UHA
HEALTH INSURANCE
Better **Health.** Better **Life.**

Group Administrator Handbook

EMP_CON-0163-051321

Introduction to UHA

About UHA

UHA is a mutual benefit society dedicated to providing access to quality health care services while protecting our members from financial loss due to illness or injury.

UHA was founded in 1996 by physicians who were faculty members of the John A. Burns School of Medicine of the University of Hawaii. These physicians recognized the need for a health insurance company that holds quality health care as its highest value.

What's in the UHA Group Administrator's Handbook?

The purpose of this handbook is to assist you in coordinating your organization's medical benefits program with us. From enrolling your employees to balancing your monthly premium statements, this handbook describes all procedures and forms you will need to administer your health plan.

This handbook has several sections designed to answer Group Administrators' most frequently asked questions and to help ensure that UHA members receive the greatest value from their coverage:

Who Do I Contact At UHA? We provide a quick reference guide of UHA department phone numbers and their functions to guide you when you need assistance.

What Are UHA's Eligibility and Enrollment Procedures? We describe all aspects of enrolling employees, maintaining your group's eligibility records and reporting changes. All necessary forms are also provided.

How Will I Be Billed? Our schedules of monthly billing process and payment procedures are outlined for you.

How Will Our Employees Claims Be Processed? UHA's claims filing procedures and processing policies are detailed.

This handbook should be used in conjunction with the following documents provided by UHA:

The **UHA Summary of Benefits** provides a brief, non technical overview of subscriber health plan benefits.

The **Agreement for Group Health Plan** is your contract with UHA.

The **Medical Benefits Guide (MBG)** provides a comprehensive overview of your health plan benefits. You are required to make this guide available to all of your covered employees. It is available on UHA's website, member portal or upon request.

Group Administrator Reference Page

Group Name: _____

Group Number: _____

Division Number(s): _____

Effective Date: _____

Benefits: Medical Plan _____

Prescription Drug Plan _____

Vision Plan _____

Dental Plan _____

CLIENT SERVICES DEPARTMENT – YOUR EMPLOYER SUPPORT TEAM	
INQUIRIES ABOUT	**DESCRIPTION**
Benefit plan information	Requests for benefit program brochures (medical, prescription drug, vision, dental), provider directories
Enrollment Procedures	Scheduling presentation and enrollment meetings
Group Renewal Process	Renewal rates, benefit changes
Contracting	Requests for copies of the Group contract or rates

Your UHA Employer Support Team:

Client Services: clientservices@uhahealth.com

Fax (877) 222-3198

Correspondence should be sent to:

UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813

How to Contact UHA

We welcome and encourage all authorized group administrator(s) to contact us whenever you or your employees have problems or questions. UHA's staff of experienced professionals are ready to assist you. We are available on weekdays between the hours of **8:00 a.m. and 4:00 p.m**.

We have included a **Quick Reference Directory** on the following page to direct you and your employees to the department that is best able to handle a problem.

Please have the following information handy prior to your call so that we can identify you as an authorized contact:

1. Your Company Name
2. Your Group and Division number

If you are calling regarding an employee, please have ready the following information:

1. Name of employee
2. Employee's identification number

If you are calling about a dependent, please have the dependent's name ready.

Please note that due to the Health Insurance Portability and Accountability Act (HIPAA), UHA is restricted in the amount and type of medical information we can disclose to our clients. You can review our Privacy Policy on our website, uhahealth.com

CUSTOMER SERVICES On Oahu: 808.532.4000; Neighbor Islands: 800.458.4600, ext. 297; Fax: 866.572.4393	
INQUIRIES ABOUT	**DESCRIPTION**
Plan Coverage	Benefits, Co-payments, Plan Maximums, etc.
Claims	Status, Payment, Forms, etc.
Eligibility Status	Subscriber, Spouse, Dependents, Age Limit
Member ID Cards	ID Card Requests

EMPLOYER SERVICES -- ENROLLMENT SECTION On Oahu: 808.532.4007; Neighbor Island: 800.458.4600, ext. 299; Fax: 877.222.3198 email: es@uhahealth.com Downloadable forms available at uhahealth.com	
INQUIRIES ABOUT	**DESCRIPTION**
Employee Additions/ Deletions/ Changes	Updates on employee eligibility
Member Changes	Names, Address, Employee Identification Number, Birthdate
COBRA Services	Payment, Billing Statements, COBRA ID Cards, Eligibility

