RCUH Research Corporation of the University of Hawai'i *'Ahahuina Noi'i O Ke Kulanui O Hawai'i*

Employee Name:
RCUH ID:

RCUH Open Enrollment 2023-24: All-in-One Health/FSA - Enroll/Change Form (OE-B5)

(for Regular, Relief, and Non-Regular benefits-eligible status employees 50% FTE or greater for Plan Year: July 1, 2023 – June 30, 2024)

Upload form and supporting documentation to RCUH Employee Self-Service via eUpload link by May 17, 2023

RESET Form

Section 1: Medical Health Insurance (Pre-Tax; Effective date: 07/01/2023) RCUH Policy 3.520

Check one box only to indicate new enrollment. If no boxes are checked, no changes will be made to your current enrollment.

	Employee New Enrollment	2-Party* New Enrollment	Family (3+)* New Enrollment	NO CHANGE to current enrollment	Cancel/ Waive
HMSA Comprehensive Medical Basic (COMPB)	☐ $234.30	☐ $468.60	☐ $820.33	☐	☐ A new waiver form must be received every Open Enrollment an employee waives coverage. Submit Waiver on eWaive Form via eUpload in ESS.
HMSA Comprehensive Medical (COMP)	☐ $268.88	☐ $537.73	☐ $941.30		
HMSA Preferred Provider (PPO)	☐ $340.18	☐ $680.34	☐ $1,190.91		
HMSA HMO (HPH) Hawai`i Residents only Health Center: PCP:	☐ $311.45	☐ $622.90	☐ $1,090.32		
Kaiser HMO Standard - Plan A (Plan A) Hawai`i Residents only	☐ $199.33	☐ $398.67	☐ $697.67		
Kaiser HMO Comprehensive - Plan B (Plan B) Hawai`i Residents only	☐ $231.16	☐ $462.32	☐ $809.05		

Employee share of monthly premium shown only: Refer to Rate Sheet for TOTAL monthly premium cost information (40% Employee, 60% Employer). *If enrolling eligible dependents, please complete Section 3 and provide proof of relationship documentation.

OPTIONAL: The IRS requires that we provide employees an option to deduct health insurance premiums on a pre-tax (tax savings to employee) or a post-tax (no tax savings to employee) basis. Please contact RCUH HR Employee Benefits to enroll in post-tax health insurance deductions.

SECTION 2: Dental Insurance (Pre-Tax; Effective date: 07/01/2023) RCUH Policy 3.520

Check one box only to indicate new enrollment. If no boxes are checked, no changes will be made to your current enrollment.

	Employee New Enrollment	2-Party* New Enrollment	Family (3+)* New Enrollment	NO CHANGE to current enrollment	Cancel/ Waive
Hawaii Dental Service (HDS)	☐ $14.12	☐ $28.24	☐ $46.40	☐	☐

SECTION 3: Dependent Information

PROOF OF RELATIONSHIP DOCUMENTATION IS REQUIRED when adding a dependent upon submission (i.e., Marriage Certificate, Civil Union Certificate, Birth Certificate, etc.) and subject to RCUH review.

ADD/ REMOVE	Med	Den	NAME (Last,First)	Social Security Number	Date of Birth	Relation-ship	Gender	Health Center and Primary Care Physician (HMSA HMO only)

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SECTION 4: Healthcare Flexible Spending Account (MEDEXP) RCUH Policy 3.530

Plan Year: **07/01/2023 through 06/30/2024**

◯ **Enroll** ◯ **Waive**

Deduction Amount: _____ per pay period

Maximum Deduction per pay period: $127.08
Maximum Annual Contribution (Tax Year 2023): $3,050.00

Healthcare FSA: TOTAL Pledge Amount

$ 0.00 per plan year

TOTAL Pledge = Pay period Deduction x 24 pay periods

SECTION 5: Dependent Care Flexible Spending Account (DEPEXP) RCUH Policy 3.530

Plan Year: **07/01/2023 through 06/30/2024**

◯ **Enroll** ◯ **Waive**

Deduction Amount: _____ per pay period

Maximum Deduction per pay period: $208.33
Maximum Annual Contribution (Tax Year 2023): $5,000 individual, $2,500 married filing separately

Dependent Care FSA: TOTAL Pledge Amount

$ 0.00 per plan year

TOTAL Pledge = Pay period Deduction x 24 pay periods

SECTION 6: Employee Certification

While a signature (manual or electronic) is preferred, if form is submitted via Employee Self Service eUpload feature, the electronic submittal may serve as employee approval and certification of this form's content.

I am eligible for the coverage requested and declare that the individuals listed on this enrollment form are also eligible. I understand that the benefit elections made on this application are in effect as long as I continue to meet RCUH's eligibility requirements, or until I elect to change them subject to the provisions of the plan rules. I authorize my employer to make the deductions, adjustments, or cancellations from my compensation in accordance with applicable laws, rules, and regulations. This form supersedes all forms and submissions previously made for benefit coverage with the RCUH. I hereby declare that the above statements are true to the best of my knowledge and belief.

Medical Enrollment: If enrolling, I authorize RCUH to set my effective dates of coverage and to deduct monthly employee contributions for each benefit plan from my salary. I understand my rights for continuation of health coverage under COBRA and am responsible to inform my dependents covered under my health insurance of their rights. I will contact RCUH HR if electing post-tax deduction. If waiving, I understand that RCUH has given me an opportunity to enroll in RCUH's Medical Plan for my eligible beneficiaries and myself, and if I am voluntarily declining enrollment as indicated above, I can only enroll in the future during RCUH's Open Enrollment Period or due to a Qualifying Event as defined by RCUH's Policy 3.520 RCUH Health Plans. I understand that I and (if applicable) eligible dependents will be ineligible for the Premium Tax Credit (PTC), since medical coverage was offered through RCUH (employer-sponsored coverage). Information provided on this form is true and complete to the best of my knowledge.

Flexible Spending Account Enrollment: I acknowledge that my plan year pledge is irrevocable unless I experience a qualifying life event. I have reviewed and understand the options available to me for my Employer's Flexible Spending Plan pursuant to the following: (1) RCUH Policy 3.530 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. I understand that it is my obligation to determine whether contributions made under this Plan are excludable from my gross income. If any reimbursements or contributions are determined not excludable from income under the Internal Revenue Code, I will indemnify my Employer for any tax that may be due.

Employee Signature: _____ **Date:** _____

Questions about Open Enrollment?

Contact RCUH Employee Benefits: Phone: (808) 956-6979 or (808) 956-2326 or Email: rcuh_benefits@rcuh.com

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