# Department of Budget and Finance

RELEASE DATE: September 1, 2026

# REQUEST FOR PROPOSALS
# RFP NO. 27-001

# SEALED PROPOSALS
# FOR
# Benefit Consulting Services,
# Pharmacy Benefit Consulting Services, and
# Pharmacy Benefit Audit Services

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
OCTOBER 9, 2026

AT 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 DONNA A. TONAKI VIA EMAIL AT EUTF.RFP@HAWAII.GOV.

Donna A. Tonaki
Procurement Officer

**Re: Request for Proposals – RFP No. 27-001, Benefit Consulting Services, Pharmacy Benefit Consulting Services, and Pharmacy Benefit Audit Services**

**Proposal Due Date: October 9, 2026, 12:00 Noon, HST**

The Hawaii Employer-Union Health Benefits Trust Fund (EUTF) is issuing this Request for Proposals (RFP) for benefit consulting services for all of its health benefit plans, and pharmacy benefit consulting and audit services for its self-insured prescription drug plans only. This solicitation is for three separate contracts: one for overall benefit consulting services, one for pharmacy benefit consulting services, and one for pharmacy benefit audit services. However, more than one contract may be awarded by the EUTF to the same OFFEROR. The services provided in each contract are for both the active employee and retiree benefit plans.

This RFP has been divided into Sections which outline the items that are to be included in your submission (refer to Table of Contents).

Each proposal must anticipate that the OFFEROR will provide those services outlined in this RFP without exception unless said exception is specifically identified and clearly noted in Schedule 9, *Exceptions*. Any deviations from the specifications may disqualify the proposal from consideration as not responsive. Exceptions to Attachment 2, *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.

Attachment 5, *Fee Proposal*, included in this RFP shall be used for all cost and rate information. Information provided in any other format will not be accepted. Footnotes to the form may be used to provide supplemental explanations, if necessary.

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 services described herein.

## TABLE OF CONTENTS


**NOTICE TO OFFERORS**

**SECTION I** **ADMINISTRATIVE OVERVIEW**

**SECTION II** **PROPOSAL INSTRUCTIONS**

**SECTION III** **PROPOSAL EVALUATION**

**SECTION IV** **SCOPE OF WORK FOR BENEFIT CONSULTING SERVICES**

**SECTION V** **SCOPE OF WORK FOR PHARMACY BENEFIT CONSULTING SERVICES**

**SECTION VI** **SCOPE OF WORK FOR PHARMACY BENEFIT AUDIT SERVICES**

**SECTION VII** **PROPOSAL DOCUMENTS**

**SECTION VIII** **ATTACHMENTS AND EXHIBITS**

Attachment 1: OFFER FORM, OF-1

Attachment 2: PERFORMANCE GUARANTEES

Attachment 3: OFFEROR INFORMATION SHEET AND REFERENCES

Attachment 4: QUESTIONNAIRE

Attachment 5: FEE PROPOSAL

Exhibit A: EUTF ADMINISTRATIVE RULES

Exhibit B: CONTRACT FORM AND GENERAL CONDITIONS

Exhibit C: BUSINESS ASSOCIATE AGREEMENT

# 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, chiropractic, dental, vision, 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 administered on a fiscal year term (July 1 to June 30) and retiree plans are administered on a calendar year term (January 1 to December 31).

The EUTF is administered by a board of ten Trustees (Board), who are appointed by the Governor. Five Trustees represent the employee-beneficiaries, one of whom represents retirees. These five Trustees are selected by the Governor from a list of candidates provided by exclusive employee representative organizations. The remaining five Trustees represent the public employers. The Board's responsibilities include determining the nature and scope of benefit plans, negotiating and entering into contracts to provide such plans, establishing eligibility and management policies, and overseeing all EUTF activities. The Board has adopted rules to administer the EUTF (see Exhibit A, *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. The Benefits Office is responsible for the benefit plan design, cost control through disease management and wellness programs, and auditing of claims. The day-to-day operations of the EUTF are organized under three branches: Member Services, Financial Services, and Information Systems. The Member Services Branch Manager oversees the Member Services Branch and is supported by employees assigned to 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 carrier payments and various other payments. The Information Systems Chief is supported by information technology (IT) specialists who provide internal IT support services, including Health Insurance Portability and Accountability Act of 1996 (HIPAA) security responsibilities, and coordinate with the State Office of Enterprise Technology Services to provide additional support 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 and retirees now 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, Humana (retirees only), and Verdegard (actives only) and self-insured prescription drug plans administered by CaremarkPCS Health, L.L.C. and SilverScript Insurance Company. All employers currently pay a portion of the premium, except the County of Maui, County of Kauai, and Kauai Department of Water who pay 100% of the premium for certain plans and bargaining unit members. For actives, the employer's share is determined by the applicable collective bargaining agreements or through executive order. Any remaining balance is paid by the employee through payroll deduction. 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 2.10, *Current Plan Design and Funding Arrangements*. Evidence of coverage documents and benefit summaries can be found on the EUTF website (http://eutf.hawaii.gov/carriers).

## 1.2 PURPOSE

The EUTF is soliciting proposals from qualified OFFERORS to provide benefit consulting services for all of its health benefit plans, and pharmacy benefit consulting and audit services for its self-insured prescription drug plans only. This solicitation is for three separate contracts: one for overall benefit consulting services, one for pharmacy benefit consulting services, and one for pharmacy benefit audit services. However, more than one contract may be awarded by the EUTF to the same OFFEROR. The services provided in each contract are for both the active employee and retiree benefit plans.

## 1.3 TERMS AND ACRONYMS USED THROUGHOUT THE SOLICITATION

| | | |
|---|---|---|
| ACA | = | Patient Protection and Affordable Care Act |
| 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 State 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 |
| PBM | = | Pharmacy Benefit Manager |
| PLO | = | Priority-listed offeror |
| 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 who is eligible to enroll in the health plans offered by the EUTF |

## 1.4 CONTRACT PERIOD

The term of any contracts resulting from this RFP, subject to approval by the State, shall be as follows:

1. First Contract Period: July 1, 2027 through June 30, 2029
2. Optional Second Contract Period: July 1, 2029 through June 30, 2031
3. Optional Third Contract Period: July 1, 2031 through June 30, 2033

Under the Pharmacy Benefit Audit Services contract, audit periods will be on an annual basis (or plan years may be combined at the EUTF's discretion), starting with January 1 to December 31, 2026 for the retiree plans and July 1, 2026 to June 30, 2027 for the active employee plans in Year 1 of the First Contract Period. The audits must be completed by the end of the Contract Period unless extended by the Board.

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 complete any unfinished audits and 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.

## 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.

Donna A. Tonaki
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 October 9, 2026, 12:00 noon, Hawaii Standard Time (HST). Late proposals will be rejected and not considered. The table below represents the schedule that will be followed. All times indicated are based on HST. The EUTF reserves the right to change any date(s) and times as deemed necessary and in the best interest of the State.

| | |
|---|---|
| Release of Request for Proposals | **September 1, 2026** |
| Pre-proposal conference | **September 8, 2026** |
| Due date to submit written questions | **September 16, 2026** |
| State's response to written questions distributed | **September 25, 2026** |
| Proposals due (date/time) | **October 9, 2026<br>12:00 Noon, HST** |
| Priority-listed OFFEROR interviews (if required) | **Week of November 16, 2026** |
| Best and Final Offers due (if required) | **November 24, 2026** |
| Estimated date for notice of award | **December 16, 2026** |

## 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 Microsoft Teams. If your firm will be participating in the pre-proposal conference, please email eutf.rfp@hawaii.gov and provide the names, titles, and email addresses of those attending. You will be provided the Microsoft Teams link to the pre-proposal conference at that time. The pre-proposal conference will be held as follows:

Date: September 8, 2026
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 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/about-eutf/procurement/). 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 the EUTF. The individual listed below is the sole point of contact from the date this RFP is released 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*.

Ms. Donna A. Tonaki
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 link to the RFP and all related documents that are posted on the SPO website can also be obtained from the EUTF website (http://eutf.hawaii.gov/about-eutf/procurement/).

## 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 may submit only one proposal for the Benefit Consulting Services contract, one proposal for the Pharmacy Benefit Consulting Services contract, and one proposal for the Pharmacy Benefit Audit Services contract. A submission of proposals for multiple contracts by the same OFFEROR should be combined into one document.

OFFERORS have the option to submit their proposals under one of the two options below:

1. Hard copies:
   - One signed master proposal. The master proposal must be single-sided, unbound, and clearly marked, "Master."
   - Eight hard copies of the proposal. Each copy shall be marked, "Copy __ of 8." Copies may be bound and double-sided.
   - Two electronic copies (on two 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 Excel format for the completed proposal sheets and Word format for the completed questionnaire. The redacted version of the proposal shall redact any proprietary and confidential, trade secret information in the form of marked-out (blacked out) pages of the master proposal for submission to the public under any request compliant with the public information disclosure laws of the State.

2. Emailed and file-sharing electronic copies:
   - Complete electronic versions of the master and redacted proposals, presented in logical sections (e.g., proposal, attachments, forms) shall be submitted in PDF format. Completed proposal sheets and the questionnaire shall be submitted in Excel and Word format, respectively, as instructed in the RFP. The redacted version of the proposal shall redact any proprietary and confidential, trade secret information in the form of marked-out (blacked out) pages of the master proposal for submission to the public under any request compliant with the public information disclosure laws of the State.
   - The EUTF will accept emailed electronic files up to 35MB. If the OFFEROR's electronic files exceed 35MB, the EUTF will accept multiple emails and each email shall be numbered in the subject line or within the email message (e.g., "email #1" or "email 1 of __"). It is the OFFEROR's sole responsibility to ensure that a complete emailed proposal is electronically received by the EUTF at eutf.rfp@hawaii.gov no later than the closing date and time specified in Section 1.7, *RFP Schedule and Significant Dates*.
   - For files larger than 35MB that cannot be emailed, OFFERORS also have the option of emailing their own file-sharing link to eutf.rfp@hawaii.gov. It is the OFFEROR's sole responsibility to ensure that emailed links to file-sharing services are received by the EUTF

no later than the closing date and time specified in Section 1.7, *RFP Schedule and Significant Dates*.

The OFFEROR's proposal, including the required submission types noted above, must be received by the 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.

If selecting the hard copy option:
OFFERORS are encouraged to confirm their delivery agent's requirements for Hawaii. Proposals must be physically received by the EUTF via mail or hand delivery by **Friday, October 9, 2026, 12:00 noon, HST** and addressed to:

Ms. Donna A. Tonaki
State of Hawaii
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
Honolulu, HI 96813

If the proposal is to be hand delivered via courier (e.g., FedEx, UPS), the outside envelope shall be marked, "RFP No. 27-001, hand delivered, proposal due Friday, October 9, 2026, 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. 27-001, Benefit Consulting Services, Pharmacy Benefit Consulting Services, and Pharmacy Benefit Audit Services

## 1.12 RECEIPT, OPENING AND RECORDING OF PROPOSALS

Proposals will be time stamped upon receipt and held in a secure place by the Procurement Officer until the established due date. Proposals will not be opened publicly, but in the presence of two State officials on or after the proposal submission deadline specified in Section 1.7, *RFP Schedule and Significant Dates*, or as amended. 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 – The OFFEROR provides a written notice delivered by hand, email (eutf.rfp@hawaii.gov), mail, or fax that accompanies the actual modification.
- Withdrawal – The 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. The 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, virtually 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 destroy or 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 responses regardless of whether any award results from this RFP. Travel and expenses 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 but are not limited to:

- 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 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 Hawaii Awards and Notices Data System (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, *Proposal Evaluation*, of this RFP.

Prior to holding any discussions with PLOs, a priority list shall be generated consisting of OFFERORS determined to be acceptable or potentially acceptable. However, an award may be made without such discussions.

If numerous acceptable and potentially acceptable proposals are submitted, the Evaluation Committee may limit the priority list to the highest ranked, responsive, and responsible OFFERORS. The PLOs may be afforded the opportunity to submit a BAFO. 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 submittal 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 Exhibit C, *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 General Conditions* can be found as Exhibit B. 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 the 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 B, *Contract Form and General Conditions*. In submitting the proposal, the OFFEROR will be deemed to have agreed to each provision set forth in Exhibit B, *Contract Form and General Conditions*, unless the OFFEROR specifically identifies the provision to which objection is made and submits alternative language as part of Schedule 9, *Exceptions*. The EUTF shall have no obligation to accept terms and conditions that vary from those set forth in Exhibit B, *Contract Form and General Conditions*, this RFP and any amendments thereto. Exceptions to Attachment 2, *Performance Guarantees*, will not be accepted by the EUTF.

Upon selection and award of the contract, the EUTF will send the formal contract 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 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 Section 103D-310(c), HRS, 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. Section 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 may not receive the award. To demonstrate compliance, OFFERORS are encouraged to subscribe to Hawaii Compliance Express (HCE). OFFERORS who do not participate in HCE must 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 in HCE should do so prior to submitting an offer at https://vendors.ehawaii.gov. The annual registration fee is currently $12.00 and the "Certificate of Vendor Compliance" is accepted for both contract execution 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 working days after the posting of the award of the contract. The Procurement Officer or designee shall hold the debriefing within seven 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 working days after the date that the debriefing is completed, as specified in Section 103D-303(h), HRS.

## 1.28 PROTEST PROCEDURES

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

Ms. Donna A. Tonaki
Hawaii Employer-Union Health Benefits Trust Fund
201 Merchant Street, Suite 1700
Honolulu, HI 96813

A protest shall be submitted in writing within five 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 working days after the posting of award or if requested, within five working days after the Procurement Officer's debriefing was completed.

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

## 1.29 SPECIAL CONDITIONS

The following Special Conditions supplement Exhibit B, *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 services required under the contract. By accepting the award of contract, the Contractor certifies that it has all certificates, licenses, and approvals necessary to lawfully provide all services required under the contract.

2. Compliance with EUTF Laws and Rules. The Contractor shall comply with: Chapter 87A, HRS, as 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. Liquidated Damages. In the event of any breach of the contract by the Contractor, liquidated damages shall be assessed against the Contractor in the sum of $5,000.00 per calendar day until the breach is remedied by the Contractor.