EMPLOYER SERVICES – PREMIUM BILLING SECTION: On Oahu: 808.532-4000, ext. 353; Neighbor Island: 800.458.4600, ext.353; Fax: 877.222.3198	
INQUIRIES ABOUT	**DESCRIPTION**
Employer Premium Statement Payments	Errors, omissions, incorrect amounts due, non-receipt of statements, late payments

FINANCIAL SERVICES On Oahu: 808.522.7897; Neighbor Islands: 800.458.4600, ext. 247; Fax: 866.577.3035
INQUIRIES ABOUT
Schedule A, Tax Filing Requests

Submit Enrollment/Termination/Change forms to UHA:

Mail: Employer Services Department-Enrollment Section
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813 – 4100

Fax: (877) 222-3198 **if you send by fax, please do not mail the original or a duplicate copy.**

Email: es@uhahealth.com

Online Employer Portal:

- Online Enrollment
- Online View Bill
- Online Pay Bill
- uhahealth.com/page/online-employer-services

Making Changes to your Group's Address or Authorized Contact(s)

For any changes to your group's demographic information or to add or remove a Group Administrator, please complete the "Group Information Change Form" which can be found on our website, uhahealth.com.

The form must be signed by an Authorized Group Administrator or a Company Officer in order to be processed.

Print Form

UHA HEALTH INSURANCE

Group Information Change Form

Complete this form when making changes to your group's demographic information or adding/removing a Group Administrator.
Please note: This form is not for Online Access. Sign up for access to UHA's Online Employer Services Portal by submitting an Online Agreement and Authorization Form or visit our website: uhahealth.com.

Group Name _____ Group Number _____

Demographic Changes | Effective Date of Changes: _____

Physical Address: _____
(Street, City, State, Zip Code)

Mailing Address: _____
(Street, City, State, Zip Code)

Phone: (___) _____ **Fax:** (___) _____ **Email:** _____

Group Administrator(s) - Add/Remove/Update | Effective Date of Changes: _____

Action Required (check one): ☐ Add GA ☐ Remove GA ☐ Update GA Info

Name: _____ **Position Title:** _____

Mailing Address: _____
(Street, City, State, Zip Code)

Phone: (___) _____ **Fax:** (___) _____ **Email:** _____

Group Administrator(s) - Add/Remove/Update | Effective Date of Changes: _____

Action Required (check one): ☐ Add GA ☐ Remove GA ☐ Update GA Info

Name: _____ **Position Title:** _____

Mailing Address: _____
(Street, City, State, Zip Code)

Phone: (___) _____ **Fax:** (___) _____ **Email:** _____

(Agent must already be a Group Administrator, Owner, or Company Officer)

Authorized Group Administrator/Company Officer Signature: _____ **Date:** _____

Authorized Group Administrator/Company Officer Name: _____

Please submit completed form to:
UHA Health Insurance
Attn: Client Services Department
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Fax: 1-866-796-3484
Email: clientservices@uhahealth.com

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UHA Benefits and Programs

Benefit Comparison Plan

Here is a brief comparison of UHA's Health plans and what they cover. Complete details can be found in the respective MBGs.

UHA HEALTH INSURANCE

Benefit Plan Summary UHA 3000 and UHA 600

QUESTIONS?
Call Customer Services
(808) 532-4000
Toll-free: 1-800-458-4600

Plan Provisions[1]	UHA 3000		UHA 600	
Dependent Child Coverage	Less than 26 years of age		Less than 26 years of age	
Annual Deductible[2]	$200 per person; $600 per family		None	
Annual Maximum Out-of-Pocket	$2,200 per person; $6,600 per family		$2,500 per person; $7,500 per family	
Lifetime Maximum[3]	Unlimited		Unlimited	
Medical Services	**You Pay**		**You Pay**	
	Participating Provider	Non-participating Provider	Participating Provider	Non-participating Provider
PREVENTIVE CARE SERVICES[4]*				
Physical Exam (office visit) once per calendar year Preventive Screening Services Well Child Care Visit Childhood Immunizations Adult Immunizations Screening Laboratory Services - Outpatient	No co-payment			
MATERNITY SERVICES				
**Maternity Care	No co-payment		10% of EC*	30% of EC*
Birthing Room[5]			No co-payment	20% of EC*
Newborn Nursery[1]			10% of EC*	30% of EC*
DISEASE MANAGEMENT PROGRAMS[6]				
Smoking Cessation Program Asthma Education Program Diabetes Self-Management Training & Education Program Nutritional Counseling Programs	No co-payment			
PHYSICIAN SERVICES[7]				
Physician Office Visit	$12 co-payment		10% of EC*	30% of EC*
HOSPITAL SERVICES				
Room & Board (semi-private room) Hospital Ancillary Services Laboratory & Pathology - Inpatient	20% of EC*; deductible applies		10% of EC*	30% of EC*
EMERGENCY SERVICES				
Emergency Room Services	20% of EC*; deductible applies		10% of EC*	10% of EC*
Ambulance (ground or inter-island air)			20% of EC*	30% of EC*
COMPLEMENTARY ALTERNATIVE MEDICINE[1]				
Chiropractic/Acupuncture Services Benefits limited to treatment of conditions of the neuromusculoskeletal system by a licensed provider	$10 co-payment per visit First set of x-rays at 50% of EC*; full charge for add'l sets; $500 combined maximum per calendar year	Plan pays up to $20 per visit X-rays not covered $500 combined maximum per calendar year	$10 co-payment per visit First set of x-rays at 50% of EC*; full charge for add'l sets; $500 combined maximum per calendar year	Plan pays up to $20 per visit X-rays not covered $500 combined maximum per calendar year

