

# **Research Corporation Of The University Of Hawai'i**

## **BENEFITS OPEN ENROLLMENT INFORMATION PACKET**

**FOR ACTIVE REGULAR STATUS 50% FTE AND  
ABOVE EMPLOYEES**

***Benefits Plan Year Effective July 1, 2017 through  
June 30, 2018***

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## BENEFIT PLAN REMINDERS

**If you are NOT making changes to your medical and/or dental plan(s), you do NOT need to submit any forms. Your current medical and/or dental insurance will remain the same for plan year July 1, 2017 to June 30, 2018.**

**If you cancel or continue to waive your medical insurance, you MUST submit the RCUH Group Health Insurance Waiver Form – RCUH Open Enrollment (B-5WB).**

During open enrollment, you are able to make the following changes effective July 1, 2017:

- Change medical insurance plans
  - Submit the RCUH Group Health Enrollment/Change Form (B-5H)
- Enroll or terminate individual and/or dependent coverage in the medical/dental plans
  - Submit the RCUH Group Health Enrollment/Change Form (B-5H)
  - Submit the RCUH Group Health Insurance Waiver Form (B-5WB)
- Enroll in the Flexible Spending Account Plan
  - Submit the RCUH Flexible Spending Enrollment/Change Form (B-5F)
- Enroll in Supplemental Long Term Care Coverage
  - Email [jeni@ebchawaii.com](mailto:jeni@ebchawaii.com) or [lachelle@ebchawaii.com](mailto:lachelle@ebchawaii.com)

❖ **Change in Maximum Annual Election Amount for Flexible Spending Account for Medical Expenses:** New annual election for this upcoming plan year is \$2,600 per year. *Please refer to the 3.530 RCUH Flexible Spending Plans policy and the RCUH Cafeteria Plan-Summary Plan Description for further information.*

❖ **Maximum Annual Election Amount for Flexible Spending Dependent Care Expenses Account and Pre-Tax Transportation Benefits Plans:** In the upcoming plan year, **July 1, 2017 – June 30, 2018**, all employees will be able to deduct a maximum of \$5,000 per year if married filing jointly or (\$2,500 if married file taxes separately) for the Flexible Spending Dependent Care Expense Account and \$255 per month for the Pre-Tax Transportation Benefits Plans.

❖ **IMPORTANT NOTICE! Flexible Spending Accounts – Medical and/or Dependent Care Expense Reimbursement Account(s):** You **MUST ENROLL** by submitting the RCUH Flexible Spending Enrollment/Change Form (B-5F) with your election amounts(s) for the new plan year. This benefit will not automatically continue into the new plan year.

All forms are due by **May 17, 2017** and must be returned to RCUH Human Resources via one of the following methods:

- Email: [rcuh\\_benefits@rcuh.com](mailto:rcuh_benefits@rcuh.com)
- Mail: RCUH HR Dept.  
1601 East–West Road  
Burns Hall 4th Floor, Makai Wing  
Honolulu, HI 96848
- Fax: (808) 956-5022

**RCUH Human Resources Benefits Contact Information:**  
**Phone: (808) 956-2326 / (808) 956-0456**  
**Email: [rcuh\\_benefits@rcuh.com](mailto:rcuh_benefits@rcuh.com)**

## BENEFIT PLAN CHANGES

### The Benefit Open Enrollment Sessions will cover the following changes:

- New plan benefits to your plans.
- Changes to certain services including co-payments, out of pocket maximums and co-insurance.
- Changes in the cost of plan premiums.

#### ❖ Medical and Dental Premium Increase

The following are the rate increases effective July 1, 2017 to June 30, 2018 per plan for HMSA, Kaiser and HDS (refer to page 6 for the RCUH Monthly Premiums Effective July 1, 2017 to June 30, 2018):

| RCUH Group Medical and Dental Plans | % Rate Changes Effective July 1, 2017 |
|-------------------------------------|---------------------------------------|
| HMSA Preferred Provider             | 4.2%                                  |
| HMSA Health Plan Hawaii (HPH) Plus  | 4.0%                                  |
| HMSA Comprehensive Medical          | 3.0%                                  |
| HMSA HPH Basic                      | 9.5%                                  |
| Kaiser Plan A                       | -0.5%                                 |
| Kaiser Plan B                       | 0%                                    |
| HDS                                 | 0%                                    |

## OPEN ENROLLMENT SESSIONS

Sign-ups for Open Enrollment sessions can be done online via Employee Self Service (ESS). Please go to [www.rcuh.com](http://www.rcuh.com) to sign in to ESS.

| Date                   | Time                | Location   |
|------------------------|---------------------|--|
| Monday, May 1, 2017    | 9:00 am to 12:00 pm | Oahu – UH Manoa,<br>Kuykendall Auditorium                  |
|                        | 1:00 pm to 4:00 pm  |  |
| Tuesday, May 2, 2017   | 9:00 am to 12:00 pm | Oahu – Kaka’ako,<br>JABSOM Auditorium MEB, 314             |
|                        | 1:00 pm to 4:00 pm  |  |
| Wednesday, May 3, 2017 | 9:00 am to 12:00 pm | Kauai - Kauai Community College, OCET 106                  |
|                        | 1:00 pm to 4:00 pm  |  |
| Thursday, May 4, 2017  | 9:00 am to 12:00 pm | Big Island - Imiloa  |
|                        | 1:00 pm to 4:00 pm  |  |
| Friday, May 5, 2017    | 9:00 am to 12:00 pm | Maui – Maui Community College, Pilina<br>Multipurpose Room |
|                        | 1:00 pm to 4:00 pm  |  |

|                                   |                           |  |
|-----------------------------------|---------------------------|--|
| <p><b>Monday, May 8, 2017</b></p> | <p>1:30 pm to 3:30 pm</p> | <p>Oahu – HITS</p> <ul style="list-style-type: none"> <li>• UH – Manoa Kuykendall 201 (Origination Site)</li> <li>• Leeward Community College – Learning Commons Room 108B</li> <li>• UH West Oahu – Library Room B-157</li> <li>• Windward Community College – Akoakoa Room 113A</li> <li>• Kauai Community College – Learning Resource Center Room 122</li> <li>• Maui Community College – Kaaile Room 105 CD</li> <li>• UH Hilo – Media Services Room 359</li> <li>• Honolulu Community College – Building 7 Room 305</li> <li>• Kapiolani Community College – Naio Room 207</li> </ul> |
|-----------------------------------|---------------------------|--|