4. 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 and personal and advertising injury of $1,000,000 per occurrence. 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 $3,000,000 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, the 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. Prior to 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 the 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 the Contractor's execution of the contract, the Contractor agrees to deposit with the EUTF certificate(s) of insurance necessary to satisfy the EUTF that the insurance provisions of this contract have been complied with and to keep such insurance in effect during the entire term of this contract, including those of its subcontractor(s), where appropriate.

Upon request by the State, the 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 the Contractor's liability hereunder nor to fulfill the indemnification provisions and

requirements of this contract. Notwithstanding said policy or policies of insurance, the 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.

5. Commissions Prohibited

It is expressly understood that the Contractor shall not receive any commissions, in-kind benefits, or fees from health care providers, insurance carriers, employee-organizations, pharmacy benefit managers, pharmaceutical manufacturers or other entities that could give rise to a potential conflict of interest.

6. Conflict of Interest

The Contractor shall fully disclose its contractual relationships with and any other arrangement that may raise conflict of interest issues that it has with:

a. The public employers or employee-organizations identified in Chapter 87A, HRS
b. Any insurance carriers, pharmacy benefit managers or other third parties that provide or may provide insurance coverage or perform other benefit administrative services for the EUTF and/or the public employers or employee-organizations identified in Chapter 87A, HRS.

The EUTF reserves the right to require the Contractor to terminate any and all contractual relationships and/or arrangements that raise conflict of interest issues as a condition to the EUTF's entry into a contract with the Contractor. During the term of the contract, the Contractor shall not enter into any contractual relationship, arrangement, or other situation that raises a conflict of interest with its performance of services for the EUTF.

7. 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. 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.
b. 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 the Contractor has received under the contract and all copies thereof.

# 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)
- Proposal Documents (Section VII)
    - Schedule 1: Offeror Information Sheet and References (Attachment 3)
    - Schedule 2: Organization Description
    - Schedule 3: Account Team
    - Schedule 4: Financial Statements
    - Schedule 5: Work Samples
    - Schedule 6: Questionnaire (Attachment 4)
    - Schedule 7: Fee Proposal (Attachment 5)
    - Schedule 8: Confidential Information
    - Schedule 9: Exceptions
- Any additional attachments/marketing information (optional)

### 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 and 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 or 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 this 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 the Contractor's 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 B, *Contract Form and General Conditions*, are acceptable or state any proposed modifications in Schedule 9, *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 2, *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 the 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 (original or electronic) on the *Offer Form, OF-1*, 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 AWARD OR REJECTION

Award will be made to the 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.

## 2.5 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.

## 2.6 TIME FOR ACCEPTNCE

The OFFEROR agrees to be bound by its proposal for a contract effective date as stipulated in Section 1.4, *Contract Period*.

## 2.7 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 Schedule 9, *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.

## 2.8 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) COMPLIANCE

All OFFEROR systems and services must be in compliance with the HIPAA Electronic Data Exchange (EDI), Privacy, and Security rules and regulations on the appropriate dates established by the U.S. Department of Health & Human Services. The successful OFFEROR will be required to sign Exhibit C, *Business Associate Agreement*.

## 2.9 FUNDING

Execution of any contract between the State and the successful OFFEROR is contingent upon the availability of funds. In addition, any contract resulting from this RFP shall be enforceable only to the extent of the availability of funds. No damages or interest shall accrue against the State or EUTF as a result of the non-availability of funds.

Depending on the prices proposed, the current level of funding may be insufficient to support the entire scope of the project. If the current level is insufficient to support the entire project, the State reserves the right to negotiate with the OFFEROR(s) to reduce the price(s) and/or the project's scope of work, and to select specific sections described in the Scope of Work for inclusion in the resulting contract. Any such contract will be written to include only those portions selected by EUTF and may be written to be contingent upon further funding for the project. However, the evaluation of the proposals shall be based on the proposals' satisfying the entire scope regardless of whether less than the entire scope is included in the contract.

EUTF also reserves the right to subsequently select additional sections of the scope to be completed by the Contractor as additional funds become available. The price of any additional sections shall be at the prices agreed upon between EUTF and the Contractor prior to the execution of the contract. The existing contract will then be amended to include the selected additional sections at those mutually agreed upon final prices.

## 2.10 CURRENT PLAN DESIGN AND FUNDING ARRANGEMENTS

The EUTF currently offers the following health benefit plans:

| Active Employee Plan | Plan Type | Funding Arrangement | Contract Term |
|---|---|---|---|
| **EUTF Actives** | | | |
| HMSA 90/10 PPO[1] | Medical (with chiropractic) | Fully insured with risk sharing[2] | July 1, 2025, with available extensions through June 30, 2029 |
| HMSA 80/20 PPO | Medical (with chiropractic) | Fully insured with risk sharing[2] | |
| HMSA 75/25 PPO | Medical (with chiropractic) | Fully insured with risk sharing[2] | |
| HMSA HMO[1] | Medical (with chiropractic) | Fully insured with risk sharing[2] | |
| CVS Caremark[3] | Prescription drug | Self-insured | |
| Kaiser Permanente Comprehensive HMO | Medical and prescription drug (with chiropractic) | Fully insured | |
| Kaiser Permanente Standard HMO | Medical and prescription drug (with chiropractic) | Fully insured | |
| Verdegard | Supplemental medical and prescription drug | Self-insured | |
| HDS | Dental | Fully insured with risk sharing[4] | July 1, 2027, with available extensions through June 30, 2031 |
| HMSA Vision[5] (new carrier) | Vision | Fully insured with risk sharing[4] | |
| Securian[6] | Life insurance | Fully insured | |
| **HSTA VB Actives** | | | |
| HMSA 90/10 PPO | Medical (with chiropractic) | Fully insured with risk sharing[4] | July 1, 2025, with available extensions through June 30, 2029 |
| HMSA 80/20 PPO | Medical (with chiropractic) | Fully insured with risk sharing[4] | |
| CVS Caremark[2] | Prescription drug | Self-insured | |
| Kaiser Permanente Comprehensive HMO | Medical and prescription drug (with chiropractic) | Fully insured | |
| HDS | Dental and supplemental dental | Fully insured with risk sharing[4] | July 1, 2027, with available extensions through June 30, 2031 |
| HMSA Vision[5] (new carrier) | Vision | Fully insured with risk sharing[4] | |
| Securian[6] | Life insurance | Fully insured | |

[1] The HMSA 90/10 plan was closed to new subscribers effective July 1, 2026, and the HMSA HMO plan was closed to new subscribers effective July 1, 2025.

[2] The HMSA medical plans are reconciled at the end of the 4-year contract term by contract (actives/retirees).
[3] The self-insured prescription drug plan administered by CVS Caremark are bundled with the HMSA medical plans. The EUTF active plan uses an open non-specialty formulary (Basic Control Formulary) and a closed specialty formulary (Advanced Control Specialty Formulary). The HSTA VB active plan uses an open non-specialty formulary (Standard Opt Out Formulary) and does not have a separate specialty formulary. The EUTF also has a specialty carve-out arrangement where specialty drugs, when dispensed from a provider other than a retail or specialty pharmacy, can be covered under the HMSA medical plan.
[4] The dental and vision plans are reconciled at the end of the contract year by contract (actives/retirees).
[5] The HMSA Vision plan is a standalone vision plan, powered by EyeMed.
[6] Life insurance benefits are based on a $4.12 monthly premium.

| **Retiree Plan** | **Plan Type** | **Funding Arrangement** | **Contract Term** |
|---|---|---|---|
| **EUTF Retirees** | | | |
| HMSA 90/10 PPO for non-Medicare retirees | Medical | Fully insured with risk sharing[2] | January 1, 2025, with available extensions through December 31, 2028 |
| HMSA 90/10 PPO for Medicare retirees[1] | Medical | Fully insured with risk sharing[2] | |
| Humana Medicare Advantage LPPO | Medical | Fully insured | |
| CVS Caremark for non-Medicare retirees[3] | Prescription drug | Self-insured | |
| SilverScript EGWP[3] | Prescription drug | Self-insured | |
| Kaiser Permanente Comprehensive HMO for non-Medicare retirees | Medical and prescription drug | Fully insured | |
| Kaiser Permanente Senior Advantage | Medical and prescription drug | Fully insured | |
| HDS | Dental | Fully insured with risk sharing[4] | January 1, 2027, with available extensions through December 31, 2030 |
| HMSA Vision[5] (new carrier) | Vision | Fully insured with risk sharing[4] | |
| Securian[6] | Life insurance | Fully insured | |
| **HSTA VB Retirees** | | | |
| HMSA 90/10 PPO for non-Medicare retirees | Medical (with chiropractic) | Fully insured with risk sharing[2] | January 1, 2025, with available extensions through December 31, 2028 |
| HMSA 90/10 PPO for Medicare retirees[1] | Medical (with chiropractic) | Fully insured with risk sharing[2] | |

| Retiree Plan | Plan Type | Funding Arrangement | Contract Term |
|---|---|---|---|
| CVS Caremark for non-Medicare retirees[3] | Prescription drug | Self-insured | |
| SilverScript EGWP[3] | Prescription drug | Self-insured | |
| Kaiser Permanente Comprehensive HMO for non-Medicare retirees | Medical and prescription drug (with chiropractic) | Fully insured | |
| Kaiser Permanente Senior Advantage | Medical and prescription drug (with chiropractic) | Fully insured | |
| HDS | Dental | Fully insured with risk sharing[4] | January 1, 2027, with available extensions through December 31, 2030 |
| HMSA Vision[5] (new carrier) | Vision | Fully insured with risk sharing[4] | |
| Securian[6] | Life insurance | Fully insured | |

[1] The HMSA medical plans for Medicare retirees have the same plan design as the HMSA plans for non-Medicare retirees but is a supplemental medical plan that coordinates with Medicare.
[2] The HMSA medical plans are reconciled at the end of the 4-year contract term by contract (actives/retirees).
[3] Retirees have the option to enroll in the self-insured prescription drug plan administered by CVS Caremark and SilverScript only or with the HMSA or Humana medical plan. The EUTF non-Medicare retiree plan uses the same formularies as the EUTF active plan. The HSTA VB non-Medicare retiree plan uses the same formulary as the HSTA VB active plan. The EUTF and HSTA VB EGWP plans use a Medicare Part D formulary (Bronze Formulary) and a wrap plan that provides additional coverage. The EUTF also has a specialty carve-out arrangement where specialty drugs, when dispensed from a provider other than a retail or specialty pharmacy, can be covered under the HMSA medical plan.
[4] The dental and vision plans are reconciled at the end of the contract year by contract (actives/retirees).
[5] The HMSA Vision plan is a standalone vision plan, powered by EyeMed.
[6] Life insurance benefits are based on a $4.12 monthly premium.

Evidence of coverage documents and benefit summaries can be found on the EUTF website (eutf.hawaii.gov).

# PROPOSAL EVALUATION

## 3.1 INTRODUCTION

The EUTF seeks the highest quality organization to provide Benefit Consulting Services, Pharmacy Benefit Consulting Services, and/or Pharmacy Benefit Audit Services. Throughout the selection process, the EUTF reserves the right, in its sole discretion:

a. To not award the contract to the lowest priced 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 the RFP. The evaluation process will be conducted in up to six phases:

Phase 1 – Evaluation of Mandatory Requirements
Phase 2 – Establishment of PLOs
Phase 3 – Discussions with PLOs (Optional)
Phase 4 – Request for BAFOs (Optional)
Phase 5 – Final Evaluation of Proposals (Optional)
Phase 6 – Award

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 (refer to Section 1.7, *RFP Schedule and Significant Dates*).
    - 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.
    - Submission of audited financial statements or other evidence of financial stability. If OFFEROR is not able to submit audited financial statements with the proposal, the OFFEROR must agree to submit audited financials if selected as a PLO.
    - 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.

- Other mandatory requirements for the pharmacy benefits consulting and audit services proposals:
  a. Be either:
     i. 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. Have not previously breached a confidentiality agreement with the EUTF's pharmacy benefits manager (PBM);
  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 that is currently pending or contemplated against the PBM or its affiliates, which lawsuit, investigation, or other proceeding is unrelated to EUTF; and
  d. Enter into a confidentiality agreement with the PBM that is reasonably acceptable to the PBM and the EUTF prior to commencing any audit activities.

2. Establishment of PLOs. 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 in Section 3.3, *Evaluation Criteria and Points*.

3. Discussions with PLOs (Optional). In this phase, the Evaluation Committee may conduct interviews with the PLOs as listed in the timeline provided in Section 1.7, *RFP Schedule and Significant Dates*. This phase is optional and may not be included in the evaluation.

4. Request for BAFOs (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.

5. Final Evaluation of Proposals (Optional). In this phase, the Evaluation Committee will conduct final evaluations in accordance with the criteria listed in Section 3.3, *Evaluation Criteria and Points*. This phase is optional and may not be included in the evaluation.

6. Award. The EUTF Board will make the final selection.

## 3.3 EVALUATION CRITERIA AND POINTS

The evaluation criteria listed below will be used to evaluate and rank each contract proposal.

| **Criteria** | **Points** |
|---|---|
| Fees and costs | 30 |
| The stability, relevant history, and experience of the OFFEROR's organization and consultants and servicing team proposed for the EUTF, including references | 40 |
| Agreement to perform services under the terms requested in this RFP (including Section 1.29, *Special Conditions*) | 30 |
| Total | 100 |

1. Fees and costs. This category will be evaluated based on the total cost of the services to be provided by the OFFEROR, excluding the hourly rates of the optional services as described in Section 4.10, *Additional Contract Work*. For fee evaluation, the OFFEROR proposing the lowest total fee will receive the maximum points of 30. The total fee includes all proposal periods including extensions. Other OFFERORS will be awarded points based on the following formula:

   Lowest fee proposed / Fee proposed by OFFEROR x Maximum points = Points awarded to OFFEROR

   In the event that an OFFEROR bids on more than one contract and proposes a discount (shown as a percentage) for being awarded both contracts, the OFFEROR's proposal score for the fee evaluation will be scored using the formula as stated above, taking into consideration the proposed fee with and without any discount that may be proposed.

