective date of coverage shall be the date the employee-beneficiary returns from the lawful strike.

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 Enrollment in Medicare Part B and Medicare Part D for Retired Employees and Cancellation Due to Failure to Enroll
- 5.04 Cancellation Due to Failure to Enroll or Failure to Maintain Enrollment in Medicare; Effective Date of Cancellation
- 5.05 Termination of Enrollment; Effective Dates of Termination
- 5.06 Reinstatement of Enrollment; Effective Dates of Reinstatement
- 5.07 Reimbursement of Retired Employee-Beneficiaries and Their Dependent-Beneficiaries Who Relocate Outside of the State of Hawaii

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 eligible as an employee as defined in 87A-1, Hawaii Revised Statutes. 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 eligible; or (2) the first day of the first pay period following the date the employee-beneficiary is first eligible; or (3) the first day of the second pay period following the date the employee-beneficiary is first eligible. The employee-beneficiary shall select the effective date of coverage in an enrollment application that must be filed within forty five (45) days of the date that the employee-beneficiary is first eligible. If the employee-beneficiary fails to make an effective date of coverage selection, the effective date of coverage shall be the date the employee-beneficiary is first eligible.
- (b) 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 if a properly completed enrollment application is filed within forty five (45) days of the loss of coverage. The employee-beneficiary may only enroll during the next open enrollment period when the enrollment application is received more than forty five (45) days after the loss of coverage.

- (c) 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's coverage under non-Fund health benefit plans is terminated. The effective date of coverage shall be the date of the employee-beneficiary's loss of coverage if a properly completed enrollment application is filed within forty five (45) days of the loss of coverage. The employee-beneficiary may only enroll during the next open enrollment period when the enrollment application is received more than forty five (45) days after the loss of coverage. The Fund shall determine the required proof documents.
- (d) Enrollment Due to Changes in Marital, 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, partnership or family status, e.g., marriage, entry into a domestic or civil union partnership, birth, adoption, guardianship, or issuance of a qualified medical child support order. At the option of the employee-beneficiary, the effective date of coverage shall be one of the following dates: (1) the date of the event; or (2) the first day of the first pay period following the date of the event; or (3) the first day of the second pay period following the event, except for a qualified medical child support order, which shall be limited to the date of the event. The date of the event shall be:
- (1) For marriages the date on the marriage certificate;
 - (2) For civil unions the date on the civil union certificate;
 - (3) For domestic partnerships the date the notary notarizes the Declaration of Domestic Partnership;
 - (4) For births the date of birth;
 - (5) For adoptions the date of the adoption;

- (6) For placement of adoption or guardianships the date of guardianship;
- (7) For placement of a foster child the date indicated on the State of Hawaii Department of Human Services Form 1564, Admission to Foster Home; and
- (8) For 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.
- (9) For dependent-beneficiary joining the employee-beneficiary's household, the date the dependent-beneficiary joins the household.

The employee-beneficiary shall select the effective date of coverage in an enrollment application that must be filed within forty five (45) days of the date of the event, except for newborns which is within one hundred eighty (180) days of the birth. If the employee-beneficiary fails to make an effective date of coverage selection, the effective date of coverage shall be the date of the event. The Fund shall determine the required proof documents.

- (e) 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 becomes a retired member of the Employees' Retirement System as defined in 87A-1, Hawaii Revised Statutes. The effective date of the coverage shall be the first of the month on or after the employee-beneficiary's date of retirement provided a completed enrollment application is received by the Fund within sixty (60) days of retirement.

For disability retirement, at the option of the employee-beneficiary, the effective date of coverage shall be the first of the month on or after the employee-beneficiary's date of retirement or the 1st of the month of the date of the Employees' Retirement System disability certification letter provided that a completed enrollment application is received by the Fund within 60 days of certification from the Employees' Retirement System of a disability retirement.

Retired employee beneficiaries shall be eligible to enroll in the Fund's health benefit plans during the next open enrollment period for enrollment applications received more than sixty (60) days after the date of retirement.

- (f) Surviving Spouse, Partner, or Child of a Deceased Retiree Not Enrolled in the Fund or an Employee Who was Killed in the Performance of Duty Who Was Not Enrolled in the Fund. A surviving spouse, 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 the date the retiree passed away or the date the employee was killed in the performance of duty, provided a completed enrollment application is received by the Fund within sixty (60) days of the retiree passing away or within sixty (60) days of the date the employee was killed in the performance of duty for dependents not enrolled at the time of death. Surviving spouses, partners, or unmarried children of a deceased retiree or an employee who was killed in the performance of duty shall be eligible to enroll in the Fund's health benefit plans during the next open enrollment period for enrollment applications received more than sixty (60) days after the passing away of the retiree or more than sixty (60) days after the date the employee was killed in the performance of duty.
- (g) 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, Partnership, Legal Guardianship, 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 a partnership, birth of a child, adoption of a child, addition of a foster child, the issuance of a qualified medical support order, or when a dependent-beneficiary joins the employee-beneficiary's household. At the option of the employee-beneficiary, the effective date of the change in enrollment shall be one of the following dates: (1) the date of the event; or (2) the first day of the first pay period following the date of the event; or (3) the first day of the second pay period following the event, except for a qualified medical support child support order, which shall be limited to the date of the event, provided an enrollment application is filed with the employer for active employee-beneficiaries and to the Fund for retirees within forty five (45) days of the event, except in the event of a birth of a child in which case the enrollment application shall be filed with the employer or in the case of a retired employee-beneficiary with the Fund within one hundred eighty (180) days of the birth.
- (1) With respect to the addition of a spouse or civil union partner, as well as dependent(s) of a new spouse or civil union partner, the event date shall be the date indicated on the marriage or civil union certificate.
 - (2) With respect to the addition of a domestic partner, as well as the dependent(s) of a domestic partner, the event date shall be the date the notary notarizes the Declaration of Domestic Partnership.
 - (3) With respect to the birth of a child, the event date shall be the birth date.
 - (4) With respect to the addition of a foster child, the event date shall be the date indicated on the State of Hawaii Department of Human Services Form 1564, Admission to Foster Home.
 - (5) With respect to the adoption of a child, the event date shall be the date of the adoption (which may occur up to 1 year after the child was initially placed for adoption). For placement of adoption or legal guardianship, the event date shall be the date of guardianship.
 - (6) With respect to a qualified medical child support order, the event date shall be the date specified in the order, or if no date is specified, the date that the order is issued.