AGENDA at each Enrollment Session:

| Session                           | 9am-12:00pm | 1pm-4:00pm |
|-----------------------------------|-------------|------------|
| Q&A with Carriers                 | 9:00am      | 1:00pm     |
| RCUH Welcome and Introduction     | 9:30am      | 1:30pm     |
| HMSA                              | 9:40am      | 1:40pm     |
| Kaiser                            | 10:00am     | 2:00pm     |
| HDS Dental                        | 10:20am     | 2:20pm     |
| NBS FSA/DCAP, Transit/Parking     | 10:35am     | 2:35pm     |
| Standard Group Life and Group LTD | 10:50am     | 2:50pm     |
| UNUM Group Long Term Care         | 11:05am     | 3:05pm     |
| RCUH Conclusion and Reminders     | 11:15am     | 3:15pm     |
| Q&A with Carriers                 | 12:00pm     | 4:00pm     |

*Open Enrollment sessions are accessible for individuals with disabilities. For more information or to request an accommodation due to your disability, please contact RCUH Human Resources at (808) 956-3100 or email [rcuhr@rcuh.com](mailto:rcuhr@rcuh.com) at least one week prior to the enrollment session you signed up for.*

| <b><u>IMPORTANT UPCOMING DATES TO REMEMBER</u></b> |   |
|--|---|
| <b>May 1-8, 2017</b>                               | Attend a Benefit Open Enrollment Session                      |
| <b>May 17, 2017</b>                                | <u>DEADLINE</u> for Benefits Enrollment/Change Election Forms |
| <b>July 1, 2017</b>                                | Start date of Benefits Enrollment/Changes                     |

## RCUH MONTHLY PREMIUMS EFFECTIVE JULY 1, 2017 – JUNE 30, 2018

\*Health Plan Premiums are deducted via payroll deduction on the second pay period of each month

|   |                | PREMIUM COST* |            |                 |
|---|----------------|---------------|------------|-----------------|
| MEDICAL PLANS   |                | Employee      | Employer   | Total (EE + ER) |
| <b>HMSA Preferred Provider Plan</b><br>(with Drug, Vision, Chiropractic)    | Single Plan    | \$225.12      | \$337.68   | \$562.80        |
|   | 2-Party Plan   | \$450.18      | \$675.26   | \$1,125.44      |
|   | 3+ Family Plan | \$778.28      | \$1,167.42 | \$1,945.70      |
| <b>HMSA Comprehensive Medical Plan</b><br>(with Drug, Vision, Chiropractic) | Single Plan    | \$188.95      | \$283.43   | \$472.38        |
|   | 2-Party Plan   | \$377.87      | \$566.81   | \$944.68        |
|   | 3+ Family Plan | \$653.20      | \$979.80   | \$1,633.00      |
| <b>HMSA Health Plan Hawaii Plus</b><br>(with Drug, Vision, Chiropractic)    | Single Plan    | \$215.57      | \$323.35   | \$538.92        |
|   | 2-Party Plan   | \$431.09      | \$646.63   | \$1,077.72      |
|   | 3+ Family Plan | \$745.27      | \$1,117.91 | \$1,863.18      |
| <b>HMSA Health Plan Hawaii Basic</b><br>(with Drug, Vision, Chiropractic)   | Single Plan    | \$190.34      | \$285.50   | \$475.84        |
|   | 2-Party Plan   | \$380.65      | \$570.97   | \$951.62        |
|   | 3+ Family Plan | \$658.02      | \$987.02   | \$1,645.04      |
| <b>Kaiser Plan A</b><br>(with Drug, Vision, Chiropractic)                   | Single Plan    | \$168.07      | \$252.11   | \$420.18        |
|   | 2-Party Plan   | \$336.14      | \$504.21   | \$840.36        |
|   | 3+ Family Plan | \$581.53      | \$872.30   | \$1,453.83      |
| <b>Kaiser Plan B</b><br>(with Drug, Vision, Chiropractic)                   | Single Plan    | \$193.41      | \$290.11   | \$483.52        |
|   | 2-Party Plan   | \$386.82      | \$580.22   | \$967.04        |
|   | 3+ Family Plan | \$669.19      | \$1,003.79 | \$1,672.98      |
| <b>DENTAL PLAN</b>  |                |               |            |                 |
| <b>HDS</b>  | Single Plan    | \$13.42       | \$20.13    | \$33.55         |
|   | 2-Party Plan   | \$26.84       | \$40.26    | \$67.10         |
|   | 3+ Family Plan | \$44.10       | \$66.15    | \$110.25        |

## HMSA MEDICAL PLAN SUMMARY (High Level Summary)

| RCUH - 2017   | HMSA   | HMSA   | HMSA   | HMSA   |
|---|--|--|--|--|
|   | PPO  | CompMed                                      | HPH Plus                                     | HPH Basic                                    |
| <b>Coverage</b>                                     | Worldwide                                    | Worldwide                                    | State of Hawaii                              | State of Hawaii                              |
| <b>Out of Pocket Maximum:<br/>Individual/Family</b> | \$2500/\$7500                                | \$2500/\$7500                                | \$2500/\$7500                                | \$2500/\$7500                                |
| <b>Lifetime Maximum:<br/>Individual/Family</b>      | Unlimited                                    | Unlimited                                    | Unlimited                                    | Unlimited                                    |
| <b>Deductible</b>                                   | \$0 - Par<br>\$100/\$300 - Non Par           | \$0  | \$0  | \$0  |
| <b>Outpatient</b>                                   |  |  |  |  |
| - Office Visit                                      | \$12   | \$14   | \$20   | \$20   |
| - Preventative Care                                 | \$0 - Par, 30% - Non Par                     | \$0  | \$0  | \$0  |
| - Ambulatory Surgery<br>Center                      | 10% - Par<br>30% - Non Par                   | 20%  | 10%  | 20%  |
| <b>Other Professional</b>                           |  |  |  |  |
| - Immunizations                                     | \$0 - Par, 30% - Non Par                     | \$0  | \$0  | \$0  |
| <b>Ambulance and Emergency Services</b>             |  |  |  |  |
| - Ambulance   | 20% - Par, 30% - Non Par                     | 20%  | 20%  | 20%  |
| - Claims & Emergency Room<br>- Urgent Care          | 20% in/20% out<br>\$12 in/30% out            | 20% in/20% out<br>\$14 in/\$14 out           | \$100 in network<br>\$20 in network          | 20% in network<br>\$20 in network            |
| <b>Laboratory and Imaging</b>                       |  |  |  |  |
| - Laboratory  | 10% in/20% out - par<br>30% nonpar           | 20% in/20% out<br>- par or nonpar            | 10% in/\$10 out<br>- in network              | 20% in/20% out<br>- in network               |
| - Testing Services                                  | 10% in/20% out - par<br>30% nonpar           | 20% in/20% out<br>- par or nonpar            | 10% in/20% copay out<br>- in network         | 20% in/20% out<br>- in network               |
| - Diagnostic Image                                  | 10% in/20% out - par<br>30% nonpar           | 20% in/20% out<br>- par or nonpar            | 10% in/20% out<br>- in network               | 20% in/20% out<br>- in network               |
| <b>Hospital Inpatient</b>                           |  |  |  |  |
| - Inpatient   | 10% - Par<br>30% - Non Par                   | 20%  | 10%  | 20%  |
| <b>Mental Health and Chemical Dependency</b>        |  |  |  |  |
| - Mental Health Outpatient                          | \$12 - par<br>30% nonpar                     | \$14   | \$20   | \$20   |
| - Mental Health Inpatient                           | 10% - par<br>30% nonpar                      | 20%  | 10%  | 20%  |
| <b>Other</b>  |  |  |  |  |
| - Aids & Appliances                                 | DME 20%                                      | DME 20%                                      | DME 20%                                      | DME 50%                                      |
| - Chiropractic                                      | 24 @\$10                                     | 24 @\$10                                     | 24 @\$10                                     | 24 @\$10                                     |
| <b>Prescription Drugs</b>                           |  |  |  |  |
| Essential Drug Formulary                            |  |  |  |  |
| Tier Structure                                      | \$7/\$30/\$30+\$45 Cost<br>Share/\$100/\$200 | \$7/\$30/\$30+\$45 Cost<br>Share/\$100/\$200 | \$7/\$30/\$30+\$45 Cost<br>Share/\$100/\$200 | \$7/\$30/\$30+\$45 Cost<br>Share/\$100/\$200 |
| Out-of-Pocket Max:                                  | \$3,600/\$4,200                              | \$3,600/\$4,200                              | \$3,600/\$4,200                              | \$3,600/\$4,200                              |
| <b>Vision</b>                                       |  |  |  |  |
| - Office Visit                                      | \$10 exam                                    | \$10 exam                                    | Refer to Medical copay for<br>exam           | Refer to Medical copay for<br>exam           |