2. The stability, relevant history, and experience of the OFFEROR's organization and consultants and servicing team proposed for the EUTF, including references. 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 providing active employee and retiree plans, the number of enrolled participants, benefit plans offered, multi-employer, complexity of administration and a similar form of administrative entity (Trustee Board with dedicated administrative organization) and geographic dispersion of participant population.

3. Agreement to perform services under the terms requested in this RFP (including Section 1.29, *Special Conditions*). 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.

## SCOPE OF WORK FOR BENEFIT CONSULTING SERVICES

### 4.1 PROJECT OVERVIEW

If awarded a contract to provide overall Benefit Consulting Services for the EUTF, the OFFEROR agrees to provide the following professional services in a satisfactory, timely, and proper manner, in accordance with the directions of the Board and subject to any limitations imposed by the Board.

### 4.2 EXISTING BENEFIT PLAN CONTRACTS

The following shall be performed by the Contractor during the term of the contract and any extensions thereof, for the existing benefit plans offered by the EUTF:

1. Carrier presentations. The Contractor shall assist with review of Board presentations by the insurance carriers, including but not limited to the following:

    a. Utilization reports. The Contractor shall review semi-annual and annual utilization reports provided by the insurance carriers.

    b. Plan changes. The Contractor shall review plan changes proposed by the insurance carriers and make a recommendation based on factors including but not limited to the reason for the plan change, other plan coverage, the rate impact, and the member impact. In making its recommendation, the Contractor should address the requirements of HRS Section 87A-15 which provides that EUTF employee benefit plans shall be offered at a cost affordable to both the public employers and public employees.

    c. Clinical programs. The Contractor shall assist with the implementation, monitoring, and evaluation of disease management and wellness programs provided by the insurance carriers, such as the Virta Digital Diabetes Program and the CVS Weight Management Program currently offered through the HMSA medical plans. This includes review of reporting provided by the insurance carriers.

    d. Disease burden and HEDIS reports. The Contractor shall review annual disease burden and HEDIS reports by the medical insurance carriers.

2. Reports. All reports that the Contractor is required to give to the EUTF under the contract shall be in form and substance satisfactory to the EUTF. The Contractor shall meet report deadlines and format requirements as indicated in an agreed upon report calendar which will be included as part of the contract. If the report due date falls on a weekend or State holiday, the due date will be the next business day. The report descriptions and monthly Board meetings specified below may be subject to change. Printing and delivery of hard copy reports shall be provided at no additional cost.

    a. Rate renewals. The Contractor shall submit a report to the Board (in June) compiling, evaluating, and making recommendations to the retiree monthly rates effective January 1st of the following year. The Contractor shall submit a report to the Board (in December) compiling, evaluating, and making recommendations to the active employee monthly rates

effective July 1st of the following year. Reports shall include self-insured prescription drug rates.

b. Rate projections. The Contractor shall submit a report to the Board of 5-year rate projections based on standard trend assumptions one month after the rates are approved by the Board. Projections shall include self-insured prescription drug rates.

c. IBNR calculations. The Contractor shall submit a report to the Board (in August) of projected incurred but not reported (IBNR) calculations as of fiscal year end for the self-insured benefit plans.

d. Plan experience report. The Contractor shall compile the claims experience data provided through the monthly financial reports submitted by the insurance carriers and self-funded plan administrators and submit a quarterly report to the Board (in March, May, August, and November) summarizing the plan experience (i.e., surplus/deficit) by comparing the premiums collected to the claims experience and enrollment for all benefit plans offered by the EUTF. Reports shall include self-insured prescription drug plan experience.

e. Performance guarantee report. The Contractor shall compile the performance guarantee measures provided through the quarterly performance guarantee reports submitted by the insurance carriers and self-funded plan administrators and submit a semi-annual report to the Board (in March and August) summarizing the performance guarantee reporting from the insurance carriers and self-insured administrators, including any penalty amounts received or owed. Reports shall include PBM performance guarantees.

f. Biennial report. Starting with the 2027 plan year for retirees and the 7/1/27-6/30/28 plan year for the actives, the Contractor shall submit a comprehensive biennial report to the Benefits Committee (in May and November) summarizing its analysis and evaluation of the retiree and active benefit plans offered by the EUTF. The Contractor's analysis and evaluation shall combine medical and prescription drug data and include the following: enrollment; a State peer comparison of premiums, plan design, and claims trend; identification of cost drivers; and recommendations on plan changes that should be considered in the future.

g. Clinical programs report. The Contractor shall submit a one-time report to the Benefits Committee (date to be determined) summarizing its analysis and evaluation of current and available clinical point solution programs offered by the insurance carriers and PBM that should be considered to address cost drivers.

h. Special reports. Upon request, the Contractor shall prepare special reports, surveys, and analyses on all benefit plans offered by the EUTF, including unusual trends in plan rates and claims experience, applicable federal and state laws, rules, and regulations, legislation, trends and/or new developments in the marketplace, alternatives to improve plan design and/or contain cost (e.g., self-insurance, restructuring of current plan design, tradeoffs, etc.), and other matters relating to the operation and administration of the benefit plans.

3. Carrier contracts. The Contractor shall review existing benefit plan contracts with the insurance carriers and self-funded plan administrators and assist with contract and rate renewal negotiations if requested.

4. Carrier evaluations. The Contractor shall assist with semi-annual EUTF staff evaluation of the insurance carriers and self-funded plan administrators.

## 4.3 NEW BENEFIT PLAN CONTRACTS

The following shall be performed by the Contractor in preparation for the expiration or termination of benefit plan contracts with the insurance carriers and self-funded administrators:

1. RFP preparation. The Contractor shall prepare an RFP for benefit plan services for the EUTF following the schedule below. Services for preparing an RFP shall include drafting and reviewing the RFP in its entirety, including reviewing performance guarantees to ensure that they are consistent with historical and industry standards.

| Benefit Plan | Month of Issue | Benefit Plan Contract Period | Contractor Contract Period |
|---|---|---|---|
| Medical and Prescription Drug | October 2027 | Retirees: 1/1/29-12/31/32 Actives: 7/1/29-6/30/33 | First Contract Period: 7/1/27-6/30/29 |
| Dental | January 2030 | Retirees: 1/1/31-12/31/34 Actives: 7/1/31-6/30/35 | Second Contract Period: 7/1/29-6/30/31 |
| Vision | January 2030 | Retirees: 1/1/31-12/31/34 Actives: 7/1/31-6/30/35 | Second Contract Period: 7/1/29-6/30/31 |
| Life | January 2030 | Retirees: 1/1/31-12/31/34 Actives: 7/1/31-6/30/35 | Second Contract Period: 7/1/29-6/30/31 |
| Medical and Prescription Drug | October 2031 | Retirees: 1/1/33-12/31/36 Actives: 7/1/33-6/30/37 | Third Contract Period: 7/1/31-6/30/33 |

2. RFP management. Services for management of the RFP process once the RFP is issued shall include assisting with written responses to questions from offerors, compiling questionnaire responses, conducting reference checks, preparing questions for PLO interviews, providing an evaluation of proposals received as described below, and providing other related services as are reasonably necessary to enable the Administrator and Board to award (or not award) a contract under the RFP.

3. RFP evaluation. The Contractor shall submit a report to the Board and/or Evaluation Committee summarizing and evaluating each proposed benefit plan, including a) proposed monthly premiums for active and retired employees, proposed benefits, and other significant features of each proposed insured benefit plan, b) proposed monthly administration fees or other compensation, proposed services, and other significant features of each proposed self-funded benefit plan, c) the offerors' experience, responses to questions, and network and member disruption, and d) the Contractor's recommendation of the funding arrangement, rates, benefits, and other features for the proposed benefit plan.

4. Carrier contracts. The Contractor shall review new benefit plan contracts with the insurance carriers and self-funded plan administrators and assist with contract negotiations if requested.

The fee to provide services described in this section shall be included in the Contractor's annual fee.

## 4.4 OPEN ENROLLMENT

Each year, the EUTF holds at least one open enrollment period for active employees and one open enrollment period for retired employees. Generally, the active open enrollment period will be held in May and the retiree open enrollment period in October. The EUTF may also hold special open enrollment periods during other times of the year. The Contractor is responsible for the following prior to each open enrollment period:

1. Reference Guide (or Summary Plan Description). The Contractor shall a) draft the Reference Guide in its entirety, b) determine content and ensure compliance with federal and state laws, c) review sections drafted by others, and d) format and prepare the printer's proof at least three months prior to the open enrollment period or by some other date as specified by EUTF staff.

2. Evidence of coverage documents and benefit summaries/guides. The Contractor shall review all evidence of coverage documents and benefit summaries/guides provided by the insurance carriers and self-funded plan administrators at least three months prior to open enrollment or such other date as specified by EUTF staff. For active employee medical and prescription drug plans, the Contractor shall also review the Summary of Benefits and Coverage (SBC) as required by ACA.

3. Other enrollment material. The Contractor shall review other enrollment and member communication material if requested.

All open enrollment material listed above shall be reviewed for content, accuracy, and compliance with federal and state laws.

## 4.5 PROGRAM MANAGEMENT

The following shall be performed by the Contractor in support of the EUTF's benefit plan administration and operations:

1. Operations. The Contractor shall provide information, advice, and recommendations on benefit plan administration and operations if requested. This shall include review of Strategic Plan objectives and tactics if requested.

2. Training. The Contractor shall provide training to the Board and EUTF staff in areas pertaining to the benefit plans offered by the EUTF, including plan design and compliance with federal and state laws, if requested.

3. Grievances, claims, and appeals. The Contractor shall assist with rules, policies, and procedures for handling a) grievances, claims, and appeals made by participants in EUTF plans, b) subrogation claims, and c) claims that the EUTF has against persons or entities for fraud, abuse, or other matters related to its operation of its plans, if requested. The Contractor shall also assist with claim submission and supporting documentation to third parties (e.g., insurance carriers, Medicare, federal and state governmental agencies, etc.) if requested.

4. EUTF administrative fees. The Contractor shall assist with the calculation and allocation of EUTF administrative fees if requested.

5. Legislative and legal matters. The Contractor shall assist with legislative and legal matters pertaining to the EUTF benefit plans, including responding to letters from governmental entities or third parties, if requested.

6. Plan documents. The Contractor shall assist with drafting and reviewing plan documents for self-insured plans if requested.

## 4.6 GENERAL CONSULTING ADVICE

The Contractor shall keep the Board and Administrator informed and advised of trends, developments, and changes that may affect the operation and administration of the EUTF benefit plans, including new or anticipated changes in legislation, federal and state laws, rules, and regulations, and the marketplace. The Contractor shall also provide the EUTF with an analysis as to how new or existing federal or state laws, rules, regulations or federal or state legislation will affect the EUTF. The Contractor shall have on staff, or shall retain, qualified personnel, including legal counsel, for the purposes or rendering such advice.

## 4.7 MEETINGS

1. Trustee meetings. The Contractor shall be available to the Board, its Committees, and the Administrator to provide advice and recommendations regarding the operation, administration, and/or management of the EUTF benefit plans. The Lead Consultant shall attend, in person if requested, the Board's regular, special, and Benefits Committee meetings as may be required by the Board or the Administrator. There are generally six Benefits Committee meetings a year which occur a week prior to the monthly Board meeting. Travel cost shall be included in the Contractor's annual fee. (The Lead Consultant is expected to travel to Hawaii at least six times a year.)

2. Meetings with the insurance carriers and Plan Administrators. The Lead Consultant shall attend, in person if requested, monthly operation meetings with insurance carriers and self-funded plan administrators to discuss benefits and plan design, administrative services, and other matters relating to the EUTF benefit plans. These meetings generally occur the week prior to the monthly Board meeting. Currently, monthly meetings are with the medical insurance carriers and PBM only, however, meetings with other insurance carriers could be scheduled.

## 4.8 FEDERAL AND STATE LAWS, RULES AND REGULATIONS

The Contractor shall apprise the EUTF of any current or new federal or state laws, rules, or regulations that affect the EUTF including, but not limited to:

1. Health Insurance Portability and Accountability Act (HIPAA)
2. Consolidated Omnibus Budget Reconciliation Act (COBRA)
3. Mental Health Parity and Addiction Equity Act (MHPAEA)
4. Patient Protection and Affordable Care Act (ACA)
5. Consolidated Appropriations Act, 2021
6. Inflation Reduction Act of 2022
7. Consolidated Appropriations Act, 2026
8. CMS rules and regulations pertaining to Medicare

The Contractor shall a) notify EUTF staff of any new, or changes in, laws, rules, and regulations, b) perform periodic assessment of the EUTF's efforts to comply with such laws, rules, and regulations, including updating its policies, procedures, and notices, c) assist the EUTF to ensure compliance of such laws, rules, and regulations, and d) provide training to EUTF staff in regards to such laws, rules, and regulations if requested. The Contractor shall also provide the EUTF with an analysis as to how new or existing federal or state laws, rules, regulations or federal or state legislation will affect the EUTF. The Contractor shall have on staff, or shall retain, qualified personnel, including legal counsel, for the purposes or rendering such advice.

## 4.9 REVIEW OF THE PHARMACY BENEFIT CONSULTANT

The Contractor is responsible for reviewing the deliverables of the Pharmacy Benefit Consultant, including but not limited to:

1. Assist with the evaluation of proposals in response to a RFP for PBM services.
2. Assist with the calculation and allocation of administrative fees charged by the EUTF for the self-insured prescription drug plans.
3. Coordinate data sharing between the medical carriers and PBM.
4. Evaluate the impact of the self-funded prescription drug claims on the medical plans.

## 4.10 ADDITIONAL CONTRACT WORK

At the option of the Board, the Contractor shall provide assistance with claims audits. Including but not limited to assistance in the preparation and review of responses to an RFP for claims audit services; monitoring the progress of the claims audits; and review of audit reports including, but not limited to, resolution of audit findings and recommendations. Audits to include medical, prescription drug, supplemental medical and prescription drug, dental, vision, and life insurance.