- (7) With respect to a dependent-beneficiary joining the employee-beneficiary's household; the event date shall be the date the dependent-beneficiary joined the employee-beneficiary's household if the dependent-beneficiary lived in a residence outside of the geographic areas covered by the employee-beneficiary's present benefit plan.

The Fund shall determine the required proof documents for each of the above events.

- (b) Deletions of Dependents Due to Changes in Marital, Partnership or Family Status, or Legal Guardianship. 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 a partnership; death of a spouse, partner or child; the end of any required coverage of a child under a qualified medical support order; a child ceases to be eligible for coverage under Rule 3.01 or a dependent covered due to legal guardianship turns the age of 18 (age of majority). The effective date of change in coverage shall be the first day of the first pay period following the occurrence of the event. Enrollment applications must be filed with the employer or in the cases of retirees to the Fund within forty-five (45) days of the event. Employee-beneficiaries may be responsible for paying all claims incurred, reimbursements received or employer contributions paid for any ineligible person after the event date for enrollment applications filed more than forty five (45) days after the event pursuant to Rule 4.12(c).

The Fund shall determine the required proof documents.

- (c) Loss of Spouse's or Partner's Coverage. An employee-beneficiary may change enrollment to add a spouse or partner, as well as the spouse or partner's dependents, 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 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 partner lost coverage in the spouse's or partner's health benefit plan, provided an enrollment application is received by the employer or in the case of a retiree by the



Fund within forty five (45) days of the loss of coverage. Coverage for a spouse or partner may be added at the next open enrollment period when enrollment applications are received after forty five (45) days of the loss of coverage.

The Fund shall determine the required proof documents.

- (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 reaches the limiting age, as defined in Section 1.02 (unless the child is an adult disabled child under Section 3.01). An enrollment application shall be filed with the employer or in the case of a retiree with the Fund within forty five (45) days of the loss of eligibility. The effective date of the change in enrollment shall be the first day of the first pay period following the loss of eligibility.
- (e) Changes Between Plans. An employee-beneficiary may change between health benefit plans offered or sponsored by the Fund when:
- (1) The employee-beneficiary or dependent-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 first day of the pay period following the employee-beneficiary or dependent-beneficiary's relocation except for retired employee-beneficiaries and dependent-beneficiaries enrolled in a Medicare medical and/or prescription drug plan.

For retired employee-beneficiaries and dependent-beneficiaries enrolled in a Medicare medical and/or prescription drug plan, the effective date of the change shall be made prospectively at the end of the month of the relocation or the end of the month in which the EUTF is notified, whichever is later.
 - (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. The requirements of Rule 5.01(c) apply, except for the cancellation of the

supplemental health benefits plan which will be cancelled upon notification of the loss of the primary coverage in the Non-Fund health benefits plan.

- (3) The employee-beneficiary is enrolled in a health benefits plan sponsored by the Fund and gains coverage under a Non-Fund health benefits plan. The employee-beneficiary may enroll in a supplemental health benefit plan offered or sponsored by the Fund. The effective date of the change shall be the first day of the pay period following the cancellation of the health benefits plan sponsored by the Fund.
- (4) With respect to a qualified medical child support order, if an employee-beneficiary is enrolled in a plan whose services are limited to the State of Hawaii and whose dependent subject to the qualified medical child support order lives outside the State of Hawaii, the employee-beneficiary shall be allowed to change their plan selection to one whose services are available to the dependent.

The Fund shall determine the required proof documents.

- (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(g), 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 and Medicare Part D for Retired Employees and Cancellation Due to Failure to Enroll

- (a) Retired employee-beneficiaries or dependent-beneficiaries of retirees shall submit 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 if enrolled in a medical and/or prescription drug plan.

Failure to provide proof of enrollment in Medicare Part B within sixty (60) days of eligibility shall result in loss of medical and/or prescription drug coverage retroactive to the date of Medicare Part B medical insurance plan eligibility.

- (b) Employee-beneficiaries who retire and are eligible for Medicare Part B at the time of retirement and their dependent beneficiaries who are eligible for Medicare Part B at the time of the employee-beneficiary's retirement shall provide proof of enrollment in Medicare Part B at the time of retirement or within sixty (60) days of retirement. Failure to provide proof of enrollment in Medicare Part B within sixty (60) days of retirement shall result in loss of medical and/or prescription drug coverage retroactive to the date of retirement.
- (c) Retired employee-beneficiaries and their spouses/partners shall be reimbursed quarterly the cost of their Medicare Part B premiums, including Income Related Monthly Adjustment Amount (IRMAA) Medicare Part B premiums, less penalties. Reimbursements shall be made using direct deposit unless the method of payment is waived by the Fund and another method is determined to be more appropriate.
- (1) Medicare Part B premium reimbursements shall be effective the date the Medicare Part B is effective or the first day of the month that the fund receives appropriate proof of enrollment in Medicare Part B and a valid direct deposit agreement, whichever is later. In addition, proof of payment to the Social Security Administration or Centers for Medicare & Medicaid Services is required to begin Medicare Part B reimbursements.
- (2) If a retired employee-beneficiary's direct deposit is returned by the financial institution or check is returned as undeliverable, a notice from the Fund will be sent to the retired employee-beneficiary. The retired employee-beneficiary has sixty (60) days from the date of the notice to submit a valid direct deposit agreement or a retiree address change form (returned check) to avoid a break in their reimbursement. Failure to provide a valid direct deposit agreement or a retiree address change form (returned check) within sixty (60) days of the date of the notice will result in cancellation of Medicare Part B premium reimbursements retroactive to the first day of the month of the quarter that the direct deposit was returned or when the check was returned undeliverable. If the reimbursement is cancelled, the retired employee-beneficiary's Medicare Part B premium reimbursements can be reinstated when a valid direct deposit agreement or a retiree address change form (returned check) is received with an effective date of the first day

of the month that the valid direct deposit agreement or the retiree address change form (returned check) is received.

- (3) Retired employee-beneficiaries and/or their spouses/partners shall provide the Fund appropriate proof of an IRMAA added to their Medicare Part B premium. If proof is submitted to the fund more than two years after the effective date of the IRMAA premium, the fund shall only reimburse for a two year retroactive period, subject to 5.03(c)(1).
- (4) Each public employer shall pay to the Fund a contribution equal to the amount paid by the Fund to the retired employee-beneficiaries and their spouses/ partners.