All PLAN BENEFITS ARE BASED ON ELIGIBLE CHARGE. \*This amount does not include tax; \*\*Eligible charges are the amount that HMSA's Participating Providers have agreed to accept as payment in full for services rendered. Services received from a nonparticipating provider will likely result in significantly higher out-of-pocket expenses since the member is responsible for any difference between HMSA's eligible charges & the nonparticipating provider's actual charges.

NOTE: This is a high level summary & does not contain complete information. Please refer to plan certificate for complete information on benefits & provisions

|  |                     |                                     |
|--|---------------------|-------------------------------------|
| 1601 East-West Road                          | Tel: (808) 956-6979 | Equal Opportunities Employer        |
| Burns Hall 4 <sup>th</sup> Floor, Makai Wing | Fax: (808) 956-5200 | Minorities/Women/Disability/Veteran |
| Honolulu, HI 96848                           | www.rcuh.com        |                                     |

## KAISER MEDICAL PLAN SUMMARY (High Level Summary)

### 2017 Benefit changes

| RCUH - 2017                                     | Kaiser   | Kaiser              |
|---|--|---------------------|
|   | Kaiser Plan B  | Kaiser Plan A       |
| <b>Coverage</b>                                 | Oahu, Maui, Hawaii and Kauai                           |                     |
| <b>Out of Pocket Maximum: Individual/Family</b> | \$2500/\$7500  | \$3000/\$9000       |
| <b>Lifetime Maximum: Individual/Family</b>      | Unlimited  | Unlimited           |
| <b>Deductible</b>                               | \$0  | \$0                 |
| <b>Outpatient</b>                               |  |                     |
| - Office Visit                                  | \$20   | \$25                |
| - Preventive Care                               | \$0  | \$0                 |
| - Ambulatory Surgery Center                     | 10%  | \$25                |
| - Office Based Drugs & Supplies                 | \$20   | 20%                 |
| <b>Other Professional</b>                       |  |                     |
| - Immunizations                                 | \$0  | \$0                 |
| <b>Ambulance and Emergency Services</b>         |  |                     |
| - Ambulance                                     | 20%  | 20%                 |
| - Claims & Emergency Room                       | \$100 in/\$100 out                                     | 20%                 |
| - Urgent Care                                   | \$20 in/20% out  | \$25 in/20% out     |
| <b>Laboratory and Imaging</b>                   |  |                     |
| - Laboratory                                    | \$10basic/20% spec                                     | 20%                 |
| - Testing Services                              | 20% spec   | 20%                 |
| - Diagnostic Image                              | \$10basic/20% spec                                     | 20%                 |
| <b>Hospital Inpatient</b>                       |  |                     |
| - Inpatient                                     | 10%  | \$150               |
| - Extended Care Facility                        | 120 days - 10%   | 120 days - \$0      |
| <b>Mental Health and Chemical Dependency</b>    |  |                     |
| - Mental Health Outpatient                      | \$20   | \$25                |
| - Mental Health Inpatient                       | 10%  | \$150               |
| <b>Other</b>                                    |  |                     |
| - Aids & Appliances                             | DME 20%/Diab 50%                                       | DME 20%/Diab 50%    |
| - Hearing Aids                                  | 60%  | 60%                 |
| - Chiropractic                                  | 20 @\$20   | 20 @\$20            |
| <b>Prescription Drugs</b>                       |  |                     |
| Tier Structure                                  | \$5/\$10/\$45/\$75                                     | \$3/\$10/\$45/\$200 |
| Out-of-Pocket Max:                              | Inclusive  |                     |
| <b>Vision</b>                                   |  |                     |
| - Office Visit                                  | Plan pays up to \$150 for all services with exam visit |                     |

**NOTE: This is a high level summary & does not contain complete information. Please refer to plan certificate for complete information on benefits & provision**



## HDS DENTAL PLAN SUMMARY

This summary includes a brief description of your HDS dental benefits. All benefits are governed by the provisions of your employer's agreement with Hawaii Dental Service and HDS's procedure code guidelines. All dental claims must be filed within 12 months of the date of service for HDS claims payment.