If the Board authorizes the Contractor to provide work or services that are outside the scope of work agreed to in the contract between the EUTF and the Contractor, such additional work or services shall be provided for a fee to be mutually agreed upon between the Contractor and the Board based upon the hourly rates provided in Attachment 5, *Fee Proposal*. Unless expressly authorized by the Board, no payment for additional work or services shall be made by the EUTF unless a fee is agreed upon in advance of the work or services being performed.

## SCOPE OF WORK FOR PHARMACY BENEFIT CONSULTING SERVICES

### 5.1 PROJECT OVERVIEW

If awarded a contract to provide Pharmacy Benefit Consulting Services for the EUTF, the OFFEROR agrees to provide the following professional services in a satisfactory, timely, and proper manner, in accordance with the directions of the Board and subject to any limitations imposed by the Board.

### 5.2 EXISTING PBM CONTRACTS

The following shall be performed by the Contractor during the term of the contract and any extensions thereof, for the existing PBM contracts:

1. PBM presentations. The Contractor shall assist with review of Board presentations by the PBM, including but not limited to the following:

    a. Utilization reports. The Contractor shall review quarterly utilization reports provided by the PBM.

    b. Plan changes. The Contractor shall review plan changes proposed by the PBM and make a recommendation based on factors including but not limited to the reason for the plan change, other plan coverage, the rate impact, and the member impact. In making its recommendation, the Contractor should address the requirements of HRS Section 87A-15 which provides that EUTF employee benefit plans shall be offered at a cost affordable to both the public employers and public employees. The Contractor shall also review PBM forms that authorize claims system changes after plan changes are approved by the Board.

    c. Clinical programs. The Contractor shall assist with the implementation, monitoring, and evaluation of clinical and point solution management programs (if any) provided by the PBM. This includes review of reporting provided by the PBM.

2. Reports. All reports that the Contractor is required to give to the EUTF under the contract shall be in form and substance satisfactory to the EUTF. The Contractor shall meet report deadlines and format requirements as indicated in an agreed upon report calendar which will be included as part of the contract. If the report due date falls on a weekend or State holiday, the due date will be the next business day. The report descriptions and monthly Board meetings specified below may be subject to change. Printing and delivery of hard copy reports shall be provided at no additional cost.

    a. Biennial report. Starting with the 2028 plan year for retirees and the 7/1/28-6/30/29 plan year for actives, the Contractor shall submit a comprehensive biennial report to the Benefits Committee (in April and October) summarizing its analysis and evaluation of the retiree and active self-insured prescription drug plans. The Contractor's analysis and evaluation shall include the following: enrollment; a State peer comparison of plan design (copay structure, formulary, and utilization management) and claims trend; identification of cost drivers; and recommendations on plan changes that should be considered in the future.

b. Market check. The Contractor shall perform the mid-contract term market check as described in the PBM contract and negotiate and make recommendations of revised terms to the Board (in August 2030) to ensure that the EUTF's current pricing terms are appropriate and competitive within the industry based on its claims volume and membership.

c. Special reports. Upon request, the Contractor shall prepare special reports, surveys, and analyses on the self-insured prescription drug plans, including unusual trends in plan rates and claim experience, applicable federal and state laws, rules, and regulations, legislation, trends and/or new developments in the marketplace, alternatives to improve plan design and/or contain cost, and other matters relating to the self-insured prescription drug benefit.

3. PBM contracts. The Contractor shall review existing PBM contracts and assist with contract negotiations if requested.

4. PBM evaluation. The Contractor shall assist with semi-annual EUTF staff evaluation of the PBM.

## 5.3 NEW PBM CONTRACT

The following shall be performed by the Contractor in preparation for the expiration or termination of the PBM contract:

1. RFP preparation. The Contractor shall draft and review all sections of the RFP for Medical and Prescription Drug benefit services pertaining to the self-insured prescription drug benefit. See Section 4.3, *New Benefit Plan Contracts*, for the RFP schedule.

2. RFP management. Services for management of the RFP process once the RFP is issued shall include assisting with written responses to questions from offerors, compiling questionnaire responses, conducting reference checks, preparing questions for PLO interviews, providing an evaluation of proposals received as described below, and providing other related services as are reasonably necessary to enable the Administrator and Board to award (or not award) a contract under the RFP.

3. RFP evaluation. The Contractor shall submit a report to the Board and/or Evaluation Committee summarizing and evaluating each PBM proposal, including proposed monthly administration fees or other compensation, value of network and rebate guarantees, experience, responses to questions, network disruption, member disruption and proposed services. The analysis provided will be relied upon by the Evaluation Committee in recommending a new PBM.

4. PBM contracts. The Contractor shall review new PBM contracts and assist with contract negotiations if requested.

5. In the event that the prescription drug plans are no longer self-insured, the EUTF reserves the right to terminate its contract with the Contractor as provided in Exhibit B, *Contract Form and*

*General Conditions*. In such an event, the Contractor shall comply with the provisions provided in Section 1.29.7, *Transition Procedures*.

The fee to provide services in this section shall be included in the Contractor's annual fee.

## 5.4 OPEN ENROLLMENT

Each year, the EUTF holds at least one open enrollment period for active employees and one open enrollment period for retired employees. Generally, the active open enrollment period will be held in May and the retiree open enrollment period in October. The EUTF may also hold special open enrollment periods during other times of the year. The Contractor is responsible for the following prior to each open enrollment period:

1. Reference Guide (or Summary Plan Description). The Contractor shall review sections of the Reference Guide pertaining to the self-insured prescription drug benefit.

2. Evidence of coverage documents and benefit summaries. The Contractor shall review all evidence of coverage documents and benefit summaries pertaining to the self-insured prescription drug benefit at least three months prior to open enrollment or such other date as specified by EUTF staff. For active employee prescription drug plans, the Contractor shall also review the Summary of Benefits and Coverage (SBC) as required by ACA.

3. Other enrollment material. The Contractor shall review other enrollment and member communication material if requested.

All open enrollment material listed above shall be reviewed for content, accuracy, and compliance with federal and state laws.

## 5.5 PROGRAM MANAGEMENT

The following shall be performed by the Contractor in support of the EUTF's benefit plan administration and operations:

1. Operations. The Contractor shall provide information, advice, and recommendations on prescription drug plan administration and PBM management, including ensuring amounts owed by the PBM due to service warranties and/or enrollment errors are reasonable and paid, if requested. This shall include review of Strategic Plan objectives and tactics if requested.

2. Training. The Contractor shall provide training to the Board and EUTF staff in areas pertaining to the self-insured prescription drug plan benefit, including the PBM contract, plan design, and compliance with federal and state laws, if requested.

3. Grievances, claims, and appeals. The Contractor shall assist with rules, policies, and procedures for handling a) grievances, claims, and appeals made by participants in EUTF plans, b) subrogation claims, and c) claims that the EUTF has against persons or entities for fraud, abuse, or other matters related to its operation of its plans, if requested. The Contractor shall

also assist with claim submission and supporting documentation to third parties (e.g., insurance carriers, Medicare, federal and state governmental agencies, etc.) if requested.

4. Legislative and legal matters. The Contractor shall assist with legislative and legal matters pertaining to the EUTF self-insured prescription drug plans, including responding to letters from governmental entities or third parties, if requested.

5. Plan documents. The Contractor shall assist with drafting and reviewing plan documents for self-insured prescription drug plans if requested.

## 5.6 PHARMACY BENEFIT CONSULTING ADVICE

The Contractor shall keep the Board and Administrator informed and advised of trends, developments, and changes that may affect the operation and administration of the EUTF self-insured prescription drug plans, including new or anticipated changes in legislation, federal and state laws, rules, and regulations, and the marketplace. The Contractor shall also provide the EUTF with an analysis as to how new or existing federal or state laws, rules, regulations or federal or state legislation will affect the EUTF. The Contractor shall have on staff, or shall retain, qualified personnel, including legal counsel, for the purposes or rendering such advice.

## 5.7 MEETINGS

1. Trustee meetings. The Contractor shall be available to the Board, its Committees, and the Administrator to provide advice and recommendations regarding the operation, administration, and/or management of the EUTF self-insured prescription drug plans. The Lead Pharmacy Consultant shall attend, in person if requested, the Board's regular, special, and Benefits Committee meetings as may be required by the Board or the Administrator. There are generally two Benefits Committee meetings a year, pertaining strictly to the self-insured prescription drug plans, which occur a week prior to the monthly Board meeting. Travel cost shall be included in the Contractor's annual fee. (The Lead Pharmacy Consultant is expected to travel to Hawaii at least twice a year.)

2. Meetings with the PBM. The Lead Pharmacy Consultant shall attend, in person if requested, monthly operation meetings with the PBM. These meetings generally occur the week prior to the monthly Board meeting.

## 5.8 FEDERAL AND STATE LAWS, RULES AND REGULATIONS

The Contractor shall apprise the EUTF of any current or new federal or state laws, rules, or regulations that affect the EUTF self-insured prescription drug plans, including, but not limited to:

1. Health Insurance Portability and Accountability Act (HIPAA)
2. Consolidated Omnibus Budget Reconciliation Act (COBRA)
3. Mental Health Parity and Addiction Equity Act (MHPAEA)
4. Patient Protection and Affordable Care Act (ACA)
5. Consolidated Appropriations Act, 2021
6. Inflation Reduction Act of 2022

7. Consolidated Appropriations Act, 2026
8. CMS rules and regulations pertaining to Medicare

The Contractor shall a) notify EUTF staff of any new, or changes in, laws, rules, and regulations, b) perform periodic assessment of the EUTF's efforts to comply with such laws, rules, and regulations, including updating its policies, procedures, and notices, c) assist the EUTF to ensure compliance of such laws, rules, and regulations, and d) provide training to EUTF staff in regards to such laws, rules, and regulations if requested. The Contractor shall also provide the EUTF with an analysis as to how new or existing federal or state laws, rules, regulations or federal or state legislation will affect the EUTF. The Contractor shall have on staff, or shall retain, qualified personnel, including legal counsel, for the purposes or rendering such advice.

## 5.9 ADDITIONAL CONTRACT WORK

If the Board authorizes the Contractor to provide work or services that are outside the scope of work agreed to in the contract between the EUTF and the Contractor, such additional work or services shall be provided for a fee to be mutually agreed upon between the Contractor and the Board based upon the hourly rates provided in Attachment 5, *Fee Proposal*. Unless expressly authorized by the Board, no payment for additional work or services shall be made by the EUTF unless a fee is agreed upon in advance of the work or services being performed.

## SCOPE OF WORK FOR PHARMACY BENEFIT AUDIT SERVICES

### 6.1 PROJECT OVERVIEW

If awarded a contract to provide Pharmacy Benefit Audit Services for the EUTF, the OFFEROR agrees to provide the following professional services in a satisfactory, timely, and proper manner, in accordance with the directions of the Board and subject to any limitations imposed by the Board.

### 6.2 PHARMACY BENEFIT PLAN AUDIT SERVICES

The objective of the pharmacy benefit plan audits is to evaluate operational procedures and controls established for effective plan administration, and to determine:

1. Whether claims have been paid properly
2. The dollar amount of any improperly paid claims
3. The options available to recover overpayments resulting from improperly paid claims
4. The PBM's compliance with performance guarantees
5. Recommendations for improvement in the delivery of services and plan design.

The following audit components shall be performed by the Contractor during the term of the contract and any extensions thereof. The EUTF reserves the right to modify the scope and frequency of the audits based on prior audit findings and recommendations.

1. **Administrative Procedures Review** shall explore the day-to-day administrative policies, procedures, and internal quality control measures critical to minimizing financial loss and maintaining participant satisfaction levels. Review of the PBM's SOC-1 report is to be supplemented with a questionnaire specific to the PBM's administration of the EUTF's Plan; onsite interviews are not anticipated. Topics will include, but not be limited to:

    - Division of administrative functions within the PBM and identification of any outsourced administrative functions (e.g., investigations, fraud review, recoveries) and quality measures in place to monitor performance;
    - Eligibility receipt, timely update, reconciliation procedures, and system interfaces;
    - Detection of other coverage (i.e. coordination with other group coverage including Medicare Part D plans, workers' compensation and third party liability)
    - System edits for detection of coding errors and alerts for claims requiring manual review and processing;
    - Procedures employed to identify potential fraud and abuse
    - Maintenance of network pharmacy lists and MAC pricing with distinction between in- and out-of-network pharmacies; and
    - Quality assurance procedures to monitor benefit accuracy in accordance with Plan provisions and industry best practices.

2. **Eligibility Comparison** of the EUTF's file to paid claims data to identify payments made for any ineligible date of service.

3. **100% Electronic Analysis** of all prescription transactions administered by the PBM including review of:

    - Independent verification of AWP discounts,
    - Comparison of actual claim discounts and dispensing fees to contractual guarantees,
    - Comparison of actual claim adjudication to plan design and benefit rules,
    - Member cost share,
    - Duplicate claims,
    - Identification of contractual term improvement opportunities, and
    - Consistency in coordination of benefits, including subrogation and workers' compensation

4. **Rebate Audit Review** shall include all payments from manufacturers or other third parties to the PBM as they relate to EUTF plans. The manufacturer payment and rebate audit review shall include a comprehensive review that includes:
    - Identification of all rebateable claims and identification of categories properly excluded from rebates, according to the PBM contract
    - Verification of earned rebates by quarter by National Drug Code (NDC)
    - Comparison of earned rebates file to manufacturer rebate submission file
    - Onsite review of applicable manufacturer contracts to verify at a minimum 75% of total rebate amounts due are properly paid to the EUTF
    - Comparison of PBM receipts from manufacturers to earned rebate file
    - Comparison of actual rebates to contractual guarantees

5. **Rebate Credit Review** shall include approximately 75% of the dollar value of the rebate credits as part of the onsite rebate credit review that includes:
    - Review accuracy to ensure Rebate credit was calculated correctly
    - Review accuracy to ensure that rebate on the claims was invoiced accurately
    - Calculate and analyze the WAC and drug cost by NDC before and after the change

6. **Performance Guarantees** assessment with validation of source documents used to self-report each category and comparison of self-reported achievements to sampled claim audit results.