Payment of these reimbursements shall be made only for retired employee-beneficiaries and/or their spouses/partners 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 or Centers for Medicare & Medicaid Services.

- (d) Retired employee-beneficiaries and dependent-beneficiaries whose medical and/or prescription drug coverages were cancelled due to failure to show proof of enrollment in Medicare Part B may be reinstated in the same medical and/or prescription drug plans upon proof of enrollment in Medicare Part B. The effective date of coverage shall be the later of the effective date of the Medicare Part B coverage or the medical and/or prescription drug coverage enrollment date.
- (e) Retired employee-beneficiaries and their dependent-beneficiaries eligible for Medicare shall be enrolled in a Fund Medicare prescription drug plan if they wish to enroll in a Fund retiree prescription drug plan. Exceptions to this Rule include employee-beneficiaries and/or dependent-beneficiaries who reside outside of the Fund's Medicare prescription plan service area.

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

- (a) If a retired employee-beneficiary's federal Medicare Part B medical insurance plan is not in effect when he/she is eligible to enroll, the retired employee-beneficiary's enrollment in the medical and/or prescription drug plans offered or sponsored by the Fund and the medical and/or

prescription drug plan coverages for dependent-beneficiaries under that enrollment shall be cancelled.

- (b) If a retired employee-beneficiary's dependent-beneficiary's federal Medicare Part B medical insurance plan is not in effect when he/she is eligible to enroll, the dependent-beneficiary's enrollment in the medical and/or prescription drug plans offered or sponsored by the Fund shall be cancelled.
- (c) If a retired employee-beneficiary and/or dependent-beneficiary fails to enroll in the Fund's Medicare prescription drug plan their enrollment in the prescription drug plans offered or sponsored by the Fund shall be cancelled. Retired employee-beneficiaries and/or their dependent-beneficiaries living outside of the Fund's Medicare prescription drug plan's service area are exempt from this Rule.
- (d) The effective date of any cancellation under this rule shall be the date upon which the retired employee-beneficiary or their dependent-beneficiary, as applicable, first became eligible to enroll or ceased to be enrolled in the federal Medicare Part B medical insurance plan. The retired employee-beneficiary or their dependent-beneficiary shall be responsible for paying all claims incurred from the date the retired employee-beneficiary or their dependent-beneficiary became eligible to enroll, but did not enroll.

5.05 Termination of Enrollment; Effective Dates of Termination

- (a) Termination Due to Surviving Spouse's or Partner's Remarriage or Entry into Another Partnership. A surviving spouse's or 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 partner's remarriage or entry into another 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 partner's remarriage or entry into another partnership. The surviving spouse or partner shall be responsible for paying all claims incurred or for the employer contributions paid from the first day of the pay period following the date of the surviving spouse's or partner's remarriage or entry into a partnership for enrollment applications received more than forty five (45) days after the remarriage or entry into another partnership. Notwithstanding the foregoing, a child that is eligible to be an employee-beneficiary under Rules 3.01(a)(4) or Rule 3.01(a)(5) may continue his or



her coverages by filing an enrollment application under Rule 5.01(f). The effective date of coverage shall be the date of termination of coverage due to the surviving spouse's or partner's remarriage or entry into a 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 reaches the limiting age, as defined in Section 1.02 and does not qualify as an adult disabled child under Section 3.01; or
 - (2) The employee-beneficiary fails to complete a legal adoption of the child within twelve (12) months of the date that the child is covered by the Fund's benefit plans; or
 - (3) The child no longer meets the requirements to be considered an adult disabled child as stated in Section 3.01.

With regards to subsection (1), a child that reaches the limiting age, as defined in Section 1.02, whose coverages were cancelled due to failure to show proof of student certification, may be reinstated with no break in coverage in the same benefit plans upon submission of proof documents within forty five (45) days of the birthdate.

Notwithstanding Rule 5.05 (b)(2), 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.

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)(2), 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 specified by the order or award. The employee-beneficiary shall pay 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: (1) the employee-beneficiary's return to employment; or (2) the first day of the first pay period following the employee-beneficiary's return to employment; or (3) the first day of the second pay period following the employee-beneficiary's return to employment. The employee-beneficiary shall select the effective date of coverage in an enrollment application filed within forty five (45) 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 forty five (45) 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 file an enrollment application within forty five (45) days of his or her return to work, the employee-beneficiary shall be eligible to reenroll during the next open enrollment period.
- (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 forty five (45) days of the date that the employee-beneficiary returns to work. If the employee-beneficiary fails to make a start date selection, the effective date of coverage shall be the date of the employee-beneficiary's return to work. If the employee-beneficiary fails to file an enrollment application within forty five (45) days of his or her return to work, 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.

- (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) Enrollment in Medicare Advantage Plan by a Retired Employee. If the enrollment of a retired employee-beneficiary or their dependent-beneficiary was terminated due to failure to enroll in the Fund's Medicare Advantage plan, their coverage shall be reinstated effective the first of the month in which the Fund or their health insurance carrier receives a properly completed enrollment application.
- (f) 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(g),



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.

5.07 Reimbursement of Retired Employee-Beneficiaries and Their Dependent-Beneficiaries Who Relocate Outside of the State of Hawaii

- (a) Retired employee-beneficiaries and their dependent-beneficiaries of retirees who relocate outside of the State of Hawaii shall be eligible for reimbursement for premiums paid for personal medical and prescription drug plans issued by companies outside of the State of Hawaii who have also contracted with the Fund to provide medical and prescription drug plans that are only available to State of Hawaii residents.
- (b) The reimbursement shall be the lesser of:
 - (1) The actual cost of the personal medical and prescription drug plan; or
 - (2) The amount of the state or county contribution for the most comparable medical and prescription drug plan offered by the Fund.
- (c) Retired employee-beneficiaries or dependent-beneficiaries shall provide the Fund appropriate proof of premiums paid. Reimbursements are paid by the Fund in arrears on a quarterly basis upon receipt of documentation that the premiums for an individual health insurance policy has been paid by the retired employee-beneficiary. If proof is submitted more than two years after the premiums were paid, the Fund shall only reimburse for a two year retroactive 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, August 26, 2009, August 4, 2014, December 9, 2015, June 30, 2016, July 25, 2017, June 26, 2018, and August 27, 2019. The rules shall take effect on the first day after filing with the Lieutenant Governor's Office.