| SUMMARY OF BENEFITS   | PLAN COVERS | WAIT PERIOD (months) |
|---|-------------|----------------------|
| <b>PLAN MAXIMUM</b> per person per calendar year  | \$1000      |                      |
| <b>NEW – DIAGNOSTIC AND PREVENTIVE PLAN MAXIMUM WAIVER</b>  |             |                      |
| <b>All these services will not be applied to your Plan Maximum</b>  |             |                      |
| <b>DIAGNOSTIC</b>   |             |                      |
| Examination – twice per calendar year   | 100%        | N/A                  |
| Bitewing X-rays – twice per calendar year through age 14; once per calendar year thereafter   | 100%        | N/A                  |
| Other X-rays (full mouth X-rays limited to once every five years)   | 90%         | N/A                  |
| <b>PREVENTIVE</b>   |             |                      |
| Cleanings – twice per calendar year   | 100%        | N/A                  |
| Expectant mothers – Cleanings or *Periodontal Maintenance three times per calendar year   |             |                      |
| Diabetic patients – Cleanings or *Periodontal Maintenance four times per calendar year  |             |                      |
| *Periodontal Maintenance benefit level  | *70%        |                      |
| Fluoride - twice per calendar year (through age 19)   | 100%        | N/A                  |
| Fluoride Varnish – once per calendar year; limited to patients who are at high risk of caries due to root exposure, dry mouth syndrome, history of radiation therapy or other conditions documented by the dentist                                      | 100%        | N/A                  |
| Space maintainers (through age 17)  | 100%        | N/A                  |
| Sealants (through age 18) – One treatment application, once per lifetime only to permanent molar with no prior occlusal restorations, regardless of the number of surfaces sealed   | 100%        | N/A                  |
| <b>RESTORATIVE</b>  |             |                      |
| Amalgam (silver-colored) fillings   | 70%         | N/A                  |
| Composite (white – colored) fillings - limited to anterior (front) teeth  | 70%         | N/A                  |
| Crowns and gold restorations (once every seven years when teeth cannot be restored with amalgam or composite fillings)  | 50%         | 12                   |
| NOTE: Composite (white) and Porcelain (white) restorations on posterior (back) teeth will be processed as the alternate benefit of the metallic equivalent – the patient is responsible for the cost difference up to the amount charged by the dentist |             |                      |
| <b>ENDODONTICS</b>  |             |                      |
| Pulpal therapy  | 70%         | N/A                  |
| Root canal treatment, retreatment, apexification, apicoectomy   |             |                      |
| <b>PERIODONTICS</b>   |             |                      |
| Periodontal scaling and root planing – once every two years   | 70%         | N/A                  |
| Gingivectomy, flap curettage and osseous surgery – once every three years   |             |                      |
| Periodontal Maintenance – twice per calendar year after qualifying periodontal treatment  |             |                      |
| <b>PROSTHODONTICS</b>   |             |                      |
| Fixed bridges (once every seven years; age 16 and older)  | 50%         | 12                   |
| Dentures - complete and partial (once every seven years; ages 16 and older)   |             | 12                   |
| Implants  |             | 12                   |
| <b>ORAL SURGERY</b>   |             |                      |
|   | 70%         | N/A                  |
| <b>ADJUNCTIVE GENERAL SERVICES</b>  |             |                      |
| Palliative treatment (for relief of pain but not to cure)   | 70%         | N/A                  |
|   | 100%        | N/A                  |
| <b>ORTHODONTICS</b>   |             |                      |
|   | 50%         |                      |
| <b>\$1000 Lifetime Maximum amount paid in eight quarterly payments of \$125.00.</b>   |             |                      |
| Per eligible Employee, Spouse, Child  |             |                      |
| <i>Orthodontic services are not covered if services were started prior to the date the patient became eligible under this employer's plan.</i>  |             |                      |
| <i>If a patient's eligibility ends prior to the completion of the orthodontic treatment, payments will not continue.</i>  |             |                      |
| <i>If your employer elects to remove the orthodontic benefit, coverage will end on the last day of the month that the change occurred.</i>  |             |                      |

**Note:** Plan pays based on the allowed amount, which is the amount that a participating dentist agrees to accept for services that are covered benefits.

## GROUP LIFE INSURANCE / GROUP LONG TERM DISABILITY INSURANCE

| BASIC LIFE INSURANCE          | <i>Provided by Standard Insurance Company</i>  |
|-------------------------------|--|
| Eligibility                   | Applies to regular status employees who are working 75% FTE or more.   |
| Employee Coverage Amount      | An employee may select one of the following Basic Life coverage amounts:<br>Option 1 – 2 times earnings up to \$600,000<br>Option 2 – 2 times earnings up to \$200,000<br>Option 3 – 2 times earnings up to \$100,000<br>Option 4 – 2 times earnings up to \$50,000 (not subject to Imputed Income)  |
| Age Reduction                 | Reduction of Coverage Amount to:<br>45% at age 70, 35% at age 75 and 25% at age 80   |
| <b>Features and Services:</b> |  |
| MEDEX Travel Assist           | Helps with emergencies when traveling more than 100 miles from home or internationally for trips of up to 180 days. Benefits include Pre-trip Assistance, Medical Assistance Services, Travel Assistance Services and more. The benefit covers eligible employees and their family members. Coordination of these services must be made through MEDEX (e.g., no claims for reimbursement will be accepted if services were coordinated through other means). |
| Accelerated Benefit           | 75% of coverage amount to \$500,000 with 12-month life expectancy  |
| Repatriation Benefit          | Provides an additional benefit to help pay for the expenses incurred by the transport of an insured employee's remains when the employee dies more than 200 miles from home.   |

| LONG TERM DISABILITY INSURANCE | <i>Provided by Standard Insurance Company</i>   |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
|--------------------------------|---|------------|-------------------------------|----|--|----|---|----|--|----|---------|----|-----------------|----|-----------------|----|-----------------|-----|--------|
| Eligibility                    | Applies to regular status employees who are working 75% FTE or more. Not available to non-U.S. citizens working outside of the U.S. or Canada.  |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| Employee Coverage              | Maximum Benefit: 60% of employee's pre-disability earnings not to exceed \$15,000 per month   |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| Definition of Disability       | <ol style="list-style-type: none"> <li>1. Are unable, as a result of physical disease, injury, pregnancy or mental disorder to perform with reasonable continuity the material duties of your own occupation; or</li> <li>2. Suffer a loss of at least 20% of your pre-disability earnings when working in your own occupation.</li> </ol>  |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| Maximum Benefit Period         | <p>If an employee becomes disabled before age 62, LTD benefits may continue until age 65 or to the Social Security Normal Retirement Age (SSNRA) or 3 years 6 months, whichever is longest. If an employee becomes disabled at age 62 or older, the benefit duration is determined by the age when disability begins:</p> <table border="1"> <thead> <tr> <th><u>Age</u></th> <th><u>Maximum Benefit Period</u></th> </tr> </thead> <tbody> <tr> <td>62</td> <td>To SSNRA, or 3 yrs 6 months, whichever is longer</td> </tr> <tr> <td>63</td> <td>To SSNRA, or 3 yrs, whichever is longer</td> </tr> <tr> <td>64</td> <td>To SSNRA, or 2 yrs 6 months, whichever is longer</td> </tr> <tr> <td>65</td> <td>2 years</td> </tr> <tr> <td>66</td> <td>1 year 9 months</td> </tr> <tr> <td>67</td> <td>1 year 6 months</td> </tr> <tr> <td>68</td> <td>1 year 3 months</td> </tr> <tr> <td>69+</td> <td>1 year</td> </tr> </tbody> </table> | <u>Age</u> | <u>Maximum Benefit Period</u> | 62 | To SSNRA, or 3 yrs 6 months, whichever is longer | 63 | To SSNRA, or 3 yrs, whichever is longer | 64 | To SSNRA, or 2 yrs 6 months, whichever is longer | 65 | 2 years | 66 | 1 year 9 months | 67 | 1 year 6 months | 68 | 1 year 3 months | 69+ | 1 year |
| <u>Age</u>                     | <u>Maximum Benefit Period</u>   |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| 62                             | To SSNRA, or 3 yrs 6 months, whichever is longer  |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| 63                             | To SSNRA, or 3 yrs, whichever is longer   |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| 64                             | To SSNRA, or 2 yrs 6 months, whichever is longer  |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| 65                             | 2 years   |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| 66                             | 1 year 9 months   |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| 67                             | 1 year 6 months   |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| 68                             | 1 year 3 months   |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| 69+                            | 1 year  |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| Waiting Period                 | 90 days   |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |
| Other Services                 | Return to Work Incentive, Survivors Benefits, Assisted Living Benefit, Rehabilitation Plan  |            |                               |    |  |    |   |    |  |    |         |    |                 |    |                 |    |                 |     |        |