A **Written Report of Findings** shall be presented in draft form to the PBM for review and comment in which their response to the findings shall be incorporated into the final draft report provided for the EUTF's review. This written report shall include:

- Objectives of the audit;
- Procedures taken to complete the audit;
- Evaluation of the vendor's policies and administration for managing claims costs to ensure that procedures support maximized savings;
- Number of claims examined and total paid amount of the claims;
- Number and dollar value of claims with financial errors and procedural errors expressed as a percentage of the total claims audited;
- A description of the error categories found during the review with attention to systemic or human cause and required corrective measures;
    - ✓ Identify error patterns or trends, identify causes, assess effects, and provide recommendations for corrections.

  - ✓ Provide a table of payment errors with a clear description of the sampled error and/or other errors detected through review of the patient's history; the report should clearly identify those errors that were subject to internal audit but bypassed detection.
- An action plan for overpayment recovery should be included within the report recommendations;
- Comparison of audit results to performance guarantees and industry standards;
- Recommendations to improve overall administration and/or claims processing accuracy;
- Comparison of current year's audit with prior year results (for subsequent audits); and
- Summary comments and recommendations for each plan regarding improving plan design to ensure that the EUTF receives high quality services in a cost effective, timely manner.

Where multiple benefit plan contract years are audited simultaneously, the EUTF anticipates the written report will document findings for the separate performance guarantee periods.

The Contractor shall attend and make presentations to the EUTF Board on the final report for each audit period for the active employee and retiree plans.

The audit periods for the active employee and retiree plans are described in Section 1.4, *Contract Period*, and Attachment 5, *Fee Proposal*. The OFFEROR must agree to perform all audit periods and audit components. However, EUTF reserves the right to combine audit periods or eliminate audit components based on prior findings, auditor recommendations, and budget.

If awarded a contract to provide pharmacy benefit consulting and audit services for the EUTF, the EUTF reserves the right to terminate the Pharmacy Benefit Consulting Services at the end of a contract period and continue to retain the OFFEROR for only the Pharmacy Benefit Audit Services or vice versa.

# PROPOSAL DOCUMENTS

## 7.1 OFFEROR INFORMATION SHEET AND REFERENCES

Attach as Schedule 1, Attachment 3, *Offeror Information Sheet and References*.

Include a list of key personnel responsible for providing services described in this RFP, major health care insurers/PBMs with whom your organization does business, and current client references (preferably public sector clients and/or clients similar in size and composition to the EUTF) for each contract proposal. The clients provided must be for the Lead Consultant, Lead Pharmacy Consultant, and Lead Pharmacy Auditor. The EUTF will contact the references directly.

## 7.2 ORGANIZATION DESCRIPTION

Attach as Schedule 2, a description of your organization operations, background, and experience in providing employee benefit plan and pharmacy consulting and pharmacy benefit audit services. The organization description should include the organization's history, structure, size and resources, types of work performed, and types of clienteles served.

Audit firms must meet the following requirements:

1. Be either:
    - A public accounting firm that is a member of the American Institute of Certified Public Accountants (AICPA), or
    - 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;
2. Have not previously breached a confidentiality agreement with the EUTF's current PBM;
3. 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 that is currently pending or contemplated against the PBM or its affiliates, which lawsuit, investigation, or other proceeding is unrelated to EUTF; and
4. Enter into a confidentiality agreement with the PBM that is reasonably acceptable to the PBM and the EUTF prior to commencing any audit activities.

## 7.3 ACCOUNT TEAM

Attach as Schedule 3, an organizational chart and a list of members on the EUTF account team and other subject matter experts (in-house or outside) available to provide services described in this RFP, including but not limited to advisement on employee benefit plan laws, contract administration, benefit plan communication, and operating procedures. Include the name, title, address, phone number, email address, areas of expertise, and duties and responsibilities of each individual.

For key personnel identified in Attachment 3, *Offeror Information Sheet and References*, include resumes with the following additional information: professional licenses and certifications, memberships in professional societies, representative clients, years of full-time employee benefit plan consulting and/or auditing experience, number of assigned accounts, and the amount of time per week the individual will spend on the EUTF account. Key personnel assigned to this contract must have a minimum of five years of professional employee benefit plan consulting and/or auditing work experience and have worked on large private and/or public sector client groups of 10,000 persons or more with both insured and self-insured employee benefit plans similar to those provided by the EUTF.

The account team shall be available during EUTF business hours (7:45am to 4:30pm HST, Monday through Friday, excluding State observed holidays) to answer questions from, or hold discussions with, the Board or its designee in person, the Administrator, EUTF staff, the EUTF's carriers or PBM, or the State Department of the Attorney General regarding any matter pertaining to the EUTF. If awarded a contract, the key personnel identified in Attachment 3, *Offeror Information Sheet and References*, shall not be replaced without the prior approval of the Administrator.

## 7.4 FINANCIAL STATEMENTS

Attach as Schedule 4, evidence of the OFFEROR's financial stability (e.g., audited financial statements or latest annual report).

The OFFEROR shall provide a copy of its most recent external rating from Standard & Poor's, Fitch, Moody's, or A.M. Best. The OFFEROR shall indicate if there has been any downgrade in its ratings in the last two years. If the OFFEROR's company is not rated by any of these agencies, submit documentation of a similar nature which attests to its financial stability. If the OFFEROR is not able to submit evidence with the proposal, the OFFEROR must agree to submit evidence if selected as a PLO.

## 7.5 WORK SAMPLES

Attach as Schedule 5, a sample of your employee benefit plan consulting and audit work performed by your organization's Lead Consultant, Lead Pharmacy Consultant, and Lead Auditor who will be assigned to this EUTF contract. If submitting an offer for the Benefit Consulting Services and/or Pharmacy Benefit Consulting Services contract, provide a work sample that is closest to the biennial report described in Sections 4.2.2.f and 5.2.2.a and a separate work sample that best shows the value of the services you can provide.

## 7.6 QUESTIONNAIRE

Attach as Schedule 6, Attachment 4, *Questionnaire*.

**Provide answers to the questionnaire in Word format using the template provided. Do not alter the questions or question numbering.**

The OFFEROR must complete all sections of the questionnaire and provide an answer to each question even if the answer is "not applicable" or "unknown." Answer the questions as directly as

possible. For example, if the question asks, "How many…" provide a number. If the question asks, "Do you…" indicate Yes or No followed by a brief explanation to clarify if necessary.

**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 to convey. Referring to an attachment for further information should be avoided or limited as much as possible. Any response that does not directly address the question and that only contains marketing information will be considered non-responsive. OFFERORS will be held accountable for the accuracy and validity of all answers.

The submission of a proposal will be deemed a certification that the OFFEROR will comply with all requirements set forth in this RFP. RFP responses will become part of the contract between the successful OFFEROR and the EUTF.

## 7.7 FEE PROPOSAL

Attach as Schedule 7, Attachment 5, *Fee Proposal*.

Proposed fees must adhere to the requirements provided in Section 3.2.1, *Evaluation of Mandatory Requirements*, and be provided using the proposal sheets, in Excel format, provided. Please print the completed proposal forms for the hard copy submissions of your proposal.

## 7.8 CONFIDENTIAL AND PROPRIETARY INFORMATION

Attach as Schedule 8, a list of 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.

The OFFEROR shall include 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 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.

## 7.9 EXCEPTIONS

Attach as Schedule 9, a list where the OFFEROR takes exception to the terms, conditions, specifications, or other requirements listed in the RFP. Reference the RFP section where the exception is taken, a description of the exception taken, and the proposed alternative, if any.

Unless listed, 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 2, *Performance Guarantees*, will not be accepted by the EUTF.

## ATTACHMENTS AND EXHIBITS

ATTACHMENT 1: OFFER FORM, OF-1

ATTACHMENT 2: PERFORMANCE GUARANTEES

ATTACHMENT 3: OFFEROR INFORMATION SHEET AND REFERENCES

ATTACHMENT 4: QUESTIONNAIRE

ATTACHMENT 5: FEE PROPOSAL

EXHIBIT A: EUTF ADMINISTRATIVE RULES

EXHIBIT B: CONTRACT FORM AND GENERAL CONDITIONS

EXHIBIT C: BUSINESS ASSOCIATE AGREEMENT

ATTACHMENT 1
OFFER FORM, OF-1

Benefit Consulting Services and Pharmacy Benefit Consulting and Audit Services
STATE OF HAWAII
DEPARTMENT OF BUDGET AND FINANCE
HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND (EUTF)
RFP NO. 27-001

Procurement Officer
State of Hawaii
Department of Budget and Finance/EUTF
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
PERFORMANCE GUARANTEES

Performance guarantees are not negotiable. Performance under these guarantees will be self-measured, calculated annually, and paid within 60 days after the end of each contract year.

**Benefit Consulting Services**

| Standard | Penalty Dollars at Risk |
|---|---|
| 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 the evaluation criteria which currently includes, but may be subject to change, timeliness and accuracy of responses and reports, ability to work with the EUTF and insurance carriers, and initiative and foresight in providing recommendations. | Total dollars at risk shall be $30,000 per year, calculated annually and paid within 60 days after the end of each contract year. |
| Provide all reports as described in this RFP and mutually agreed upon report calendar, plus any additional reports requested by the EUTF within time periods determined by the EUTF. | Total dollars at risk shall be $1,000 per missed report deadline capped at $10,000 per year, calculated annually and paid within 60 days after the end of each contract year. |
| Attendance of all regular Board and Benefits Committee meetings (in person if requested) by the Lead Consultant, or if agreed to by the Administrator, the Associate Consultant, unless prior approval not to attend is obtained from the Administrator. | Total dollars at risk shall be $1,000 per missed meeting capped at $10,000 per year, calculated annually and paid within 60 days after the end of each contract year. |

**Pharmacy Benefit Consulting Services**

| Standard | Penalty Dollars at Risk |
|---|---|
| Achieve a level 4 or higher (on a scale of 1 to 5) on Contractor consulting service levels to the EUTF as rated by the EUTF on an annual basis. EUTF to determine the evaluation criteria which currently includes, but may be subject to change, timeliness and accuracy of responses and reports, ability to work with the EUTF and PBM, and initiative and foresight in providing recommendations. | Total dollars at risk shall be $20,000 per year, calculated annually and paid within 60 days after the end of each contract year. |
| Provide all reports as described in this RFP and mutually agreed upon report calendar, plus any additional reports requested by the EUTF within time periods determined by the EUTF. | Total dollars at risk shall be $1,000 per missed report deadline capped at $5,000 per year, calculated annually and paid within 60 days after the end of each contract year. |
| Attendance of all regular Board and Benefits Committee meetings (in person if requested) by the Lead Pharmacy Consultant, unless prior approval not to attend is obtained from the Administrator. | Total dollars at risk shall be $1,000 per missed meeting capped at $5,000 per year, calculated annually and paid within 60 days after the end of each contract year. |

**Pharmacy Benefit Audit Services**

| Standard | Penalty Dollars at Risk |
|---|---|
| Achieve a level 4 or higher (on a scale of 1 to 5) on Contractor audit service levels to the EUTF as rated by the EUTF on an annual basis. EUTF to determine the evaluation criteria which currently includes but may be subject to change, continuity in project manager and lead technical personnel, updates to the EUTF at least every two (2) weeks, adherence to project timeline, content of the written report, and accuracy in the audit review. | Total dollars at risk shall be $20,000.00 per year, calculated annually and paid within 60 days after the end of each contract year. |

ATTACHMENT 3
OFFEROR INFORMATION SHEET AND REFERENCES

| **Offeror Information** | |
|---|---|
| Organization Name | |
| Parent Company Name (if any) | |
| Contact Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |

**Key Personnel**
Identify key personnel responsible for providing services described in this RFP. Include the name, title, address, phone number, and email address of each individual.

| **Key Personnel** | |
|---|---|
| **Lead Consultant** | |
| Lead Consultant Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |
| **Associate Consultant** | |
| Associate Consultant Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |
| **Lead Pharmacy Consultant** | |
| Lead Pharmacy Consultant Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |
| **Lead Auditor** | |
| Lead Auditor Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |

**Health Insurance Carriers and PBMs**

Provide a list of four major health insurance carriers who offer employee benefit plans and four major PBMs with whom your organization does business. Include the name, title, address, phone number, and email address of the key contact person with whom your firm negotiates rates and benefit plan coverages.

| **Health Insurance Carriers** | |
|---|---|
| **Carrier #1** | |
| Carrier Name | |
| Contact Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |
| **Carrier #2** | |
| Carrier Name | |
| Contact Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |
| **Carrier #3** | |
| Carrier Name | |
| Contact Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |
| **Carrier #4** | |
| Carrier Name | |
| Contact Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |

| **Pharmacy Benefit Managers** | |
|---|---|
| **PBM #1** | |
| PBM Name | |
| Contact Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |

| Pharmacy Benefit Managers | |
|---|---|
| **PBM #2** | |
| PBM Name | |
| Contact Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |
| **PBM #3** | |
| PBM Name | |
| Contact Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |
| **PBM #4** | |
| PBM Name | |
| Contact Name | |
| Title | |
| Address | |
| Phone Number | |
| Email | |

**Reference Information**

Provide three current client references for each contract proposal. The clients provided must be for the Lead Consultant, Lead Pharmacy Consultant, and Lead Auditor and should be comparable to the EUTF in terms of the following:

1. A public sector client with multiple employers (State and local government)
2. Provides active employee and retiree plans
3. Number of enrolled participants
4. Number and type of benefit plans offered
5. Geographic dispersion of participant population
6. Trust Fund setup (Board of Trustees with a dedicated Administration office)
7. Administration complexity

| Client References for Benefit Consulting Services | |
|---|---|
| **Reference #1** | |
| Client Name | |
| Plan Administrator Name | |
| Address | |
| Phone Number | |
| Email | |

| **Client References for Benefit Consulting Services** | |
|---|---|
| Active Employee Plans<br>• Number of employees covered<br>• Number of PPO plans offered<br>• Number of HMO plans offered | |
| Retiree Plans<br>• Number of retirees covered<br>• Number of PPO plans offered<br>• Number of HMO plans offered | |
| Annual premium volume | |
| Description of work performed | |
| **Reference #2** | |
| Client Name | |
| Plan Administrator Name | |
| Address | |
| Phone Number | |
| Email | |
| Active Employee Plans<br>• Number of employees covered<br>• Number of PPO plans offered<br>• Number of HMO plans offered | |
| Retiree Plans<br>• Number of retirees covered<br>• Number of PPO plans offered<br>• Number of HMO plans offered | |
| Annual premium volume | |
| Description of work performed | |
| **Reference #3** | |
| Client Name | |
| Plan Administrator Name | |
| Address | |
| Phone Number | |
| Email | |
| Active Employee Plans<br>• Number of employees covered<br>• Number of PPO plans offered<br>• Number of HMO plans offered | |
| Retiree Plans<br>• Number of retirees covered<br>• Number of PPO plans offered<br>• Number of HMO plans offered | |
| Annual premium volume | |
| Description of work performed | |

| **Client References for Pharmacy Benefit Consulting Services** | |
|---|---|
| **Reference #1** | |
| Client Name | |
| Plan Administrator Name | |
| Address | |
| Phone Number | |
| Email | |
| Active Employee Plans<br>• Number of employees covered<br>• Number of self-insured prescription drug plans offered | |
| Retiree Plans<br>• Number of retirees covered<br>• Number of self-insured prescription drug plans offered | |
| Annual premium volume | |
| Description of work performed | |
| **Reference #2** | |
| Client Name | |
| Plan Administrator Name | |
| Address | |
| Phone Number | |
| Email | |
| Active Employee Plans<br>• Number of employees covered<br>• Number of self-insured prescription drug plans offered | |
| Retiree Plans<br>• Number of retirees covered<br>• Number of self-insured prescription drug plans offered | |
| Annual premium volume | |
| Description of work performed | |
| **Reference #3** | |
| Client Name | |
| Plan Administrator Name | |
| Address | |
| Phone Number | |
| Email | |
| Active Employee Plans<br>• Number of employees covered<br>• Number of self-insured prescription drug plans offered | |

| **Client References for Pharmacy Benefit Consulting Services** | |
|---|---|
| Retiree Plans<br>• Number of retirees covered<br>• Number of self-insured prescription drug plans offered | |
| Annual premium volume | |
| Description of work performed | |

| **Client References for Pharmacy Benefit Audit Services**<br>(Clients must have completed one full audit cycle within the past three years.) | |
|---|---|
| **Reference #1** | |
| Client Name | |
| Plan Administrator Name | |
| Address | |
| Phone Number | |
| Email | |
| Active Employee Plans<br>• Number of employees covered<br>• Number of self-insured prescription drug plans offered | |
| Retiree Plans<br>• Number of retirees covered<br>• Number of self-insured prescription drug plans offered | |
| Annual premium volume | |
| Description of work performed | |
| **Reference #2** | |
| Client Name | |
| Plan Administrator Name | |
| Address | |
| Phone Number | |
| Email | |
| Active Employee Plans<br>• Number of employees covered<br>• Number of self-insured prescription drug plans offered | |
| Retiree Plans<br>• Number of retirees covered<br>• Number of self-insured prescription drug plans offered | |
| Annual premium volume | |
| Description of work performed | |
| **Reference #3** | |
| Client Name | |
| Plan Administrator Name | |
| Address | |

| **Client References for Pharmacy Benefit Audit Services**<br>(Clients must have completed one full audit cycle within the past three years.) | |
|---|---|
| Phone Number | |
| Email | |
| Active Employee Plans<br>• Number of employees covered<br>• Number of self-insured prescription drug plans offered | |
| Retiree Plans<br>• Number of retirees covered<br>• Number of self-insured prescription drug plans offered | |
| Annual premium volume | |
| Description of work performed | |

ATTACHMENT 4
QUESTIONNAIRE

**Benefit Consulting Services and Pharmacy Benefit Consulting Services Offeror**
**Answer questions A1 to D17, E18, and F20 to F30**

**Pharmacy Benefit Audit Services Offeror**
**Answer questions A1 to D17, E19, and G31 to J69**

| | **OFFEROR RESPONSE** |
|---|---|
| **A. General Information** | |
| 1. Do you agree that if this proposal results in your firm being awarded a contract and if there are inconsistencies between what was requested in the RFP and what is contained in your 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 (Y/N)? If no, explain. | |
| 2. Do you agree to be bound by the terms of the RFP and your proposal until a final contract is executed (Y/N)? If no, explain. | |
| 3. Are there Special Conditions outlined in Section 1.29 that you cannot meet (Y/N)? If yes, explain. | |
| **B. Organization Description** | |
| 4. State if your firm has operated under a different name within the past 10 years and provide the name that your firm previously operated under. | |
| 5. In the past three years, has your firm acquired, been acquired by, or merged with another organization (Y/N)? If yes, explain. | |
| 6. Is your firm anticipating undertaking any mergers, acquisitions, sell-offs, or change of ownership (Y/N)? If yes, explain. | |
| 7. Does your firm, including any affiliates, subsidiaries, or principals of the firm, have any pending or has had any legal actions against the State of Hawaii, the EUTF Board, any EUTF Trustee, or any insurance carriers/PBM identified in Section 2.10, *Current Plan Design and Funding Arrangements*, within the last five years (Y/N)? If yes, explain. | |

| | **OFFEROR RESPONSE** |
|---|---|
| 8. Disclose any current project responsibilities that may present a conflict of interest, including other EUTF projects. | |
| 9. Will any subcontractors be used to complete this project? If so, please identify the subcontractor and describe in detail the services it will provide. | |
| **C. Experience** | |
| 10. What is your organization's annual premium volume for health and group life insurance coverages written in: 1) the State of Hawaii, and 2) all jurisdictions including the State of Hawaii? | |
| 11. How many years has your firm been providing benefit consulting services, providing pharmacy benefit consulting services, and/or conducting independent PBM audits? | |
| 12. How many public sector clients does your firm have? | |
| 13. How many employer group clients based in Hawaii does your firm have? | |
| **D. Data Security** | |
| 14. Does your firm have a Social Security number privacy policy in place? | |
| 15. Describe the type of encryption, security and privacy procedures utilized by your firm when handling protected health information. | |
| 16. What specific safeguards does your firm have in place to prevent theft of confidential participant information? | |
| 17. Describe the data security provided for the claims data to be received from the insurance carriers/PBM. | |
| **E. Fee Proposal** | |
| 18. Confirm your annual fees are "all inclusive" and include all the services described in this RFP. | |
| 19. Confirm your understanding that the EUTF may alter the audit schedule (i.e., skip or combine years); therefore, the auditor must prepare an audit schedule for each year and submit for EUTF's approval before work commences. | |
| **F. Consulting Methodology** | |

| | **OFFEROR RESPONSE** |
|---|---|
| 20. What benchmarks will be used when comparing our plan design, utilization and pricing terms? | |
| 21. Does your firm have a claims data warehouse and if yes, how does your firm use the data collected? | |
| 22. Describe the methodology used when making plan change recommendations as described in Sections 4.2.1.b and 5.2.1.b, *Plan changes*. | |
| 23. Describe the methodology used to ensure the rate impact for proposed plan changes by the insurance carriers is reasonable. | |
| 24. Describe the methodology used when making recommendations on moving coverage from the medical plan to the prescription drug plan or vice versa. | |
| 25. Describe the methodology used to identify coverage gaps. | |
| 26. Describe the methodology used when evaluating clinical programs as described in Sections 4.2.1.c and 5.2.1.c, *Clinical programs*. | |
| 27. Describe the rate renewal methodology used when making rate recommendations as required in Section 4.2.2.a, *Rate renewals*. | |
| 28. Describe the methodology used to evaluate proposals for a new benefit plan/PBM contract as described in Sections 4.3.3 and 5.3.3, *RFP evaluation*. | |
| 29. Describe the methodology used to perform the market check as described in Section 5.2.2.b, *Market check*. | |
| 30. Do you have any creative ideas or suggestions to improve the EUTF benefit plans in terms of plan design, plan options, benefit plan administration, etc. (Y/N)? If yes, explain. | |
| **G. Audit Experience** | |
| 31. How many PBM audits did your firm conduct during calendar year 2024 and 2025 that were similar in size and scope to the services required by this RFP? | |
| 32. Provide the number of 2026 PBM audits currently underway note the number of audits similar in scope to the services required by this RFP. | |

| | **OFFEROR RESPONSE** |
|---|---|
| 33. Indicate the largest plan size from your 2025 audits listing client population number of PBM claims. | |
| 34. Describe any significant actions taken or pending against your company or any entities of your company by clients that contested the results of your findings. Include separate information related to any subcontractor engagement. | |
| 35. Has your firm ever been prevented by a vendor from performing a client's audit, or had the client terminate your contract prior to completion? If yes, describe the circumstances. | |
| 36. Briefly describe any aspects of your audit process that are unique to your firm and that distinguish you from your competitors. | |
| 37. Identify any restrictions you believe the PBM may present in completion of the scope of services defined in this RFP. | |
| **H. Project Management** | |
| 38. Please confirm who will present the audit reports to the EUTF Board? | |
| 39. Include a timeline demonstrating the first audit period of this proposed contract; display targeted dates for delivery of the preliminary draft reports to EUTF and the anticipated date(s) for their review comments and/or discussion. The timeline should assume notice of award on 12/16/26, contract to be effective 7/1/27 | |
| **I. Administrative Procedures Review** | |
| 40. Provide an overview of your operational review process (limit one page). Further detail is required in response to the following questions. | |
| 41. Confirm the proposed services will address the review components identified in the RFP Audit Scope. Identify any tasks not included and provide a brief explanation with your reason; include any variations between benefit categories. | |
| 42. How will you report on the vendor's subrogation opportunities pursued, recovered or lost? If this service is outsourced, will you determine the outcome of individual cases? | |
| 43. How will you determine that the vendors have an adequate system to identify potential areas | |

| | **OFFEROR RESPONSE** |
|---|---|
| of claim abuse such as fraudulent claims, duplicate claims, overcharging by providers, unnecessary physician services, etc.? | |
| 44. How will you report on the vendor's subrogation opportunities pursued, recovered or lost? If this service is outsourced, will you determine the outcome of individual cases? | |
| 45. How will you assess and document claims payment and claims appeal turn-around time to ensure that standards are strictly enforced for both? | |
| 46. Briefly identify any modifications in your proposed review elements to those listed in the Scope of Work defined in Section V of this RFP. | |
| **J. Audit Process and Steps** | |
| 47. Provide an overview of your proposed prescription drug review process (limit one page). Further detail is required in response to the following questions. | |
| 48. Do your auditors maintain any licensure/credentials that enhance their qualifications to conduct a prescription drug audit? | |
| 49. Will your staff be assigned to work sequentially on the different aspects of the audit or concurrently? | |
| 50. What steps will your auditors take to minimize disruption and reduce the impact of the audit on the PBM and their staff? | |
| 51. How will your auditors resolve problems/discrepancies that may occur during the audit (i.e., interpersonal problems or interpretation of contractual obligations)? | |
| 52. Explain how your auditors emphasize and/or report on areas which, if changed or corrected, could result in cost savings to the program. | |
| 53. If your audit uncovers claims administration weaknesses, confirm that these will be discussed with the vendor prior to inclusion in your final report. | |
| 54. Explain how your auditor will assess the retail claims adjudication system used by the PBM (including coding accuracy, etc.), and related performance guarantees. | |
| 55. Describe the steps your auditors will take to confirm that the PBM's claim payment | |

| | **OFFEROR RESPONSE** |
|---|---|
| system permits and correctly applies multi-tiered copays (including the assessment of copays for brand name drugs when generic drugs are available) and copays assessed to participants. | |
| 56. How will your auditors review and assess the quality of Drug Utilization Review (DUR) services (prospective, concurrent and retrospective) provided by the PBM or its subcontractor? | |
| 57. How will your auditors assess that the EUTF is receiving maximum rebates negotiated by the PBM with manufacturers? | |
| 58. What is your process for reconciling issues identified with the PBM? | |
| 59. Has CVS/Caremark previously provided you with access and support for an onsite or remote access rebate audit? Identify any obstacles you may have encountered or anticipate in relation to the EUTF plan. | |
| 60. What is the date of your most recent onsite or remote access rebate audit for CVS? | |
| 61. Confirm the prescription drug audit will include electronic testing of 100% of all claims processed for each of the following. Provide an explanation if the proposal does not electronically test 100% or does not perform the stated task for a specific benefit category.<br>a. Patient eligibility on the date of service(s) with comparison to EUTF records;<br>b. Independent verification of average wholesale price (AWP)<br>c. Comparison of actual claim discounts and dispensing fees to contractual guarantees<br>d. Comparison of actual claim adjudication to plan design and benefit rules<br>e. Appropriate patient cost-shares (i.e., copayment, deductible, coinsurance);<br>f. Potential duplication of payments;<br>g. Reimbursement of expenses excluded or limited by plan design; and<br>h. Consistency in coordination of benefits, including subrogation and workers' compensation. | |

| | **OFFEROR RESPONSE** |
|---|---|
| 62. Confirm the prescription rebate audit includes the following.<br>a. Identification of all rebateable claims and identification of categories properly excluded from rebates, according to the PBM contract.<br>b. Verification of earned rebates by quarter by NDC<br>c. Comparison of earned rebates file to manufacturer rebate submission file<br>d. Onsite review of applicable manufacturer contracts to verify at a minimum 75% of total rebate amounts due are properly paid to the EUTF.<br>e. Comparison of PBM receipts from manufacturers to earned rebate file<br>f. Comparison of actual rebates to contractual guarantees | |
| 63. Confirm the prescription rebate credit review includes approximately 75% of the dollar value of the rebate credits as part of the onsite rebate credit review that includes.<br>a. Review accuracy to ensure rebate credit was calculated correctly.<br>b. Review accuracy to ensure that rebate on the claims was invoiced accurately<br>c. Calculate and analyze the WAC and drug cost by NDS before and after the change | |
| 64. How will you verify the validity of any processing errors discovered during an electronic review of claims? | |
| 65. Each performance guarantee requires confirmation of the measures self-reported to EUTF. Provide an overview of the process you propose to ensure compliance with performance guarantees. | |
| 66. Indicate how your auditors define errors; explain any weighting. Will your definition be consistent with that used in the administrator's established guarantees? | |
| 67. Provide your definition of payment and non-financial errors with mention of any overlap in classification of procedural errors and payment errors. | |
| 68. How will you assess and document claims payment and claims appeal turn-around time | |

| | **OFFEROR RESPONSE** |
|---|---|
| to ensure that standards are strictly enforced for both? | |
| 69. How will you evaluate the automated system used to process/pay claims? How will you assess any systems that are not automated? | |

ATTACHMENT 5
FEE PROPOSAL

Please submit the total contract cost for providing each of the services noted below. Fees shall include labor, materials, supplies, travel and any other costs incurred, including costs to attend meetings with EUTF Administration and Board of Trustees, to provide the specified services.