Christian Fern, Chairperson
Hawaii Employer-Union Health
Benefits Trust Fund

APPROVED



10-08-19

David Y. Ige
Governor
State of Hawaii

Date Filed, Office of the Lieutenant
Governor

APPROVED AS TO FORM:



Deputy Attorney General

19 OCT -8 100 61

LIEUTENANT GOVERNOR'S
OFFICE

EXHIBIT D

CONTRACT FORM 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 _____

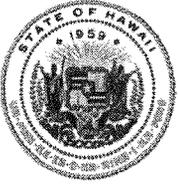
Print Title _____

Name of Contractor _____

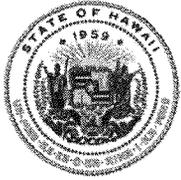
Date _____



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. Head of the purchasing agency 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 and ten per cent (10%) or more of the initial contract price, must receive the prior approval of the head of the purchasing agency.
 - 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 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 website:

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

EXHIBIT F

BUSINESS ASSOCIATE AGREEMENT

BUSINESS ASSOCIATE AGREEMENT

This Agreement is effective as of _____, between the Hawaii Employer-Union Health Benefits Trust Fund, State of Hawai‘i (hereinafter the “STATE”), by its Administrator, whose address is 201 Merchant Street, Suite 1700, Honolulu, Hawaii 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, Hawaii 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 Hawaii, 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, Hawaii 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 Protected 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, Hawaii 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 11 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, 6, 7, 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.

HAWAII EMPLOYER-UNION HEALTH BENEFITS
TRUST FUND (“STATE”)

By _____
Its Administrator

Date: _____, 201____

[*name of business associate*]
 (“BUSINESS ASSOCIATE”)

By _____
Its _____

Date: _____, 201____

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

State
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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	

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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 (Not used) A - MedA (Not used) 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 or Medical plan code (CVS only)	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

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Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
3	Subscriber Identifier	REF02	53	10	*Member Policy Number		For CVS, this reports Medical plan code for MOOP	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*	303 338 339 350	Maintenance Effective Date Medicare B Begin Date Medicare B End Date Medical plan code (CVS file only)	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			

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Note: Content column with an asterisk refers to Valid values column

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Line	Field (element)	Ref. Des.	Ref. Page	Length	Contents	Valid Values	Description	Note
13	Member Residence Zip Code - 2	N403	69	4	<i>SubscriberZipCode2</i>			
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	<i>N3*SubscriberStreetAddress1</i>			
12	Member Residence Street Address - 2	N302	67	51	<i>*SubscriberStreetAddress2</i>			
13	Member Residence City	N401	68	19	<i>N4*SubscriberCityName</i>			
13	Member Residence State	N402	68	3	<i>*SubscriberStateAbbreviationCode</i>			
13	Member Residence Zip Code - 1	N403	69	6	<i>*SubscriberZipCode1</i>			
13	Member Residence Zip Code - 2	N403	69	4	<i>SubscriberZipCode2</i>			
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

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State
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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

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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

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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

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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 (Not used) A - MedA (Not used) 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 or Medical Plan Code (CVS only)	Loop 2000, Data Element 128
3	Subscriber Identifier	REF02	53	10	*Member Policy Number		For CVS, this reports Medical plan code for MOOP	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

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10	Member Event Date Qualifier	DTP01	59 - 60	7	DTP*	340 341 356 357 303 348 349 360 361 286 338 339 350	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 Medicare B Begin Date Medicare B End Date Medical plan code (CVS file only)	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			

Note: Reference Pages refer to the ASC X12N 834 Implementation Guide for Benefit and Enrollment Maintenance May 2000
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11	Member Middle Name	NM105	62, 81 - 82	2	* <i>MiddleInitial</i>			
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* <i>SubscriberStreetAddress1</i>			
12	Member Residence Street Address - 2	N302	67	51	* <i>SubscriberStreetAddress2</i>			
13	Member Residence City	N401	68	19	N4* <i>SubscriberCityName</i>			
13	Member Residence State	N402	68	3	* <i>SubscriberStateAbbreviationCode</i>			
13	Member Residence Zip Code - 1	N403	69	6	* <i>SubscriberZipCode1</i>			
13	Member Residence Zip Code - 2	N403	69	4	<i>SubscriberZipCode2</i>			
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* <i>SubscriberStreetAddress1</i>			
12	Member Residence Street Address - 2	N302	67	51	* <i>SubscriberStreetAddress2</i>			
13	Member Residence City	N401	68	19	N4* <i>SubscriberCityName</i>			
13	Member Residence State	N402	68	3	* <i>SubscriberStateAbbreviationCode</i>			
13	Member Residence Zip Code - 1	N403	69	6	* <i>SubscriberZipCode1</i>			
13	Member Residence Zip Code - 2	N403	69	4	<i>SubscriberZipCode2</i>			
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

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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14	Member Disability Date Format Qualifier	DTP02	126	3	*D8		Date Expressed in Format CCYYMMDD	
14	Member Disability Date	DTP03	126	9	*CCYYMMDD			
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

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	Interchange Control Number	IEA02	B.7	10	*Same number as Header Control Number			
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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

EXHIBIT H

ENROLLMENT COUNTS

The following table shows the enrollment count, by carrier as of October 31, 2019.

Plans	Total Subscribers	Total Members
<i>Active - EUTF</i>		
EUTF HMSA 90/10 PPO	3,684	5,936
EUTF HMSA 80/20 PPO	14,045	25,864
EUTF HMSA 75/25 PPO	15,430	32,021
EUTF HMSA HMO	1,061	1,656
EUTF Kaiser Comprehensive HMO	5,237	9,408
EUTF Kaiser Standard HMO	8,303	15,861
EUTF HMA Supplemental	778	2,196
<i>Active - HSTA VB</i>		
HSTA VB HMSA 90/10 PPO	1,148	2,342
HSTA VB HMSA 80/20 PPO	2,326	5,948
HSTA VB Kaiser Comprehensive HMO	860	1,965
<i>Non-Medicare Retirees - EUTF</i>		
EUTF HMSA 90/10 PPO	5,408	9,801
EUTF Kaiser Comprehensive HMO	1,061	1,824
<i>Medicare Retirees - EUTF</i>		
EUTF HMSA 90/10 PPO	31,328	43,685
EUTF Kaiser Comprehensive HMO	6,721	9,095
<i>Non-Medicare Retirees - HSTA VB</i>		
HSTA VB HMSA 90/10 PPO	34	48
HSTA VB Kaiser Comprehensive HMO	7	9
<i>Medicare Retirees - HSTA VB</i>		
HSTA VB HMSA 90/10 PPO	2,072	3,091
HSTA VB Kaiser Comprehensive HMO	228	318

EXHIBIT I

CENSUS AND NETWORK DATA

Census and network data will be supplied upon completion of the Intent to Bid Form (Attachment 2) and signed Confidentiality Agreement (Attachment 3).