## GROUP LONG TERM CARE INSURANCE

| GROUP LONG TERM CARE  | Provided by UNUM  |
|---|---|
| Eligibility   | Applies to regular status employees who are working 75% FTE or more. Not available to non-U.S. citizens working outside of the U.S. or Canada.  |
| Base Benefit Level  | Facility Monthly Benefit: \$2,000.<br>Professional Home Care Services Monthly Benefit: \$1,000 (50% of Facility Benefit Amount)<br>Assisted Living Facility Monthly Benefit: \$1,200 (60% of Facility Benefit Amount)<br>Facility Benefit Duration: 3 years<br>Professional Home Care Duration: 6 years<br>Lifetime Maximum Benefit: \$72,000   |
| Definition of Disability  | Disabled or disability for purposes of the GLTCI policy is defined as being unable to perform, without Substantial Assistance from another individual, at least two Activities of Daily Living; or requiring Substantial Supervision by another individual to protect the employee from threats to health or safety due to Severe Cognitive Impairment.<br><u><b>Activities of Daily Living</b></u><br>(a) Bathing, (b) Dressing, (c) Toileting, (d) Transferring (moving into or out of bed, chair, or wheelchair), (e) Continence, (f) Eating |
| Elimination Period  | The Elimination Period is 90 days. The Elimination Period is the number of consecutive days during which the employee must be disabled and under the regular care of a physician before benefits become payable.  |
| <b>Supplemental Coverage for Employees:</b>   |   |
| <ol style="list-style-type: none"> <li>1. Additional supplemental coverage (i.e., in addition to Base Coverage) may be purchased by the employee during the first three (3) months following date of hire.               <ol style="list-style-type: none"> <li>a. The employee will not be subject to medical underwriting and pre-qualification (i.e., guarantee issue regardless of medical history or condition) for coverage up to specific limits (i.e., medical underwriting is required for “unlimited” benefit duration, “Monthly facility benefit” above \$6,000).</li> </ol> </li> <li>2. If the employee elects not to enroll in supplemental coverage during the initial enrollment period (3 months following date of hire), he/she may elect additional coverage during the annual open enrollment period. However, he/she will be subject to medical underwriting (ex., medical questionnaire) as determined by the insurance company.</li> <li>3. The RCUH will attempt to maintain availability and accessibility of additional GLTCI coverage for employees who wish to purchase supplemental coverage in order to obtain a higher level of benefits.</li> </ol> |   |
| <b>Voluntary Eligible Family Members:</b>   |   |
| Eligible family members may also obtain GLTCI at low group rates. Eligible family members for the purpose of this policy include the employee’s spouse, reciprocal beneficiary, parents, parents-in-law, grandparents, grandparents-in-law, siblings, and adult children (family members must be between the ages of 18-84 at the time of enrollment).  |   |

**Note:** This is a high level summary. Please refer to plan certificate for complete information on benefits & provisions.

### Why Long Term Care for you and your family?

RCUH provides a benefit to you and your family members at very reasonable costs. Currently, the amount for a long-term care facility is close to \$90,000 per year. We recommend you consult with your financial advisor on how this Long Term Care program offered by RCUH can benefit your overall financial planning.

## FLEXIBLE SPENDING / DEPENDENT CARE / TRANSPORTATION ACCOUNTS

RCUH provides you the opportunity to pay for out-of-pocket medical, dental, vision, dependent care expenses with pre-tax dollars through Flexible Spending Accounts. You must enroll/re-enroll (Form B-5F) in the plan to participate for the plan year July 1, 2017 to June 30, 2018. You can save approximately 25 percent of each dollar spent on these expenses when you participate in a FSA.

A health care FSA is used to reimburse out-of-pocket medical expenses incurred by you and your dependents. A dependent care FSA is used to reimburse expenses related to care of eligible dependents while you work.

Contributions to your FSA come out of your paycheck before any taxes are taken out. This means that you don't pay federal income tax, Social Security taxes, or state income taxes on the portion of your paycheck you contribute to your FSA. You should contribute the amount of money you expect to pay out of pocket for eligible expenses for the plan period.

Here are your Plan Basics:

Plan Year: July 1, 2017 to June 30, 2018  
 Run-out Period: September 30, 2018 – Deadline to file claims for 2017-18 FSA Accounts  
 Maximum Annual Limits:  
 Health Care FSA: \$2,600  
 Dependent Care FSA: \$5,000 per year or \$2,500 if married and filing separately

Pre-Tax Transportation account allows you to use pre-tax dollars to pay for qualified transportation and parking expenses. Maximum Annual Limit is \$255.00 per month for bus passes and van pooling. For qualified parking expenses, the annual limit is \$255 per month; Annual parking passes may be submitted and NBS will reimburse you automatically as payroll contributions are received. **Check your balance** – if you are currently enrolled and may have rollover funds, you might want to revise your contribution amount for the new year to ensure you use up your rollover funds!

The following example shows how you can save money with a flexible spending account.