* The information above is intended to provide a condensed explanation of UHA medical plan benefits. Please refer to the appropriate Medical Benefits Guide (MBG) for complete information on benefits and provisions. In case of a discrepancy between this comparison and the language contained in the MBG, the MBG will take precedence.
[2] Annual deductible does not apply to all services. Refer to your Medical Benefits Guide to verify which services apply.
[3] No annual or lifetime maximum.
[4] All U.S. Preventive Services Task Force (USPSTF) A and B recommended screening services are covered at 100% as required under the provisions of the Patient Protection and Affordable Care Act (ACA).
[5] UHA 3000 annual deductible does not apply.
* EC (Eligible Charge) Refer to your Medical Benefits Guide for detailed definition.
** Covered, including prenatal, false labor, delivery, and postnatal services provided by your physician or midwife. Maternity care does not include related services such as nursery care, labor room, hospital room and board, diagnostic testing, and other lab work and radiology. Please refer to the specific benefits for more information on those services.

MKT-0944-110920

UHA Programs

UHA offers members the below programs free of charge:

Diabetes Management
To help members with diabetes better control their illness and their lives, we offer a diabetes management program as a covered benefit.

Asthma Management
Asthma is one of the most common chronic diseases in Hawaii. To help members take control of their asthma, we offer an asthma management program as a covered benefit.

Smoking/Tobacco Cessation
Quitting tobacco is much easier said than done. To aid members in their efforts, we offer smoking cessation classes and nicotine replacement products as covered benefits.

Weight Watchers®
Being overweight or obese is a widespread and very serious health problem. To help our members combat this serious problem, we have partnered with Weight Watchers® to provide nutrition counseling.

Seasonal Flu Shots
As part of our efforts to increase prevention of the flu, we are offering the flu shot to our members during the flu season (October through February).
Onsite Flu Shots are available to Employer Groups with 25 or more employees.

More information on the programs above can be found on our website, uhahealth.com or contact our Health Care Services Department at 532-4006 or 1-800-458-4600 ext. 300 when calling from the Neighbor Islands.

Coordination of Benefits

If you or any of your employees have other insurance coverage, for example through a spouse or Medicare, that provides benefits similar to those of this plan; please inform UHA. We can "coordinate" the benefits of the two plans. When benefits are coordinated, the benefits paid under this plan, when combined with the benefits paid under your other coverage, will not exceed the lesser of:

- 100% of the eligible charge
- the amount payable by your other coverage plus any deductible and copayment you would owe if the other coverage were your only coverage

Any deductible and copayment you owe under this plan will first be subtracted from the benefit payment. You remain responsible for the deductible and copayment owed under this plan, if any. Coordinating benefits between insurance carriers can benefit you and affect your claims payments.

For more information such as general rules, the Member's and UHA's responsibility, please refer to your MBG.

Eligibility Information

Active Employees

Regular employees, as defined under the Hawaii Prepaid Health Care Act (Chapter 393, Hawaii Revised Statutes), are eligible for coverage through UHA. **Eligible employees have 31 days from the date they are hired to apply for enrollment**. Requests for enrollment at any other time cannot be accommodated. No retroactive enrollment is accepted.