EXHIBIT J

ACT 226, SLH 2013



EXECUTIVE CHAMBERS
HONOLULU

NEIL ABERCROMBIE
GOVERNOR

June 27, 2013

GOV. MSG. NO. 1329

The Honorable Donna Mercado Kim,
President
and Members of the Senate
Twenty-Seventh State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Joseph M. Souki,
Speaker and Members of the
House of Representatives
Twenty-Seventh State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kim, Speaker Souki, and Members of the Legislature:

This is to inform you that on June 27, 2013, the following bill was signed into law:

HB65 HD2 SD2 CD1

RELATING TO PRESCRIPTION DRUGS
ACT 226 (13)

Aloha
Signed
Neil Abercrombie

NEIL ABERCROMBIE
Governor, State of Hawaii

JUN 27 2013

ORIGINAL

ACT 226

on

HOUSE OF REPRESENTATIVES
TWENTY-SEVENTH LEGISLATURE, 2013
STATE OF HAWAII

H.B. NO.

65
H.D. 2
S.D. 2
C.D. 1

A BILL FOR AN ACT

RELATING TO PRESCRIPTION DRUGS.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

1 SECTION 1. The legislature finds that many pharmacy
2 benefit managers and other prescription drug benefit plan
3 providers impose certain requirements, including the requirement
4 for beneficiaries to purchase prescription drugs from a mail
5 order pharmacy. The legislature also finds that this
6 requirement can create significant hardships on beneficiaries in
7 rural areas. Recent cuts to post office hours in some neighbor
8 island communities have increased delivery times for
9 prescription mail orders. These factors may prevent
10 beneficiaries from promptly obtaining urgently needed
11 prescription drugs. Furthermore, many beneficiaries, especially
12 senior citizens, trust and rely on face-to-face interactions
13 with their local pharmacists, who are more familiar with a
14 beneficiary's medical history and who can better assist with any
15 questions relating to other prescription drugs, over-the-counter
16 medications, or potentially dangerous drug interactions.

17 Mandating prescription drug purchases by mail order denies
18 beneficiaries of this important interaction, takes away consumer



1 choice, and can create hardships for beneficiaries.
2 Accordingly, the legislature concludes that beneficiaries should
3 have the choice to purchase prescription drugs from a mail order
4 pharmacy or a local retail pharmacy.

5 The purpose of this Act is to:

- 6 (1) Specify that an otherwise qualified retail community
7 pharmacy that requests to enter into a contractual
8 retail pharmacy network agreement shall be considered
9 part of a pharmacy benefit manager's retail pharmacy
10 network for purposes of a beneficiary's right to
11 choose where to purchase covered prescription drugs;
- 12 (2) Require a prescription drug benefit plan, health
13 benefits plan under chapter 87A, Hawaii Revised
14 Statutes, or pharmacy benefit manager to permit
15 beneficiaries to fill any covered prescription that
16 may be obtained by mail order at any pharmacy of the
17 beneficiary's choice within the pharmacy benefit
18 manager's retail pharmacy network;
- 19 (3) Require a prescription drug benefit plan, health
20 benefits plan under chapter 87A, Hawaii Revised
21 Statutes, or pharmacy benefit manager to file an
22 annual report with the insurance commissioner



1 disclosing certain amounts, terms, and conditions
2 associated with a prescription drug benefit plan; and
3 (4) Require affected entities to submit a report to the
4 legislature no later than twenty days prior to the
5 convening of the regular sessions of 2014 and 2015.

6 SECTION 2. The Hawaii Revised Statutes is amended by
7 adding a new chapter to be appropriately designated and to read
8 as follows:

9 "CHAPTER

10 PRESCRIPTION DRUG BENEFITS

11 § -1 Definitions. As used in this chapter, unless the
12 context indicates otherwise:

13 "Beneficiary of a prescription drug benefit plan" or
14 "beneficiary" means a person who is a member, subscriber,
15 enrollee, or dependent of a member, subscriber, or enrollee of
16 or otherwise covered under a prescription drug benefit plan.

17 "Pharmacy benefit manager" means any person, business, or
18 entity that performs pharmacy benefit management, including but
19 not limited to a person or entity under contract with a pharmacy
20 benefit manager to perform pharmacy benefit management on behalf
21 of a managed care company, nonprofit hospital or medical service



1 organization, insurance company, third-party payor, or health
2 program administered by the State.

3 "Pharmacy benefit manager's retail pharmacy network" means
4 a retail pharmacy located and licensed in the State and
5 contracted by the pharmacy benefit manager to sell prescription
6 drugs to beneficiaries of a prescription drug benefit plan
7 administered by the manager.

8 "Prescription drug benefit plan" means an accident and
9 sickness insurance plan or health benefits plan that includes
10 coverage for prescription drugs. For the purposes of this
11 definition, a "health benefits plan" has the same meaning as in
12 section 87A-1.

13 "Prescription drug benefit plan provider" means a person
14 who provides prescription drug coverage as part of an accident
15 and health or sickness insurance contract or other type of
16 health insurance or benefits plan that is offered by the person
17 and is subject to regulation under article 10A of chapter 431,
18 chapter 432, or chapter 432D.

19 "Retail community pharmacy" means a pharmacy, permitted by
20 the board of pharmacy pursuant to section 461-14, that is open
21 to the public, dispenses prescription drugs to the general
22 public, and makes available face-to-face consultations between



1 licensed pharmacists and the general public to whom prescription
2 drugs are dispensed.