*Bob and Jane's combined gross income is \$30,000. They have two children and file their income taxes jointly. Since Bob and Jane expect to spend \$2,000 in adult orthodontia and \$3,300 for day care next plan year, they decide to direct a total of \$5,000 into their FSAs.*

|                                      | Without FSAs | With FSAs      |
|--------------------------------------|--------------|----------------|
| Gross Income:                        | \$30,000     | \$30,000       |
| FSA Contributions:                   | 0            | -\$5,000       |
| Net Gross Income:                    | \$30,000     | \$25,000       |
| Estimated taxes:                     |              |                |
| Federal*                             | -2,550       | -1,776         |
| State**                              | -900         | -750           |
| FICA                                 | -2,295       | -1,913         |
| After-tax earnings:                  | 24,255       | 20,314         |
| Eligible out-of-pocket               |              |                |
| Medical and dependent care expenses: | -5,000       |                |
| Remaining spendable income:          | \$19,255     | \$20,561       |
| <b>Spendable income increase:</b>    |              | <b>\$1,306</b> |

\*Assumes standard deductions and four exemptions.

\*\*Varies, assume 3 percent.

*This example above is for illustrative purposes only. Every situation varies and we recommend that you consult a tax advisor for all tax advice.*

## CONTACT INFORMATION (KEEP AS A REFERENCE)

| PLANS  | Website Address  | Customer Service Phone Numbers   | Additional Information  |
|--|--|--|---|
| <b>HMSA</b> <ul style="list-style-type: none"> <li>State of Hawaii</li> <li>Worldwide</li> </ul> | <a href="http://www.hmsa.com">www.hmsa.com</a>                                 | <b>Oahu:</b><br>PPO/CompMED: 948-6111<br>HPH-P/HPH-B: 948-6372;<br><b>Maui:</b> 871-6295;<br><b>Hilo:</b> 935-5441;<br><b>Kona:</b> 329-5291;<br><b>Kauai:</b> 245-3393;<br><b>Worldwide:</b> 1 (800) 648-3190 | <a href="#">3.520 RCUH Health Plans</a><br><br><a href="#">I.Addendum to the 3.520 Health Plans</a> |
| <b>KAISER</b>  | <a href="http://www.kp.org">www.kp.org</a>                                     | <b>Oahu:</b> 432-5955,<br>1 (800) 966-5955 neighbor islands  |   |
| <b>HDS</b>   | <a href="http://www.hawaiiidentalservice.com">www.hawaiiidentalservice.com</a> | 1 (808) 529-9248<br>1 (800) 232-2533 ext. 248  |   |

| PLANS  | Website Address   | Customer Service Phone Numbers  | Additional Information   |
|--|---|---|--|
| <b>GROUP LONG TERM CARE (UNUM)</b><br><br><b>SUPPLEMENTAL LONG TERM CARE (UNUM)</b>                                      | <a href="http://unuminfo.com/RCUH">http://unuminfo.com/RCUH</a>                                 | 1 (800) 227-4165  | <a href="#">3.545 RCUH Long Term Care Insurance</a>  |
| <b>GROUP LIFE (STANDARD INSURANCE)</b><br><br><b>GROUP LONG TERM DISABILITY (STANDARD INSURANCE)</b>                     | <a href="#">Estimate your Life Insurance needs (click here)</a>                                 | Claims: 1 (877) 276-6616<br><br>Life Insurance Customer Service:<br>1 (800) 628-8600<br><br>LTD Insurance Customer Service:<br>1 (800) 368-1135 | <a href="#">3.540 RCUH Group Life Insurance</a><br><br><a href="#">3.570 RCUH Long-Term Disability Insurance</a>             |
| <b>FLEXIBLE SPENDING ACCOUNTS</b><br><b>DEPENDENT CARE EXPENSE</b><br><b>TRANSIT EXPENSE (NATIONAL BENEFIT SERVICES)</b> | <a href="http://www.nbsbenefits.com/health-forms/">http://www.nbsbenefits.com/health-forms/</a> | 1 (800) 274-0503  | <a href="#">3.530 RCUH Flexible Spending Plan</a><br><br><a href="#">I.Addendum to the 3.530 RCUH Flexible Spending Plan</a> |

| Contact the Plans for help with:  | Contact RCUH for help with:   |
|---|---|
| <ul style="list-style-type: none"> <li>✓ Specific benefit questions</li> <li>✓ Verifying if your doctor or other provider contracts with the plan</li> <li>✓ Verifying your medications are in the plan's drug formulary</li> <li>✓ ID cards</li> <li>✓ Claims</li> <li>✓ Loss of coverage memos/letters</li> </ul> | <ul style="list-style-type: none"> <li>➤ Changing your name, address, email, phone number</li> <li>➤ Finding forms</li> <li>➤ Adding or removing dependents</li> <li>➤ Payroll deduction information</li> <li>➤ Eligibility complaints or appeals</li> <li>➤ Life, LTD, Long Term Care insurance eligibility and enrollment questions</li> <li>➤ Eligibility questions and changes</li> </ul> |

# RCUH FORMS

- **RCUH Group Health Enrollment/Change Form B-5H**
- **RCUH Flexible Spending Enrollment/Change Form B-5F**
- **Health Insurance Waiver Form – RCUH OPEN ENROLLMENT B-5Wb**

**As a reminder, all forms are due by May 17, 2017**

## RCUH Group Health Enrollment/Change Form

**Employee Name:** \_\_\_\_\_ **RCUH Employee ID #:** \_\_\_\_\_

|  |  |
|--|--|
| <b>PRETAX Dental Insurance Coverage: Hawaii Dental Service (HDS) Select an option below:</b> |  |
| <input type="checkbox"/> New Enrollment  | <input type="checkbox"/> Cancel Coverage Effective Date: _____ |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop Dependent Effective Date: _____   |  |

|  |  |
|--|--|
| <b>PRETAX Medical Insurance Coverage Select an option and a plan below:</b>  |  |
| <input type="checkbox"/> New Enrollment  | <input type="checkbox"/> Cancel Coverage Effective Date: _____ |
| <i>*If you are cancelling medical coverage through RCUH, you need to review, complete, and submit the RCUH Health Insurance Waiver Form B5-Wa.</i> |  |
| <input type="checkbox"/> Add <input type="checkbox"/> Drop Dependent Effective Date: _____   |  |

|   |  |
|---|--|
| <p><b>Available To Hawaii Residents Only.</b></p> <input type="checkbox"/> Kaiser A Plan<br><input type="checkbox"/> Kaiser B Plan<br><input type="checkbox"/> HMSA Preferred Provider Plan (PPO)<br><input type="checkbox"/> HMSA Comprehensive Medical (CompMED)<br><input type="checkbox"/> HMSA Health Plan Hawaii Plus* (HPHP)<br><input type="checkbox"/> HMSA Health Plan Hawaii-Basic* (HPH)<br><b>*HPH/HPHP Health Center:</b> _____ | <p><b>Available To BOTH Hawaii and Out of State Residents.</b></p> <input type="checkbox"/> HMSA Preferred Provider Plan (PPO)<br><input type="checkbox"/> HMSA Comprehensive Medical (CompMED)<br><b>*Primary Care Physician (PCP):</b> _____ |
|---|--|