Qualifying Enrollment Events

Enrollment Events For Employees:

- Annual open enrollment
- Part-time to full-time status change (within 31 days of change)
- New hire (within 31 days of hire)
- Loss of other medical coverage (within 31 days of loss of coverage)

Enrollment Events For Dependents and/or Changes in Enrollment:

- Annual open enrollment
- Loss of other medical coverage (within 31 days of loss of coverage) *
- Newborn (within 31 days of birth) *
- Adoption (within 31 days of adoptive placement) **
- Stepchild (within 31 days of marriage) *
- Court Appointed Guardian (within 31 days of appointment) **
- Marriage (within 31 days of marriage) *
- Civil Union (within 31 days of union) *

Requests for enrollment at any other time cannot be accommodated. No retroactive enrollment is accepted.

* Please submit documents to verify eligibility for the enrollment event. For example, please timely submit new enrollment forms, previous insurer's termination letter, birth certificate, adoption papers, marriage or civil union licenses.

** Court Order documents required

Employees or Dependents age 65 and older

Employees or dependents age 65 and older may be able to qualify for Medicare coverage. For these employees or dependents, having Medicare coverage can lower their out-of-pocket medical costs.

If your company has 20 or less employees, Medicare qualified members may be required to have Medicare Part A and Part B in addition to their group coverage to avoid paying a penalty fee. Please refer to Medicare.gov for more information.

Please provide Medicare information for members age 65 or older if available. If no documentation is received, the members may be defaulted to Medicare primary in order to ensure proper processing of their claims.

Dependents up to age 26

Eligible dependents may be enrolled during the initial enrollment of the employee. Eligible dependents include an employee's lawful spouse, Civil Union partner, and children up to age 26 including stepchildren, legally adopted children, and qualified children placed for adoption.

Dependent enrollment eligibility updates will become effective on the first day of the month following notification to UHA. For newborns or dependents to be eligible from the date of birth or adoption, newborn or adopted child enrollment information must be received by UHA within 31 days from the date of birth or the date of adoptive custody. Premiums are due for the month in which the child is born; UHA does not prorate premiums.

> For example: If John Smith's dependent is born on March 10, the Group Administrator must submit a Member Enrollment Form to enroll the dependent by April 10 (31 days) for an effective date of March 10. Premiums are due for the entire month of March. If UHA does not receive this information within 31 days, the child will not be covered from date of birth and will not be enrolled until the next open enrollment period.
>
> The Group Administrator must submit to UHA a copy of the birth or hospital certificate for newborns, or adoptive placement and a copy of the legal adoption document for adopted dependents, with the Member Enrollment Form within 31 days of birth or adoption. If the required documents are not received with 31 days of birth or adoption, the child will not be enrolled until the next open enrollment period.

Disabled Dependent age 26 and older

UHA recognizes children as dependents under "disability" within the following guidelines:

1. Written documentation has been provided for enrollment demonstrating that:
    a. The child is incapable of self-sustaining support because of a physical or mental disability.
    b. The child's disability existed before the child reached 26 years of age.
    c. The child relies primarily on parent or legal guardian, who is a UHA member, for support and maintenance as a result of their disability.
    d. The child is enrolled with us under this coverage or another qualified health insurance coverage, and has had no break in health insurance coverage since before the child's 26th birthday.
2. Member must provide this documentation to UHA within 31 days of the child's 26th birthday and subsequently at our request, but not more frequently than annually.

To apply for extended disabled dependent coverage, the employee must do the following:

- Have the dependent's physician complete a **Dependent Disability Certification Form**
    - Please duplicate copies as needed for multiple dependents
- Submit the completed Dependent Disability Certification Form to UHA at least 31 days prior to the dependent's 's 26th birthday

- Proof of continuous coverage may also be requested.

Once the completed form and documentation is received, UHA will use the medical information submitted to determine if the child qualifies as a disabled dependent. All Dependent Disability Certification Forms are subject to review by UHA's Chief Medical Officer and/or Medical Director.

Print Form

UHA HEALTH INSURANCE
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100
T 808.532.4007
F 877.222.3198
uhahealth.com

Dependent Disability Certification Form

Return to: UHA Health Insurance
Attention: Employer Services
700 Bishop Street, Suite 300
Honolulu, HI 96813

This is to certify that I have examined _____, born on ____/____/____ and find said person to be incapable of self-sustaining employment by reason of physical or mental disability which existed before attainment of age 26. I understand that UHA will require medical records or other documentation to support this certification and I agree to promptly provide any records requested to UHA.