**Benefit Consulting Services:**

| | **Contract Period (7/1/27-6/30/29)** | | **Optional 2nd Contract Period (7/1/29-6/30/31)** | | **Optional 3rd Contract Period (7/1/31-6/30/33)** | | |
|---|---|---|---|---|---|---|---|
| | **Year 1** 7/1/27-6/30/28 | **Year 2** 7/1/28-6/30/29 | **Year 3** 7/1/29-6/30/30 | **Year 4** 7/1/30-6/30/31 | **Year 5** 7/1/31-6/30/32 | **Year 6** 7/1/32-6/30/33 | **Total** |
| Benefit Consultant Fees | $ | $ | $ | $ | $ | $ | **$** |
| Additional Work[1] | | | | | | | |
| Lead Hourly Rate | $ | $ | $ | $ | $ | $ | |
| Other Hourly Rate | $ | $ | $ | $ | $ | $ | |

[1] The hourly rates for additional work provided above will not be included as part of the proposal evaluation.

If the OFFEROR is awarded more than one contract, the OFFEROR will discount the Benefit Consultant fees provided in the table above by: __%

The EUTF reserves the right to terminate one contract and retain the other, and in such an event, the discount rate would no longer apply.

**Pharmacy Benefit Consulting Services:**

| | **Contract Period (7/1/27-6/30/29)** | | **Optional 2nd Contract Period (7/1/29-6/30/31)** | | **Optional 3rd Contract Period (7/1/31-6/30/33)** | | |
|---|---|---|---|---|---|---|---|
| | **Year 1** 7/1/27-6/30/28 | **Year 2** 7/1/28-6/30/29 | **Year 3** 7/1/29-6/30/30 | **Year 4** 7/1/30-6/30/31 | **Year 5** 7/1/31-6/30/32 | **Year 6** 7/1/32-6/30/33 | **Total** |
| Pharmacy Benefit Consultant Fees | $ | $ | $ | $ | $ | $ | **$** |
| Additional Work[1] | | | | | | | |
| Lead Hourly Rate | $ | $ | $ | $ | $ | $ | |
| Other Hourly Rate | $ | $ | $ | $ | $ | $ | |

[1] The hourly rates for additional work provided above will not be included as part of the proposal evaluation.

If the OFFEROR is awarded more than one contract, the OFFEROR will discount the Pharmacy Benefit Consultant fees provided in the table above by: __%

The EUTF reserves the right to terminate one contract and retain the other, and in such an event, the discount rate would no longer apply.

**Pharmacy Benefit Audit Services:**

| | **Contract Period (7/1/27-6/30/29)** | | **Optional 2nd Contract Period (7/1/29-6/30/31)** | | **Optional 3rd Contract Period (7/1/31-6/30/33)** | | |
|---|---|---|---|---|---|---|---|
| | **Year 1** | **Year 2** | **Year 3** | **Year 4** | **Year 5** | **Year 6** | **Total** |
| Retiree Audit Period | 1/1/26-12/31/26 | 1/1/27-12/31/27 | 1/1/28-12/31/28 | 1/1/29-12/31/29 | 1/1/30-12/31/30 | 1/1/31-12/31/31 | |
| Active Audit Period | 7/1/26-6/30/27 | 7/1/27-6/30/28 | 7/1/28-6/30/29 | 7/1/29-6/30/30 | 7/1/30-6/30/31 | 7/1/31-6/30/32 | |
| Audit Fees | | | | | | | |
| Administrative Procedures | $ | $ | $ | $ | $ | $ | |
| Eligibility Comparison | $ | $ | $ | $ | $ | $ | |
| Electronic Analysis | $ | $ | $ | $ | $ | $ | |
| Rebate Audit Review | $ | $ | $ | $ | $ | $ | |
| Rebate Credit Review | $ | $ | $ | $ | $ | $ | |
| Performance Guarantees | $ | $ | $ | $ | $ | $ | |
| **Total** | **$** | **$** | **$** | **$** | **$** | **$** | **$** |

The OFFEROR must agree to perform all audit periods and audit components. However, EUTF reserves the right to combine or eliminate audit periods or eliminate audit components based on prior findings, auditor recommendations, and budget.

If the OFFEROR is awarded more than one contract, the OFFEROR will discount the Audit fees provided in the table above by: __%

The EUTF reserves the right to terminate one contract and retain the other, and in such an event, the discount rate would no longer apply.

Authorized Signature

Title

Company Name Date

# HAWAII EMPLOYER-UNION HEALTH BENEFITS TRUST FUND

## ADMINISTRATIVE RULES

## CONTENTS


1.00 General Provisions

- 1.01 Purpose
- 1.02 Definitions
- 1.03 Public Information
- 1.04 Computation of Time
- 1.05 Officers of the Board
- 1.06 Committees of the Board
- 1.07 Meetings of the Board
- 1.08 Appearances Before the Board
- 1.09 Delegation of Authority
- 1.10 State Ethics Code
- 1.11 Controlling Law
- 1.12 Authority of the Board to Waive Rule Provisions
- 1.13 Responsibilities of Employee-Beneficiaries and Public Employers; Enforcement Actions of 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

3.00 Eligibility for Enrollment

- 3.01 Health Benefits
- 3.02 HSTA VB Health Benefits Offered by the Fund
- 3.03 Group Life Insurance

4.00 Enrollment Procedures

| | |
|---|---|
| 4.01 | Application for Enrollment |
| 4.02 | Rejection of an Enrollment Application |
| 4.03 | Dual and Split 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 |
| 4.10.7 | Overdraft or Non-Sufficient Funds Fees |
| 4.11 | Cancellation of Enrollment; Effective Dates of Cancellation |
| 4.12 | Termination of Enrollment; Effective Dates of Termination |
| 4.13 | Reinstatement of Enrollment |
| 4.14 | Mandatory Enrollment in Recurring Electronic Premium Deductions |
| 4.15 | Overpayments |

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 |

## 1.00 GENERAL PROVISIONS

1.01 Purpose
1.02 Definitions
1.03 Public Information
1.04 Computation of Time
1.05 Officers of the Board
1.06 Committees of the Board
1.07 Meetings of the Board
1.08 Appearances Before the Board
1.09 Delegation of Authority
1.10 State Ethics Code
1.11 Controlling Law
1.12 Authority of the Board to Waive Rule Provisions
1.13 Responsibilities of Employee-Beneficiaries and Public Employers; Enforcement Actions of the Fund

### 1.01 Purpose

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

### 1.02 Definitions

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

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

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

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

"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, child under legal guardianship, foster child of a retired employee hired prior to July 1, 2024, 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. 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 who lives with an employee in a regular parent-child relationship. A child under legal guardianship is a child 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.

"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.

"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) the age a child loses eligibility as a dependent-beneficiary is upon reaching age twenty-six; (2)(a) a child of a deceased retired employee who does not have a surviving parent who is eligible to be an employee-beneficiary is upon reaching age twenty-six and (2)(b) a child of an employee killed in the performance of the employee's duty and does not have a surviving parent who is eligible to be an employee-beneficiary is upon reaching age twenty-six. A child eligible due to legal guardianship loses eligibility as a dependent-beneficiary upon the age of eighteen (age of majority). A foster child of a retired employee hired prior to July 1, 2024, loses eligibility as a dependent-beneficiary upon reaching the age of eighteen (age of majority).

"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.

"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. The Fund may charge a minimum of twenty-five cents per page, or an amount to be approved by the board, for each copy of a document that it reproduces under Section 92-21, HRS, pursuant to a public record request under chapter 92F, HRS, and shall include, but not be limited to, the labor, material, electricity, equipment, certification, and other related costs for reproduction.

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 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 attorney licensed to practice law in the state of Hawaii. 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. The board shall be afforded deference with respect to the interpretation of Chapter 87A and these rules.

## 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 unless the board determines that, based on the subject matter or complexity of the requested adoption, amendment or repeal of the rule, a longer period of deliberation is warranted. 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 and documentation supporting those 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) The board at its discretion shall:

(1) Render a decision on the petition for a declaratory ruling without the petitioner's involvement in the board deliberation;

(2) Proceed with board deliberation with the petitioner appearing before the board to answer questions that the board may have. If the petitioner is to be present at the board deliberation on the petition, the board shall begin deliberations at the earliest scheduled full board meeting. The board may continue deliberations over several board meetings if the board deems it necessary 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 not be bound by the recommendations and the board may further deliberate on the petition pursuant to section (e)(2) above upon which it 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 unless the board determines that, based on the subject matter or complexity of the petition, a longer period of deliberation is warranted. Upon the disposition of the petition, the board shall promptly notify the petitioner.

(g) 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 and documentation supporting those 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.

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, or provide acceptable evidence to support any statements made, 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 unless the board determines that, based on the subject matter or complexity of the petition, a longer period of deliberation is warranted. The board shall not be required to hold a hearing on any appeal. The board may decide to voluntarily hold a hearing on an appeal if in its discretion the board determines further development of a record is warranted under the circumstances at the time and 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. The board's decision to grant or deny the appeal, hold a hearing, or delegate a matter to another person or entity for hearing and decision is final. The aggrieved party may seek judicial review of the board's decision to grant or deny the appeal, hold a hearing, or delegate a matter to another person or entity for hearing. The review shall not be subject to Chapter 91 of the Hawaii Revised Statutes. Any matter decided by the board under this section shall be considered an exhaustion of administrative remedies and any affected parties may have leave to seek due process by filing a civil complaint in the appropriate Hawaii Court.

(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; and
(4) External appeal using an IRO for urgent care.

(b) Definitions pertinent to claims and appeals.

(1) "Adverse benefit determination" means 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, means specifically a self-insured plan administered benefit.
(3) "Claim" means 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) means 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" means a claim for a Fund benefit that is not a Pre-Service Claim.

(6) "Pre-Authorization" means a 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" means 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" means 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's 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's 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's or dependent-beneficiary's attending physician may submit an appeal by contacting the self-insured plan administrator. The employee-beneficiary's 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's 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's 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's 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's 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's 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 an employee-beneficiary or dependent-beneficiary 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's 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's 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's 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's 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's 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's 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's or dependent-beneficiary's request for external review is complete and the employee-beneficiary's 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's or dependent-beneficiary's denied Claim, such as:

a) The employee-beneficiary's 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's 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's 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's 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's 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's 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's 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's 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's or dependent-beneficiary's name, contact information including mailing address and daytime phone number, employee-beneficiary's 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's 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's 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's 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's 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's 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's 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's 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's 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's 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's or dependent-beneficiary's 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 HSTA VB Health Benefits Offered by the Fund
3.03 Group Life Insurance

### 3.01 Health Benefits

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

(1) An employee;
(2) A retired employee;
(3) The surviving spouse or 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 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 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), a child ceases to be eligible at the end of the month that the dependent 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. The following persons shall be eligible for coverage as dependent-beneficiaries in the benefit plans offered or sponsored by the Fund:

(1) An employee-beneficiary's spouse or 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;
(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) and (4) above, a child's 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.

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 HSTA VB Health Benefits Offered by the Fund**

(a) Eligibility. Employee-beneficiaries who were enrolled in the HSTA VB health benefit plan(s) effective January 1, 2011 upon the dissolution of the HSTA Voluntary Employees Beneficiary Association Trust and their dependent-beneficiaries who meet the eligibility requirements detailed in Rule 3.01.

(b) Loss of Eligibility. An employee-beneficiary who voluntarily enrolls in a non-HSTA VB plan offered by the Fund shall permanently forfeit their eligibility in the HSTA VB health benefit plans. This shall include a bargaining unit change even if the employee-beneficiary subsequently returns to bargaining unit 05. This shall not apply to an employee-beneficiary who enrolls as a dependent-beneficiary in a non-HSTA VB plan offered by the Fund provided the employee-beneficiary remains enrolled in the HSTA VB life insurance.

**3.03 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 and Split 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
4.10.7 Overdraft or Non-Sufficient Funds Fees
4.11 Cancellation of Enrollment; Effective Dates of Cancellation
4.12 Termination of Enrollment; Effective Dates of Termination
4.13 Reinstatement of Enrollment
4.14 Mandatory Enrollment in Recurring Electronic Premium Deductions
4.15 Overpayments

### 4.01 Application for Enrollment

(a) General Rule. 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. References to submission of enrollment applications and other documents also include submission through the member self-service portal.

(b) Filing Date. 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) Standards and Procedures for Filing an Enrollment Application. 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) Representative for Filing an Enrollment Application. 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) General Rule. Any enrollment application may be partially or fully rejected if it is incomplete or does not contain all information required to be provided by the employee-beneficiary.

(b) Rejection. 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. Notification shall be provided to the employee-beneficiary of the rejection of any enrollment application.

**4.03 Dual and Split Enrollment**

(a) Dual 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.

(b) Split Enrollment. Employee-beneficiaries who are married or in a domestic partnership and have an enrolled dependent-beneficiary are limited to employer contributions for a family plan. If the employee-beneficiaries elect to enroll in a self and two party or self and family coverage, the employee-beneficiaries shall be responsible for health benefit premium in excess of the maximum employer contribution for a family plan. The additional premium must be paid directly to the Fund within the month for which coverage was provided. Failure to make a timely payment in full shall be treated as a shortage as defined in Rule 4.10.

**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 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) General Rule. 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; (4) cancellation of enrollment in a Fund benefit plan upon acquiring coverage from a non-Fund plan must be filed within ninety (90) days of the event.

(b) Rejection. 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.