*\*If you do not designate a Health Center and Primary Care Physician for you & your dependents, HMSA will automatically assign it for you.*  
*The IRS requires that we give employees an option to deduct health insurance premiums on a pre-tax (tax savings to employee) or post-tax (no tax savings to employee) basis. If you do **NOT** wish to obtain tax savings from a pre-tax payroll deduction of your health insurance premium, please check here .*

| Dependent's Name | SSN / ITIN<br><small>(Required for 12 month or older)</small> | Date of Birth<br><small>(mm-dd-yyyy)</small> | *Dependent Relationship  | Gender   | Med                      | Den                      | Health Center<br><small>(Required for HMSA HPHP/HPH)</small> | PCP |
|------------------|---|--|--|--|--------------------------|--------------------------|--|-----|
|                  |   |  | <input type="checkbox"/> S <input type="checkbox"/> C<br><input type="checkbox"/> CU <input type="checkbox"/> DP | <input type="checkbox"/> F<br><input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> |  |     |
|                  |   |  | <input type="checkbox"/> S <input type="checkbox"/> C<br><input type="checkbox"/> CU <input type="checkbox"/> DP | <input type="checkbox"/> F<br><input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> |  |     |
|                  |   |  | <input type="checkbox"/> S <input type="checkbox"/> C<br><input type="checkbox"/> CU <input type="checkbox"/> DP | <input type="checkbox"/> F<br><input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> |  |     |
|                  |   |  | <input type="checkbox"/> S <input type="checkbox"/> C<br><input type="checkbox"/> CU <input type="checkbox"/> DP | <input type="checkbox"/> F<br><input type="checkbox"/> M | <input type="checkbox"/> | <input type="checkbox"/> |  |     |

**\*Relationship Code: S – Spouse C – Child CU – Civil Union DP – Domestic Partner** Domestic Partnership enrollment requires additional forms. See [Policy 3.520 Health Plans](#) for form.

- I certify that any dependent(s) listed above are legally recognized dependents. (If a spouse or civil union partner is being covered), I certify that he/she is my legal spouse/partner (consistent with the definition of marriage or civil union partnership as defined by the laws of the State of Hawaii). (If a DP is being covered), I certify that we meet the eligibility criteria for DP coverage (as recognized by the State of Hawaii). (If child dependent(s) are being covered), I certify that he/she is my or my civil union partner's natural/legally adopted/step/foster child and under the age of 26, or (if over age 26) cannot support themselves because of a mental or physical disability which occurred before his/her 26th birthday. I understand that proof of dependent status is **required** and agree to submit documentation by the established deadlines. I also agree to inform the RCUH if my dependent's eligibility status changes in the future. Failure to do so may result in cancellation of benefits, and may include termination of my employment.
- Information on this application is given to obtain insurance and is true and complete to the best of my knowledge and belief. I authorize my employer to set my effective dates of coverage and to deduct monthly employee contribution for each benefit plan from my salary, wages, or other compensation including any contribution increase, decrease, adjustment, or cancellation as required by the Health Plan Agreement under applicable laws, policies, and procedures. I and any listed dependent agree to abide by the provisions of the service agreement and/or medical insurance contract and health plan regulations. I agree to abide by the terms and conditions of the Group Plan Contract(s) issued to the Research Corporation of the University of Hawaii. I have read the COBRA General Notice and I understand my rights for Continuation of Health Coverage under COBRA. I also understand that I must inform my dependents covered under my health insurance of their rights.
- I understand that failure to comply with the above or providing inaccurate information or falsifying the information contained in this form may result in disciplinary action including termination of employment. Legal action may be brought against me and/or my Dependents/Spouse/Domestic Partner/Civil Union Partner for any losses, damages (including, but not limited to reasonable attorneys' fees and other legal expenses), financial or otherwise, due to false statements provided on this enrollment (or related) form or for failure to timely notify RCUH of changed circumstances as required. In addition, any health benefits (ex., monthly premiums, claims, etc.) paid by the RCUH health plans on behalf of the Employee's dependents will be reversed and become the responsibility of the Employee.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Deadline to Submit Form: 05/17/2017**

**Submit via email: [rcuh\\_benefits@rcuh.com](mailto:rcuh_benefits@rcuh.com) or Fax: 808-956-5022**

|                              |                |                 |                |
|------------------------------|----------------|-----------------|----------------|
| RCUH USE ONLY Authorized By: | Coverage Start | Input By / Date | Edit By / Date |
| Health Plan                  |                |                 |                |





## RCUH Flexible Spending Enrollment/Change Form

**Employee Name:** \_\_\_\_\_ **RCUH Employee ID #:** \_\_\_\_\_

| PRETAX <b>Flexible Spending</b> Plan Election & Compensation Reduction   |                       |
|--|-----------------------|
| <p><b>IMPORTANT:</b> <b>PRIOR</b> to completing this form, read the Election Information Sheet and RCUH's Flexible Spending Plan information brochure, OR refer to policy <a href="#">3.530 RCUH Flexible Spending Plan</a>. <i>Select an option and indicate your election(s) below:</i></p> <p><input type="checkbox"/> New Enrollment</p> <p><input type="checkbox"/> Change Enrollment due to _____</p> <p><i>1) Your election change must be submitted to the RCUH HR Department no later than thirty (30) days after a family status change.<br/>2) Supporting documentation must be submitted to make changes to your enrollment.</i></p> |                       |
| <b>Medical Expense Reimbursement Account:</b><br>(Maximum annual contribution \$2600 = \$108.33 / pay period)  | \$ _____ / Pay Period |
| <b>Dependent Care Expense Account:</b><br>(Maximum annual contribution \$5000 = \$208.33 / pay period)   | \$ _____ / Pay Period |

| PRETAX <b>Transportation</b> Benefits  |  |
|--|--|
| <p><b>IMPORTANT:</b> <b>PRIOR</b> to electing, changing, or cancelling this coverage, read RCUH policy <a href="#">3.530 RCUH Flexible Spending Plan</a>. These elections will remain in effect and continue automatically until the RCUH HR Department is notified of your wish to terminate or alter your transportation program elections. <i>Select an option and indicate your election(s) below:</i></p> |  |
| <p><b>Parking Expense Reimbursement</b></p> <p><input type="checkbox"/> Enrollment \$ _____ / Month<br/><i>(Maximum Limit Per Month: \$255.00 / month)</i></p> <p><input type="checkbox"/> Change \$ _____ / Month</p> <p><input type="checkbox"/> Cancel: Parking Expense Reimbursement</p>   | <p><b>Transit Expense Reimbursement</b></p> <p style="background-color: yellow;"><b>Deduction occurs the month prior to coverage therefore your election form must be received at least 30 days in advance.</b></p> <p><input type="checkbox"/> Enrollment \$ _____ / Month<br/><i>(Maximum Limit Per Month: \$255.00 / month)</i></p> <p><input type="checkbox"/> Change \$ _____ / Month</p> <p><input type="checkbox"/> Cancel: Transit Expense Reimbursement</p> |
| <p><b><u>The Effective Date will be dependent upon submission of this form to RCUH Human Resources.<br/>RCUH will send a confirmation email with the effective enrollment date.</u></b></p>  |  |