1. Nature of disability _____

2. Disability has been continuous from _____
Approximate Date

3. Is the disability permanent? ☐ Yes ☐ No
If Yes, please explain:
_____

4. In your opinion, will the individual recover sufficiently to be capable of self-sustaining employment? ☐ Yes ☐ No

5. If "yes" to #4 above, by what date _____

6. Remarks _____

Signature of Attending Physician _____

Print Name _____

Date _____

Address _____

_____

TO BE COMPLETED BY UHA SUBSCRIBER

Disabled Dependent Enrollment Guidelines

A child who is age 26 or over may be enrolled as a dependent if he or she is disabled by providing UHA:

1. Written documentation acceptable to UHA demonstrating that:

    a. The child is incapable of self-sustaining support because of a physical or mental disability.
    b. The child's disability existed before the child turned 26 years of age.
    c. The child relies primarily on parent or legal guardian, who is a UHA member, for support and maintenance as a result of their disability.
    d. The child is enrolled with us under this coverage or another qualified health insurance coverage, and has had no break in health insurance coverage since before the child's 26th birthday.

2. The documentation must be provided to UHA within 31 days of the child's 26th birthday and subsequently at our request but not more frequently than annually.

To apply for disabled dependent coverage, the subscriber must:

- Have the dependent's physician complete UHA's **Dependent Disability Certification Form**. One form for one dependent.

- Assist UHA, if necessary, in obtaining the medical records or other medical documentation from the dependent's physician.

- Submit the completed Dependent Disability Certification Form to UHA at least 31 days prior to the dependent's 26th birthday.

- Upon request, provide proof of legal guardianship, medical power of attorney, federal disability certification or identification card such as Social Security disability certification letter or identification card from Centers for Medicare and Medicaid Services, tax filings or continuous coverage.

Once the completed form and documentation is received, UHA will use the information submitted to determine if the child qualifies as a disabled dependent under the subscriber's UHA coverage. All information is subject to review by UHA's Chief Medical Officer and/or Medical Director.

Reciprocal Beneficiaries

A reciprocal beneficiary relationship is a legal partnership between two people who are prohibited from marriage. UHA will extend health insurance benefits to the reciprocal beneficiary of an eligible employee if all of the following criteria are met:

- The employee is in a reciprocal beneficiary relationship as defined by Chapter 572C, Hawaii Revised Statutes; and
- The Employer Group requests in writing that UHA extend eligibility to Reciprocal Beneficiaries of its employees
- The employer or employee provides to UHA a Certificate of Registration of Reciprocal Beneficiary Relationship from the State of Hawaii Department of Health.

Domestic Partnership

Domestic partnerships refer to relationships between two persons who are eligible for marriage under Hawaii law, but are not married. UHA will extend coverage to domestic partners at the request of an Employer Group. A UHA Domestic Partnership Employer Representation form and UHA Domestic Partnership Affidavit form must be completed, signed and approved by UHA before a domestic partner can be enrolled.

Eligibility requirements for domestic partners are:

- Both domestic partners are at least 18 years of age and mentally competent to enter into a domestic partnership.
- Both domestic partners must live together and share the same place of residence and intend to continue to do so indefinitely.
- Neither may be married nor have another domestic partner.
- Neither would be prevented from marrying the other under Hawaii State law or on account of blood relationship to the other.
    a. Domestic partners are not related by blood closer than would bar marriage under Hawaii State law.
    b. Ancestors and descendants of any degree, brother and sister of the half and whole blood, uncle/niece, and aunt/nephew, whether the relationship is legitimate or illegitimate, cannot marry.
- Both domestic partners agree that they are economically, jointly and severally liable to third parties for the common necessities of life, defined as food, shelter and medical care.
- Both domestic partners agree that this shall remain the case for expenses incurred during the period that the non-employee domestic partner is covered by the group. The individuals do not need to contribute equally or jointly to the cost of these expenses as long as they agree that both are responsible for the costs.Both domestic partners must

live at the same address, and provide proof of eligibility through one or more of the following:

a. Joint ownership of property
b. Joint bank account
c. Domestic partner is named as a beneficiary on employee's life insurance policy or will
d. Joint mortgage or lease
e. Durable power of attorney for property or health care naming the domestic partner as designee

- Children of domestic partners will be allowed to enroll, if they meet UHA's standard eligibility requirements.

All other UHA eligibility requirements, qualifying events, and deadlines for all members will apply similarly to domestic partnerships. The Employer group must administer the benefits themselves and the Group must send UHA a copy of the signed affidavits for Health Plan's reference. Refer to the following pages for samples of the UHA Domestic Partnership Employer Representation and UHA Domestic Partnership Affidavit forms.