3 § -2 Retail community pharmacies; retail pharmacy
4 network; contractual agreements. (a) An otherwise qualified
5 retail community pharmacy registered to do business in this
6 State that requests to enter into a contractual retail pharmacy
7 network agreement accepting the standard terms, conditions,
8 formularies, or requirements relating to dispensing fees,
9 payments, reimbursement amounts, or other pharmacy services
10 shall be considered part of a pharmacy benefit manager's retail
11 pharmacy network for purposes of a beneficiary's right to choose
12 where to purchase covered prescription drugs under section

13 -3.

14 (b) It shall be a violation of this section for a
15 prescription drug benefit plan, health benefits plan under
16 chapter 87A, or pharmacy benefit manager to refuse to accept an
17 otherwise qualified retail community pharmacy as part of a
18 pharmacy benefit manager's retail pharmacy network.

19 (c) A contractual retail pharmacy network agreement
20 entered into under this section shall be renewed annually,
21 unless agreed to by the parties. If a prescription drug benefit
22 plan, health benefits plan under chapter 87A, or pharmacy



1 benefit manager who has entered into a contractual retail
2 pharmacy network agreement with a retail community pharmacy
3 considers such retail community pharmacy no longer otherwise
4 qualified, the prescription drug benefit plan, health benefits
5 plan under chapter 87A, or pharmacy benefit manager may appeal
6 the retail community pharmacy's qualifications with the
7 insurance commissioner.

8 (d) The insurance commissioner shall determine the
9 standards and requirements necessary for a retail community
10 pharmacy to be deemed "otherwise qualified" for purposes of this
11 section.

12 § -3 Prescription drugs; beneficiary choice; mail order
13 opt out. (a) If a retail community pharmacy enters into a
14 contractual retail pharmacy network agreement pursuant to
15 section -2, a prescription drug benefit plan, health benefits
16 plan under chapter 87A, or pharmacy benefit manager shall permit
17 each beneficiary, at the beneficiary's option, to fill any
18 covered prescription that may be obtained by mail order at any
19 retail community pharmacy of the beneficiary's choice within the
20 pharmacy benefit manager's retail pharmacy network.

21 (b) A prescription drug benefit plan, health benefits plan
22 under chapter 87A, or pharmacy benefit manager who has entered



1 into a contractual retail pharmacy network agreement with a
2 retail community pharmacy shall not:

3 (1) Require a beneficiary to exclusively obtain any
4 prescription from a mail order pharmacy;

5 (2) Impose upon a beneficiary utilizing the retail
6 community pharmacy a copayment, fee, or other
7 condition not imposed upon beneficiaries electing to
8 utilize a mail order pharmacy;

9 (3) Subject any prescription dispensed by a retail
10 community pharmacy to a beneficiary to a minimum or
11 maximum quantity limit, length of script, restriction
12 on refills, or requirement to obtain refills not
13 imposed upon a mail order pharmacy;

14 (4) Require a beneficiary in whole or in part to pay for
15 any prescription dispensed by a retail community
16 pharmacy and seek reimbursement if the beneficiary is
17 not required to pay for and seek reimbursement in the
18 same manner for a prescription dispensed by a mail
19 order pharmacy;

20 (5) Subject a beneficiary to any administrative
21 requirement to use a retail community pharmacy that is
22 not imposed upon the use of a mail order pharmacy; or



1 (6) Impose any other term, condition, or requirement
2 pertaining to the use of the services of a retail
3 community pharmacy that materially and unreasonably
4 interferes with or impairs the right of a beneficiary
5 to obtain prescriptions from a retail community
6 pharmacy of the beneficiary's choice.

7 § -4 Report to insurance commissioner. (a) No later
8 than March 31 of each calendar year, each prescription drug
9 benefit plan, health benefits plan under chapter 87A, and
10 pharmacy benefit manager shall file with the insurance
11 commissioner, in such form and detail as the insurance
12 commissioner shall prescribe, a report for the preceding
13 calendar year stating that the pharmacy benefit manager or
14 prescription drug benefit plan is in compliance with this
15 chapter. The report shall fully disclose the amount, terms, and
16 conditions relating to copayments, reimbursement options, and
17 other payments associated with a prescription drug benefit plan.

18 (b) The insurance commissioner shall review and examine
19 records supporting the accuracy and completeness of the report
20 and, no later than ninety days after the receipt of the report,
21 shall make available to a purchaser of a prescription drug
22 benefit plan and to any retail community pharmacy participating



1 in a retail pharmacy network under section -2 that provides
2 benefits to beneficiaries of a prescription drug benefit plan a
3 summary of the amount, terms, and conditions relating to
4 copayments, reimbursement options, and other payments associated
5 with a prescription drug benefit plan.

6 § -5 Violations; penalties. (a) The insurance
7 commissioner may assess a fine of up to \$10,000 for each
8 violation by a pharmacy benefit manager or prescription drug
9 benefit plan provider who is in violation of section -2
10 or -3. In addition, the insurance commissioner may order the
11 pharmacy benefit manager to take specific affirmative corrective
12 action or make restitution.

13 (b) Failure of a pharmacy benefit manager to comply with a
14 previously agreed upon contractual retail pharmacy network
15 agreement pursuant to section -2 or -3 shall be an unfair
16 or deceptive act or practice as provided in section 431:13-102.

17 (c) A pharmacy benefit manager or prescription drug
18 benefit plan provider may appeal any decision made by the
19 insurance commissioner in accordance with chapter 91.

20 § -6 Application. If this chapter or any provision of
21 this chapter conflicts at any time with any federal law, then
22 the federal law shall prevail and this chapter or the relevant



1 provisions of this chapter shall become ineffective and invalid.
2 The ineffectiveness or invalidity of this chapter or any of its
3 provisions shall not affect any other provisions or applications
4 of this chapter, which shall be given effect without the invalid
5 provision or application, and to this end, the provisions of
6 this chapter are severable.

7 § -7 Rules. The insurance commissioner may adopt rules
8 pursuant to chapter 91 to implement the requirements of this
9 chapter."

10 SECTION 3. Chapter 87A, Hawaii Revised Statutes, is
11 amended by adding a new section to be appropriately designated
12 and to read as follows:

13 "§87A- Prescription drugs; mail order opt out option. A
14 Hawaii employer-union health benefits trust fund health benefits
15 plan shall permit each beneficiary to fill any covered
16 prescription in accordance with chapter _____."