(c) Social Security Number or Individual Taxpayer Identification Number. An application will not be processed if it does not include a Social Security Number (SSN) for an employee-beneficiary and/or a SSN or Individual Taxpayer Identification Number (ITIN) for a dependent-beneficiary for whom enrollment is being requested. The employee-beneficiary and/or dependent-beneficiary shall be added retroactive to the effective date of the event upon the Fund's receipt of the employee-beneficiary's and/or dependent-beneficiary's SSN or ITIN.

### 4.06 Notification of Changes in Personal Information

Each employee-beneficiary shall immediately notify the Fund 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 fund shall determine employee-beneficiaries' entitlement to state and county contributions in retirement:

(a) Based on an employee-beneficiary's membership date as determined by the Employees Retirement System (ERS) at the date of retirement; and
(b) Pursuant to applicable state law determining the employee-beneficiary's employer contributions in retirement.

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's 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) General Rule. 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) Employee Strike Authorized by Chapter 89. 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) Transfer of Employment. 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.

### 4.10.7 Overdraft or Non-Sufficient Funds Fees

Employee-beneficiaries may be required to reimburse the Fund for any amounts relating to overdraft or non-sufficient funds fees.

### 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 ninety (90) 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 in 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;
(2) The employee-beneficiary and any covered dependent-beneficiaries had no covered services during the non-payment period; and
(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.

**4.14 Mandatory Enrollment in Recurring Electronic Premium Deductions**

(a) General Rule. Employee-beneficiaries who retire or become a surviving-beneficiary on or after September 15, 2020 and who are required to pay all or a portion of their premiums shall have their share of premiums electronically deducted and transmitted to the Fund monthly by the Employees' Retirement System of the State of Hawaii or the employee-beneficiary's financial institution in the United States that is a participant in the ACH network. Premium payments shall be made electronically unless waived by the Fund and another method is determined to be more appropriate.

(b) New Enrollment in Recurring Electronic Premium Deductions. Employee-beneficiaries who are required to pay a portion of their retiree premiums shall submit an Electronic Deduction Authorization Form within sixty (60) days of the effective date of the event that results in the required premium. Failure to submit an Electronic Deduction Authorization Form within

sixty (60) days shall result in either the rejection of the employee-beneficiary's enrollment application or termination of health benefit plans as of the first day following the last period for which full payment was received by the Fund.

If the Electronic Deduction Authorization Form is submitted after rejection of an enrollment application or termination of health benefit plans, the changes requested in the enrollment application or reinstatement of terminated health benefit plans, respectively, shall be effective retroactively to the effective date of enrollment application changes or the termination date, respectively.

(c) Returned Recurring Electronic Premium Deduction. If an employee-beneficiary's recurring electronic deduction is returned by the Employees' Retirement System of the State of Hawaii or financial institution in the United States that is a participant in the ACH network, a notice from the Fund will be sent to the employee-beneficiary. The employee-beneficiary has thirty (30) days from the date of the notice to submit a valid Electronic Deduction Authorization Form. Failure to provide a valid Electronic Deduction Authorization Form within thirty (30) days of the date of the notice will result in termination of health benefit plans as of the first day following the last period for which full payment was made. Health benefit plan(s) may be reinstated if their enrollment has not been terminated within twelve (12) months of the date of the notice of cancellation and the employee-beneficiary submits a valid Electronic Deduction Authorization Form within sixty (60) days from the date of the notice of cancellation. The reinstatement shall be made so that the employee-beneficiary and dependent-beneficiaries suffer no break in coverage.

**4.15 Overpayments**

If an employee-beneficiary is overpaid for a reimbursement, refund, or any other reason, the Fund may automatically withdraw the over-paid amount from the financial account on record for the employee-beneficiary.

## 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; (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, sixty (60) days when the termination is from a Medicaid plan. The employee-beneficiary may only enroll during the next open enrollment period when the enrollment application is received more than forty-five (45) days, sixty (60) days for Medicaid, 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; (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 an eligible foster child the date indicated on the State of Hawaii Department of Human Services Form, Admission to Foster Home;
(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; and
(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 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 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) Premium Contributions. 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 an eligible 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; (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 an eligible foster child, the event date shall be the date indicated on the State of Hawaii Department of Human Services Form, 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 Eligible Dependent's Coverage. An employee-beneficiary may change enrollment to add an eligible dependent-beneficiary in the Fund health benefit plans in which the employee-beneficiary is currently enrolled when a dependent-beneficiary loses coverage in any health benefit plan. The effective date of the change in enrollment shall be the date that the dependent-beneficiary loses coverage in the 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, sixty (60) days when the termination is from a Medicaid plan. Coverage for a dependent-beneficiary may be added at the next open

enrollment period when enrollment applications are received after forty-five (45) days, sixty (60) days for Medicaid, 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. For active employee-beneficiaries the effective date of the change shall be the first day of the pay period following the Fund being notified of the geographic relocation.

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.

(5) The retired employee-beneficiary or dependent-beneficiary enrolls in Medicare Part B. An enrollment application shall be filed within sixty (60) days of the retired employee-beneficiary's or dependent-beneficiary's Medicare Part B effective date. The effective date of the change shall be the effective date of the retired employee-beneficiary's or dependent-beneficiary's Medicare Part B or the first of the month following the Fund's receipt of the enrollment application, whichever is later. The retired employee-beneficiary and dependent-beneficiary will remain in the previous medical and/or prescription drug plan(s) until the effective date of the new medical and/or prescription drug plan(s).

(6) The employee-beneficiary is enrolled in HSTA VB health benefit plans and changes to a bargaining unit (BU) other than 05, may enroll in a non-HSTA VB health benefit plan offered by the Fund. An enrollment application shall be filed within forty-five (45) days of the effective date of the BU change. Non-HSTA VB benefit plan options shall be limited to the benefit plan(s) lost under the HSTA VB health benefit plans. If an enrollment application is not received within forty-five (45) days of the effective date of the BU change, the employee-beneficiary shall be enrolled in the comparable non-HSTA VB health benefit plan offered by the Fund. The effective date of the change shall be the effective date of the bargaining unit change.

(f) Dependent Not Enrolled in a Fund Medical and/or Prescription Drug Plan Enrolls in Medicare Part B. A retired employee-beneficiary may add coverage for dependent-beneficiaries in the Fund medical and/or prescription drug plan(s), when the dependent-beneficiary enrolls in

Medicare Part B. An enrollment application shall be filed within sixty (60) days of the dependent-beneficiary's Medicare Part B effective date. The effective date of the addition shall be the effective date of the dependent-beneficiary's Medicare Part B, except when a health insurance carrier only offers a Medicare-only medical plan, in which case the effective date of the addition shall be the dependent-beneficiary's Medicare Part B effective date or the first of the month following the Fund's receipt of the enrollment application, whichever is later. If the health insurance carrier offers a non-Medicare medical and/or prescription drug plan, the dependent-beneficiary will be enrolled in the non-Medicare medical and/or prescription drug plan until the effective date of the Medicare medical and/or prescription drug plan.

The Fund shall determine the required proof documents.

(g) Premium Contributions. 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 or Dependent Becomes Eligible to Enroll in Medicare Part B. 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 or Dependent Eligible for Medicare Part B at the Time of Retirement. 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. Retired employee-beneficiaries and/or their dependent-beneficiaries shall not be enrolled in medical and/or prescription drug coverage retroactive to the date of retirement if proof of enrollment in Medicare Part B is not provided within sixty (60) days of retirement.

(c) Medicare Part B Reimbursement. Retired employee-beneficiaries hired prior to July 1, 2023 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. Retired employee-beneficiaries hired on or after July 1, 2023 shall be reimbursed quarterly the cost of their Medicare Part B premiums, less IRMAA premiums and penalties, for the retired employee-beneficiary only. 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 Medicare Part B premium amount from 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 in the United States that is a participant in the ACH network 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) If a retired employee-beneficiary and/or their spouse/partners provide the Fund appropriate proof for retroactive Medicare Part B reimbursement not related to an IRMAA to the Fund more than six years after the effective date of the adjustment, the Fund shall only reimburse for a six-year retroactive period, subject to 5.03(c)(1). The Fund shall not retroactively reimburse the estate of a deceased retired employee-beneficiary.

(5) 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) Medicare Prescription Drug Plan. 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) Retired Employee. 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) Dependent. 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) Medicare Prescription Drug Plan. 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) Effective Date of Cancellation. 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 Rule 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;
(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.

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; (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) Reinstatement Due to Medicare Enrollment. Retired employee-beneficiaries and/or dependent-beneficiaries whose medical and/or prescription drug coverages were cancelled under 5.03(a) or who were not enrolled under 5.03(b) due to failure to show proof of enrollment in Medicare Part B, may be reinstated or enrolled in the same or elected, as applicable, 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) 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) Premium Contributions. 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) General Rule. Retired employee-beneficiaries and 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) Reimbursement of Premiums. 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) Proof of Paid Premiums. 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 have 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 Fund shall determine the required proof documents.

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, August 27, 2019, September 29, 2020, April 27, 2021, August 29, 2023, June 25, 2024, October 22, 2024, and June 24, 2025. The rules shall take effect on the first day after filing with the Lieutenant Governor's Office.

James Wataru, Chairperson
Hawaii Employer-Union Health
Benefits Trust Fund

APPROVED

Josh Green, M.D.
Governor
State of Hawaii

9-9-2025

Date Filed, Office of the Lieutenant
Governor

APPROVED AS TO FORM:

Deputy Attorney General

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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 _____,
*(Insert name of state department, agency, board or commission)*
State of Hawaii ("STATE"), by its _____,
*(Insert title of person signing for State)*
(hereafter also referred to as the HEAD OF THE PURCHASING AGENCY or designee ("HOPA")), whose address is _____
_____ and _____
("CONTRACTOR"), a _____
*(Insert corporation, partnership, joint venture, sole proprietorship. or other legal form of the Contractor)*
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
*(Legal authority to enter into this Contract)*
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**

CORPORATE SEAL
(If available)

_____
*(Name of Contractor)*

_____
*(Signature)*

_____
*(Print Name)*

_____ *
*(Print Title)*

_____
*(Date)*

**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 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 _____

Attachment - S1

STATE OF HAWAII

# SCOPE OF SERVICES

Attachment – S2

STATE OF HAWAII

# COMPENSATION AND PAYMENT SCHEDULE

Attachment – S3

STATE OF HAWAII

# TIME OF PERFORMANCE

Attachment – S4

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

## Table of Contents

Page(s)


1. Coordination of Services by the STATE ..... 2
2. Relationship of Parties: Independent Contractor Status and Responsibilities, Including Tax Responsibilities ..... 2
3. Personnel Requirements ..... 3
4. Nondiscrimination ..... 3
5. Conflicts of Interest ..... 3
6. Subcontracts and Assignments ..... 3
7. Indemnification and Defense ..... 4
8. Cost of Litigation ..... 4
9. Liquidated Damages ..... 4
10. STATE'S Right of Offset ..... 4
11. Disputes ..... 4
12. Suspension of Contract ..... 4
13. Termination for Default ..... 5
14. Termination for Convenience ..... 6
15. Claims Based on the Agency Procurement Officer's Actions or Omissions ..... 8
16. Costs and Expenses ..... 8
17. Payment Procedures; Final Payment; Tax Clearance ..... 9
18. Federal Funds ..... 9
19. Modifications of Contract ..... 9
20. Change Order ..... 10
21. Price Adjustment ..... 11
22. Variation in Quantity for Definite Quantity Contracts ..... 11
23. Changes in Cost-Reimbursement Contract ..... 11
24. Confidentiality of Material ..... 12
25. Publicity ..... 12
26. Ownership Rights and Copyright ..... 12
27. Liens and Warranties ..... 12
28. Audit of Books and Records of the CONTRACTOR ..... 13
29. Cost or Pricing Data ..... 13
30. Audit of Cost or Pricing Data ..... 13
31. Records Retention ..... 13
32. Antitrust Claims ..... 13
33. Patented Articles. ..... 13
34. Governing Law ..... 14
35. Compliance with Laws ..... 14
36. Conflict between General Conditions and Procurement Rules ..... 14
37. Entire Contract ..... 14
38. Severability ..... 14
39. Waiver ..... 14
40. Pollution Control ..... 14
41. Campaign Contributions ..... 14
42. Confidentiality of Personal Information ..... 14

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 section103D-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 for by this Contract, if the STATE learns of a material breach by CONTRACTOR of this paragraph by CONTRACTOR, the STATE may at its sole discretion:

(1) Provide an opportunity for the CONTRACTOR to cure the breach or end the violation; or

(2) Immediately terminate this Contract.

In either instance, the CONTRACTOR and the STATE shall follow chapter 487N, HRS, with respect to notification of a security breach of personal information.

e. Records Retention.

(1) Upon any termination of this Contract or as otherwise required by applicable law, CONTRACTOR shall, pursuant to chapter 487R, HRS, destroy all copies (paper or electronic form) of personal information received from the STATE.

(2) The CONTRACTOR and any subcontractors shall maintain the files, books, and records that relate to the Contract, including any personal information created or received by the CONTRACTOR on behalf of the STATE, and any cost or pricing data, for at least three (3) years after the date of final payment under the Contract. The personal information shall continue to be confidential and shall only be disclosed as permitted or required by law. After the three (3) year, or longer retention period as required by law has ended, the files, books, and records that contain personal information shall be destroyed pursuant to chapter 487R, HRS or returned to the STATE at the request of the STATE.

# BUSINESS ASSOCIATE AGREEMENT

This Agreement is effective as of _____, between the Hawaii Employer-Union Health Benefits Trust Fund, State of Hawaii (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. Ping. "Ping" shall mean a request-response utility or other method used to determine whether a specific Internet Protocol (IP) address or host exists or is accessible.

n. Port Scan. "Port Scan" shall mean a process that sends requests to a host to determine network services that are available on that host.

o. 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.

p. 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.

q. 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.

r. Secretary. "Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services or designee.

s. 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.

t. 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: _____, 20____

[*name of business associate*]
("BUSINESS ASSOCIATE")

By _____

Its _____

Date: _____, 20____

APPROVED AS TO FORM:

_____
Deputy Attorney General