Civil Unions

A Civil Union is a union between two individuals established pursuant to Chapter 570A, Hawaii Revised Statutes. UHA will extend dependent health insurance benefits to the partner of an eligible employee if the eligible employee and partner have entered into a Civil Union under Chapter 570A, Hawaii Revised Statutes. UHA may require the eligible employee to submit a certified Civil Union license evidencing a Civil Union under Chapter 507A, Hawaii Revised Statutes, in order to verify eligibility for coverage.

UHA HEALTH INSURANCE
700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4007
F 877.222.3198
uhahealth.com

UHA DOMESTIC PARTNERSHIP EMPLOYER REPRESENTATION

1. UHA will extend coverage to all eligible Domestic Partners of the Employer Group (eligibility is defined in UHA Domestic Partnership Affidavit).

2. The Employer Group does not establish policies that would discriminate against Domestic Partners. Examples of these types of practices include the following:
   a. Applying pre-existing condition clauses to Domestic Partners only,
   b. Making coverage for Domestic Partners different from that of other subscriber's dependents, and
   c. Having different rates for employees with Domestic Partners versus subscribers with other kinds of dependents.

3. The Employer Group agrees to pay the same amount toward the cost of coverage for a subscriber with an enrolled Domestic Partner or Domestic Partner with children, as it pays toward the cost of coverage for a subscriber with a spouse, or spouse with children.

4. Domestic Partnerships will remain eligible until UHA receives a written notice that has been signed by the Group Administrator or an officer of the company. Allowed changes to the eligibility of Domestic Partnerships will only be effective on the renewal date of the Employer Group.

Employer Group Name _____ **Date** _____

President or Officer Signature _____ **Print Name** _____

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UHA HEALTH INSURANCE
700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4007
800.456.4800
F 877.222.3198
uhahealth.com

UHA DOMESTIC PARTNERSHIP AFFIDAVIT

All of the statements made in this Affidavit are true and will remain true indefinitely.

"Group" herein refers to the entity listed on the UHA Schedule of Benefits.
"Health Plan" herein refers to UHA (University Health Alliance).
"We" herein refers to the UHA subscriber and their domestic partner dependent.

Eligibility Requirements

1) We are both at least 18 years of age and mentally competent to contract.
2) We both have the same place of residence, and intend to reside together indefinitely.
3) We are emotionally committed to each other, and intend to remain each other's domestic partner indefinitely.
4) Neither of us is married nor has another domestic partner.
5) Neither of us would be prevented from marrying one another on account of blood relationship to each other under Hawaii law (i.e. – are not related by blood closer than would bar marriage under Hawaii law).
6) Both of us agree that we are economically jointly and severally liable to third parties for the common necessities of life, defined as food, shelter, and medical care.
   a) Both agree that this shall remain the case for expenses incurred during the period that the non-employee domestic partner is covered by the Group.
7) Each of us agrees to immediately notify Group and Health Plan in writing if there is any change of circumstances attested to in this Affidavit.

Each of us understands that, if either of us has made a false statement regarding his or her qualifications as a domestic partner or has failed to comply with the terms of the Affidavit, and Group or Health Plan suffers any loss thereof, Group or Health Plan may bring civil action against either or both of us to recover its losses, including reasonable attorney's fees and court costs, or may rescind or cancel coverage.

Each of us understands that this Affidavit shall be terminated upon the death of one of the domestic partners or by a change in the circumstances attested to in this Affidavit.

Each of us agrees to provide written notice to Group and Health Plan if there is any change of circumstances attested to in this Affidavit within 30 days of the change by filing a "Termination of Domestic Partnership."

By executing this Affidavit, each of us agrees to be bound by the terms and conditions of coverage as set forth in the Member Benefit Guide, including the arbitration clause.

Each of us declares under penalty of perjury under Hawaii law that the assertions in the Affidavit are true and accurate to the best of our knowledge.

Signature of Employee _____ **Date of Birth** _____ **Date** _____

Signature of Non-Employee _____ **Date of Birth** _____ **Date** _____

Employer Group Name _____ **Date** _____

Authorized Signature _____ **Print Name** _____

EMP_ENR-0152-091820

UHA
HEALTH INSURANCE
700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4007
800.458.4600
F 877.222.3198
uhahealth.com

Termination of Domestic Partnership

I. DECLARATION

I, _____ (name), an employee of

_____ (employer name),

group number _____, declare that, as of _____ (date),

I am no longer in a domestic partnership with _____ (domestic partner) because:

- ☐ Our domestic partnership no longer meets all the status criteria set forth in our Declaration of Domestic Partnership, or
- ☐ The domestic partner is deceased as of _____ (date of death), or
- ☐ Our domestic partnership terminated or dissolved as of _____ (date).