17 SECTION 4. (a) Each pharmacy benefit manager,
18 prescription drug benefit plan provider, and the Hawaii
19 employer-union health benefits trust fund shall submit a report
20 to the legislature no later than twenty days prior to the
21 convening of the regular sessions of 2014 and 2015.

22 (b) Each report shall include:



- 1 (1) The number of beneficiaries affected by the provisions
2 of this measure;
- 3 (2) The number of beneficiaries who opted out of a
4 requirement to purchase prescription drugs from a mail
5 order pharmacy or, in the case of a prescription drug
6 benefit plan subject to regulation under chapter 432D,
7 Hawaii Revised Statutes, the number of beneficiaries
8 who opt to purchase prescription drugs from a retail
9 community pharmacy; and
- 10 (3) The status of the report filed with the insurance
11 commissioner as required pursuant to section -4,
12 Hawaii Revised Statutes.

13 SECTION 5. This Act shall not apply to contracts
14 negotiated between pharmacy benefit managers and community
15 retail pharmacies with a rural pharmacy designation pursuant to
16 federal law.

17 SECTION 6. If any provision of this Act, or the
18 application thereof to any person or circumstance, is held
19 invalid, the invalidity does not affect other provisions or
20 applications of the Act that can be given effect without the
21 invalid provision or application, and to this end the provisions
22 of this Act are severable.



1 SECTION 7. New statutory material is underscored.

2 SECTION 8. This Act shall take effect upon its approval
3 and shall apply to all prescription drug benefit plans issued,
4 renewed, modified, altered, or amended on or after such
5 effective date.

APPROVED this 27 day of JUN , 2013



GOVERNOR OF THE STATE OF HAWAII



EXHIBIT K

SPECIALTY DRUGS

The specialty drugs listed below are covered in the current EGWP portion. The drugs in the Advanced Control Specialty Formulary are covered in the current Wrap portion.

ABACAVIR	BALVERSA	COMETRIQ
SULFATE/LAMIVUDI	BARACLUDE	COMPLERA
ABIRATERONE	BAVENCIO	COPAXONE
ACETATE	BELEODAQ	COPIKTRA
ACTEMRA	BENDEKA	COSENTYX
ACTEMRA ACTPEN	BENLYSTA	COSENTYX
ACTHAR	BERINERT	SENSOREADY PEN
ACTIMMUNE	BESPONSA	COTELLIC
ADCIRCA	BETASERON	CUTAQUIG
ADEFOVIR DIPIVOXIL	BETHKIS	CUVITRU
ADEMPAS	BEXAROTENE	CYRAMZA
AFINITOR	BIKTARVY	CYSTADANE
AFINITOR DISPERZ	BIVIGAM	CYSTARAN
ALDURAZYME	BORTEZOMIB	CYTOGAM
ALECENSA	BOSENTAN	DACOGEN
ALIQOPA	BOSULIF	DALFAMPRIDINE ER
ALUNBRIG	BRAFTOVI	DARZALEX
ALYQ	BUPHENYL	DAURISMO
AMBRISENTAN	CABLIVI	DECITABINE
AMPYRA	CABOMETYX	DEFERASIROX
APOKYN	CALQUENCE	DELSTRIGO
APTIVUS	CAPRELSA	DESCOVY
ARALAST NP	CARBAGLU	DOPTELET
ARANESP ALBUMIN	CAYSTON	DOVATO
FREE	CELLCEPT	DUOPA
ARCALYST	CERDELGA	DUPIXENT
ARIKAYCE	CEREZYME	EDURANT
ARZERRA	CHOLBAM	EFAVIRENZ
ASTAGRAF XL	CIMDUO	EGRIFTA
ATRIPLA	CIMZIA	ELAPRASE
AUBAGIO	CIMZIA STARTER KIT	ELELYSO
AUSTEDO	CINACALCET	EMPLICITI
AVASTIN	HYDROCHLORIDE	ENBREL
AVONEX	CINQAIR	ENBREL MINI
AVONEX PEN	CINRYZE	ENBREL SURECLICK
AZACITIDINE	COMBIVIR	ENDARI

ENTYVIO	GILOTRIF	IXEMPRA KIT
EPCLUSA	GLASSIA	JADENU
EPIDIOLEX	GLATIRAMER	JADENU SPRINKLE
EPOGEN	ACETATE	JAKAFI
EPOPROSTENOL	GLATOPA	JEVTANA
SODIUM	GLEEVEC	JULUCA
EPZICOM	GRANIX	JUXTAPID
ERBITUX	HAEGARDA	JYNARQUE
ERIVEDGE	HALAVEN	KADCYLA
ERLEADA	HARVONI	KALBITOR
ERLOTINIB	HEPSERA	KALETRA
HYDROCHLORIDE	HERCEPTIN	KALYDECO
ERWINAZE	HERCEPTIN HYLECTA	KANUMA
ESBRIET	HETLIOZ	KEVEYIS
EVENITY	HIZENTRA	KEVZARA
EVOTAZ	HUMATROPE	KEYTRUDA
EXJADE	HUMATROPE COMBO	KHAPZORY
EXTAVIA	PACK	KINERET
EYLEA	HUMIRA	KISQALI
FABRAZYME	HUMIRA PEDIATRIC	KISQALI FEMARA 200
FARYDAK	CROHNS D	DOSE
FASENRA	HUMIRA PEN	KISQALI FEMARA 400
FERRIPROX	HUMIRA PEN-	DOSE
FIRAZYR	CD/UC/HS START	KISQALI FEMARA 600
FIRDAPSE	HUMIRA PEN-PS/UV	DOSE
FIRMAGON	STARTER	KITABIS PAK
FLOLAN	HYQVIA	KORLYM
FOLOTYN	IBRANCE	KRYSTEXXA
FORTEO	ICATIBANT ACETATE	KUVAN
FOSAMPRENAVIR	ICLUSIG	KYPROLIS
CALCIUM	IDHIFA	LARTRUVO
FULPHILA	ILARIS	LEMTRADA
FUSILEV	ILUMYA	LENVIMA 10 MG
FUZEON	IMATINIB MESYLATE	DAILY DOSE
GALAFOLD	IMBRUVICA	LENVIMA 12MG DAILY
GAMMAGARD LIQUID	IMFINZI	DOSE
GAMMAGARD S/D IGA	INBRIJA	LENVIMA 14 MG
LESS TH	INCRELEX	DAILY DOSE
GAMMAKED	INFLECTRA	LENVIMA 18 MG
GAMMAPLEX	INGREZZA	DAILY DOSE
GAMUNEX-C	INLYTA	LENVIMA 20 MG
GATTEX	INREBIC	DAILY DOSE
GAZYVA	INTELENCE	LENVIMA 24 MG
GENOTROPIN	INTRON A	DAILY DOSE
GENOTROPIN	INVIRASE	LENVIMA 4 MG DAILY
MINIQUICK	IRESSA	DOSE
GENVOYA	ISENTRESS	LENVIMA 8 MG DAILY
GILENYA	ISENTRESS HD	DOSE