| Employee Certification  |                    |
|---|--------------------|
| <ul style="list-style-type: none"> <li>I acknowledge that I have reviewed and understand the options available to me for my Employer's Flexible Spending Plan pursuant to the following: (1) RCUH Policy 3.53 Flexible Spending Plan (2) Internal Revenue Service Code 125 for Pre-Tax Flexible Spending Accounts and/or (3) Internal Revenue Service Code 132 for Pre-Tax Transportation Accounts and will comply accordingly.</li> <li>I understand that my Employer makes no guarantee that any benefits I elect under this Plan will be excludable from my gross income for federal or state income tax purposes. I understand that it is my obligation to determine whether or not each payment made under this Plan is excludable from my gross income for federal and state income or Social Security tax and to notify my Employer if I am aware that any particular payment may not be excludable. I agree that if I receive one or more reimbursements under this Plan that are not excludable from income under the Internal Revenue Code, I will indemnify and reimburse my Employer for any tax that may be due on such reimbursement.</li> <li>I understand that failure to comply with the above or providing inaccurate information or falsifying the information contained in this form may result in disciplinary action including termination of employment. Legal action may be brought against me and/or my Dependents/Spouse/Domestic Partner/Civil Union Partner for any losses, damages (including, but not limited to reasonable attorneys' fees and other legal expenses), financial or otherwise, due to false statements provided on this enrollment form or for failure to timely notify RCUH of changed circumstances as required.</li> </ul> |                    |
| <b>Employee Signature:</b> _____  | <b>Date:</b> _____ |

**Deadline to Submit Form: 05/17/2017**

**Submit via email: [rcuh\\_benefits@rcuh.com](mailto:rcuh_benefits@rcuh.com) or Fax: 808-956-5022**

| RCUH USE ONLY Authorized By: | Coverage Start | Input By / Date | Edit By / Date |
|------------------------------|----------------|-----------------|----------------|
| Flex                         |                |                 |                |



## Health Insurance Waiver Form – RCUH OPEN ENROLLMENT

Employee Name: \_\_\_\_\_

RCUH Employee ID #: \_\_\_\_\_

**Instructions: Provide the completed signed form to RCUH and retain a copy for yourself.**

**During RCUH's Annual Open Enrollment Period, you (and your eligible dependents) are able to enroll and/or make changes to your Health Insurance plan. Aside from Open Enrollment, the only other time you are able to enroll and/or make changes is due to a Qualifying Event as defined in RCUH Policy 3.520 RCUH Health Plans.**

**In compliance with the Patient Protection Affordable Care Act (PPACA), you are required to complete this form BEFORE THE END OF RCUH's ANNUAL OPEN ENROLLMENT PERIOD if you have decided to cancel or waive health care coverage with RCUH.** Under the Affordable Care Act, individuals are required to obtain health insurance or pay a tax penalty, unless an exception applies. This is known as the Individual Shared Responsibility Payment. Individuals can meet their obligation to obtain coverage in many ways, including by participating in an employer-sponsored coverage, purchasing insurance in the Federal Health Insurance Marketplace ([HealthCare.gov](http://HealthCare.gov)), or by obtaining government health insurance such as Medicare Part A, Medicare Advantage plans, or Medicaid. More information about the Individual Shared Responsibility Payment can be obtained from the Internal Revenue Service's website: (<http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision>)

**I have cancelled or waived coverage from RCUH's group health care plan because:**

- I (and if applicable, my eligible beneficiaries) prefer not to have coverage. (I am declining health insurance entirely.)
- I (and if applicable, my eligible beneficiaries) have coverage with another party (i.e. parent, spouse, domestic partner, civil union partner, or my own coverage purchased directly from a health insurance carrier).
- I (and if applicable, my eligible beneficiaries) have or will have coverage through the Federal Health Insurance Marketplace ([HealthCare.gov](http://HealthCare.gov)). I understand that by cancelling or waiving coverage through RCUH that I (and if applicable, my eligible beneficiaries) **will not** be eligible for a federal subsidy if applying through the Federal Health Insurance Marketplace since I was offered medical coverage through RCUH.
- I (and if applicable, my eligible beneficiaries) have coverage such as Medicare, Medicaid, TRICARE, COBRA, Veterans Program, or other coverage recognized by the Secretary of Health and Human Services as minimum essential coverage.

**By signing this waiver form I am acknowledging the following:**

- I understand that RCUH has given me an opportunity to enroll in RCUH's Group Health Insurance coverage for myself and my eligible beneficiaries but I am voluntarily declining enrollment as indicated above.
- I understand that by declining RCUH's Group Health Insurance, I can only enroll during RCUH's Open Enrollment Period or due to a Qualifying Event as defined by RCUH's Policy 3.520 RCUH Health Plans.
- I further understand that providing inaccurate information or falsifying the information contained in this form may result in disciplinary action including and up to termination of employment.

**Signature of Employee:** \_\_\_\_\_

**Date:**     /     /

Why am I required to have health coverage?

The ACA requires nearly everyone have health insurance that meets minimum standards and is affordable. Under the ACA, employees and employers are subject to Shared Responsibility provisions that with some exceptions require employees and / or employers **pay a penalty** when health insurance coverage is not maintained.

Shared Responsibility Provisions – Effective beginning tax year 2014

- **Employees:** Under the Individual Shared Responsibility Provision, you, your children, and anyone else that you claim as a dependent on your taxes are required to have health insurance that meets minimum standards. Individuals who do not maintain health insurance coverage will have to pay a penalty to the IRS.
- **RCUH:** Under the Employer Shared Responsibility Provision, employers who do not offer affordable health coverage that provides a minimum level of coverage to their full-time employees and their qualified dependents will have to a penalty to the IRS.

Further Information regarding the Individual Mandate:

<http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision>

**Deadline to Submit Form: 05/17/2017**

**Submit via email: [rcuh\\_benefits@rcuh.com](mailto:rcuh_benefits@rcuh.com) or Fax: 808-956-5022**