II. TERMINATION OF COVERAGE

I understand that termination of coverage of the domestic partner will be effective upon UHA's receipt of this Declaration, and continuation of coverage under COBRA is not provided for the domestic partner.

I affirm, under penalty of perjury, that the statements in this Declaration are true and correct.

_____ Employee Signature

____/____/____ Date

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Enrollment

Employees, other than new hires, can enroll only during your group's open enrollment period, when there is a work status change (where the employee is now eligible for coverage under prepaid laws), or loss of other medical coverage. In these instances, enrollment would only be permitted on the first of the month following the loss of coverage.

To enroll employees who have lost coverage, the Group Administrator must submit a Member Enrollment Form within 31 days from the loss of coverage. A copy of the other carrier's termination letter or HIPAA certificate must be submitted with the Member Enrollment Form so we can verify eligibility.

How To Enroll New Employees

To enroll new employees in your company's medical benefit program, you must submit a completed Member Enrollment Form for each employee. New enrollment eligibility updates will become effective on the first day of the month following notification to UHA. Employee enrollments received on or after the first day of the month will be eligible in the next month. **Please fax forms to (877) 222-3198, or mail the forms to:**

UHA
Attn: Employer Services Department
700 Bishop Street, Suite 300
Honolulu, HI 96813

Or email: ES@uhahealth.com

Because incomplete or illegible forms cause delays in enrollment, please check to see that all information is complete and accurate. Please pay special attention to the following information:

- Social Security Numbers of Subscriber and Dependents
- Eligibility Effective Date
- Hire Date
- Status Change from Part Time to 20+ hours/week
- Birth dates of Subscriber and Dependents
- Other Health Plan information
- Mailing and Physical Address of the Subscriber
- Group and Division Number
- Employee Signature
- Group Administrator Signature

Member Enrollment Form

UHA HEALTH INSURANCE

1 Group Name: _____ Group/Division #: ____ / ____

2 REASON FOR ENROLLMENT (One Selection Only)

*THIS INFORMATION IS REQUIRED.

- ☐ Annual Group Open Enrollment
- ☐ Reinstate Subscriber (no break in coverage)
- ☐ Add Dependent(s) / Spouse / Civil Union Partner (See Page 2)
- ☐ Add a new subscriber (with or without family)

*Status Change from Part-time to 20+ hours/week: ☐ YES ☐ NO

*Date of Hire: ___ / ___ / ____

3 BENEFIT INFORMATION

Plan Type: ☐ 1 Party ☐ 2 Party ☐ Family

Medical Plan: ☐ UHA 600 ☐ UHA 3000

Other Benefits: ☐ Drug ☐ Vision ☐ Dental ☐ **Pediatric Dental

Effective Date: ___ / 01 / ____ (First day of the month) MM YYYY

**PEDIATRIC DENTAL COVERAGE FOR SMALL GROUPS ONLY (1 - 50 Employees)

4 SUBSCRIBER INFORMATION Please provide all information requested

Social Security: ___ - ___ - ____ Birth Date: ___ / ___ / ____ Gender: ☐ Female ☐ Male

Last Name:

First Name:

Mailing Address:

City: State: Zip Code:

☐ Physical Address: same as mailing

City: State: Zip Code:

Contact Number: ___ - ___ - ____ E-mail Address: _____

Other health plan for you or your family in addition to UHA? ☐ Yes ☐ No Other Plan Effective Date: ___ / ___ / ____

Choose name of other plan:

- ○ HMSA
- ○ Kaiser
- ○ HMAA
- ○ Medicare - Part A
- ○ Medicare - Part B
- ○ Medicare - Part A&B
- ○ Other: _____

Policy Holder's Name: _____

Copy of other health plan ID card attached: ☐

5 REQUIRED SIGNATURES

NOTE: Verifiable digital signatures with date stamp and name of signor accepted as well as certain electronic signatures.

Under penalties of perjury, I certify that the Social Security number shown on this form is correct for myself and my dependents (or I am waiting for a number to be issued to me and/or my dependents). I also certify that the information I have provided is the most current and accurate information.