LETAIRIS	NIVESTYM	PLEGRIDY STARTER
LEUKINE	NORDITROPIN	PACK
LEVOLEUCOVORIN	FLEXPRO	POLIVY
LEVOLEUCOVORIN	NORTHERA	POMALYST
CALCIUM	NPLATE	PORTRAZZA
LEXIVA	NUBEQA	POTELIGEO
LIBTAYO	NUCALA	PREZCOBIX
LONSURF	NULOJIX	PREZISTA
LORBRENA	NUPLAZID	PRIVIGEN
LUCENTIS	NUTROPIN AQ NUSPIN	PROCRIT
LUMIZYME	10	PROCYSBI
LUMOXITI	NUTROPIN AQ NUSPIN	PROGRAF
LUPANETA PACK	20	PROLASTIN-C
LUPRON DEPOT (1-	NUTROPIN AQ NUSPIN	PROMACTA
MONTH)	5	PULMOZYME
LUPRON DEPOT (3-	OCALIVA	PURIXAN
MONTH)	OCREVUS	RADICAVA
LUPRON DEPOT (4-	OCTAGAM	RAPAMUNE
MONTH)	OCTREOTIDE	RAVICTI
LUPRON DEPOT (6-	ACETATE	REBETOL
MONTH)	ODEFSEY	REBIF
LUPRON DEPOT-PED	ODOMZO	REBIF REBIDOSE
(1-MONTH	OFEV	REBIF REBIDOSE
LUPRON DEPOT-PED	OLUMIANT	TITRATION
(3-MONTH	OMNITROPE	REBIF TITRATION
LYNPARZA	ONIVYDE	PACK
MAVENCLAD	OPDIVO	REMICADE
MAVYRET	OPSUMIT	REMODULIN
MAYZENT	ORENCIA	RENFLEXIS
MEKINIST	ORENCIA CLICKJECT	REVIATIO
MEKTOVI	ORENITRAM	REVCovi
MIGLUSTAT	ORFADIN	REVLIMID
MOZOBIL	ORKAMBI	REYATAZ
MULPLETA	OTEZLA	RIBASPHERE
MYALEPT	PALYNZIQ	RIBASPHERE RIBAPAK
MYCOPHENOLATE	PANZYGA	RINVOQ
MOFETIL	PEGASYS	RITUXAN
MYFORTIC	PEGASYS PROCLICK	RITUXAN HYCELA
MYLOTARG	PERJETA	RUBRACA
NAGLAZYME	PIFELTRO	RUCONEST
NATPARA	PIQRAY 200MG DAILY	RUZURGI
NERLYNX	DOSE	RYDAPT
NEULASTA	PIQRAY 250MG DAILY	SABRIL
NEULASTA ONPRO KIT	DOSE	SAIZEN
NEUPOGEN	PIQRAY 300MG DAILY	SAIZENPREP
NEXAVAR	DOSE	RECONSTITUTION
NINLARO	PLEGRIDY	SAMSCA
NITYR		SANDIMMUNE

SANDOSTATIN	TECFIDERA	VIRAMUNE XR
SANDOSTATIN LAR	TECFIDERA STARTER	VIREAD
DEPOT	PACK	VITRAKVI
SELZENTRY	TEGSEDI	VIZIMPRO
SENSIPAR	TEMSIROLIMUS	VOSEVI
SEROSTIM	TETRABENAZINE	VOTRIENT
SIGNIFOR	THALOMID	VPRIV
SIGNIFOR LAR	TIBSOVO	VYNDAQEL
SILDENAFIL CITRATE	TIVICAY	XALKORI
SIMPONI	TOBI	XELJANZ
SIMPONI ARIA	TOBI PODHALER	XELJANZ XR
SIROLIMUS	TOBRAMYCIN	XENAZINE
SKYRIZI	TORISEL	XERMELO
SODIUM	TRACLEER	XGEVA
PHENYLBUTYRATE	TREANDA	XOLAIR
SOLIRIS	TRELSTAR MIXJECT	XOSPATA
SOMATULINE DEPOT	TREMFYA	XPOVIO 100 MG ONCE
SOMAVERT	TREPROSTINIL	WEEKLY
SPRAVATO 56MG	TRIUMEQ	XPOVIO 60 MG ONCE
DOSE	TRIZIVIR	WEEKLY
SPRAVATO 84MG	TROGARZO	XPOVIO 80 MG ONCE
DOSE	TRUVADA	WEEKLY
SPRYCEL	TURALIO	XPOVIO 80 MG TWICE
STELARA	TYKERB	WEEKLY
STIMATE	TYMLOS	XTANDI
STIVARGA	TYSABRI	XYREM
STRENSIQ	TYVASO	YERVOY
STRIBILD	UDENYCA	YONSA
SUSTIVA	ULTOMIRIS	ZALTRAP
SUTENT	UPTRAVI	ZARXIO
SYLATRON	VALCHLOR	ZAVESCA
SYLVANT	VALRUBICIN	ZEJULA
SYMDEKO	VALSTAR	ZELBORAF
SYMFI	VECTIBIX	ZEMAIRA
SYMFI LO	VELCADE	ZOLINZA
SYMTUZA	VELETRI	ZOMACTON
SYNRIBO	VEMLIDY	ZORBIVE
TADALAFIL	VENCLEXTA	ZORTRESS
TAFINLAR	VENCLEXTA	ZYDELIG
TAGRISSO	STARTING PACK	ZYKADIA
TAKHZYRO	VENTAVIS	ZYTIGA
TALTZ	VERZENIO	
TALZENNA	VIDAZA	
TARCEVA	VIGABATRIN	
TARGRETIN	VIGADRONE	
TASIGNA	VIMIZIM	
TAVALISSE	VIRACEPT	
TECENTRIQ	VIRAMUNE	