CONSENT FOR RELEASE OF MEDICAL RECORDS: I certify by signature below that I am 18 years of age and hereby authorize any health care facility, physician, practitioner, counselor, or therapist to provide UHA or its reinsurer, all information pertaining to any medical condition, treatment, confinement, or diagnosis of myself or my dependents who are also covered by UHA. This authorization includes, but is not limited to, mental health conditions, alcohol and drug abuse, and HIV/AIDS information. This consent shall be valid for all medical information throughout the period that I am covered by UHA. This consent shall also include all information pertaining to claims incurred during the coverage period.

Subscriber's Signature: _____ Date: _____

Parent/Guardian Signature: (if Subscriber is below age of 18) _____ Date: _____

The Group Administrator and subscriber of the above named UHA Member Group certifies by signature below that the above named subscriber is a bona fide employee as defined by the Hawaii Prepaid Healthcare Act. UHA may terminate coverage for any ineligible enrollee upon confirmation of ineligibility. If enrollment of the above named enrollee(s) is found to be based on fraud or intentional misrepresentation of a material fact by the employer, coverage for the Member Group and/or the enrollee(s) may be terminated by UHA. In the event of termination, the above named Member Group agrees that any benefit payments made by UHA on behalf of the ineligible enrollee(s) must be returned in full to UHA by the ineligible enrollee(s) and/or the employer. UHA shall return all premiums paid by the employer with respect to the ineligible enrollee(s) upon termination of coverage and reimbursement of benefit payments made by UHA. By signing below, the Group Administrator also confirms that they have provided the above named subscriber with a copy of their Summary of Benefits & Coverage and Uniform Glossary.

Group Administrator Signature: _____ Date: _____

Prepared By: _____ Contact Number: _____

EMP_ENR-0212-102020

UHA
HEALTH INSURANCE

Member Enrollment Form

SUBSCRIBER NAME: ______________________________

Page 2 of 2

Instructions: Complete Sections 6 & 7 **only** if enrolling Spouse, Civil Union Partner and/or Dependent(s).

⑥ ADD SPOUSE OR CIVIL UNION PARTNER INFORMATION

Reason to Add: ☐ Marriage ☐ Civil Union Partnership **Date of Reason:** __ / __ / ____

Social Security: ___ - __ - ____ Effective Date: __ / __ / ____

Last Name: ______________________________

First Name: ______________________________

Birth Date: __ / __ / ____ Living outside of Hawaii?

Gender: ☐ M ☐ F ☐ Yes ☐ No If Yes, Enter address: ______________________________

⑦ ADD DEPENDENT(S) INFORMATION

Reason to Add: ☐ Newborn ☐ Court Order ☐ Loss of other medical coverage **Date of Reason:**
☐ Adoption/Stepchild ☐ Disabled __ __ ____

Social Security: ___ - __ - ____ Effective Date: __ / __ / ____

Last Name: ______________________________

First Name: ______________________________

Birth Date: __ / __ / ____ Living outside of Hawaii?

Gender: ☐ M ☐ F ☐ Yes ☐ No If Yes, Enter address: ______________________________

Reason to Add: ☐ Newborn ☐ Court Order ☐ Loss of other medical coverage **Date of Reason:**
☐ Adoption/Stepchild ☐ Disabled __ __ ____

Social Security: ___ - __ - ____ Effective Date: __ / __ / ____

Last Name: ______________________________

First Name: ______________________________

Birth Date: __ / __ / ____ Living outside of Hawaii?

Gender: ☐ M ☐ F ☐ Yes ☐ No If Yes, Enter address: ______________________________

Reason to Add: ☐ Newborn ☐ Court Order ☐ Loss of other medical coverage **Date of Reason:**
☐ Adoption/Stepchild ☐ Disabled __ __ ____

Social Security: ___ - __ - ____ Effective Date: __ / __ / ____

Last Name: ______________________________

First Name: ______________________________

Birth Date: __ / __ / ____ Living outside of Hawaii?

Gender: ☐ M ☐ F ☐ Yes ☐ No If Yes, Enter address: ______________________________

Member Enrollment Instructions

① **GROUP INFORMATION:** Enter the group name and the eight-digit group/division number.

② **REASON FOR ENROLLMENT:** Select a reason for submitting this form (one selection only).

- "Date of Hire" and "Status Change" are required fields for the subscriber.
- "Status Change" Select YES if the employee is working more than 20 hours per week.
- "Date of Reason" is the applicable date of the reason the member is being added.

③ **BENEFIT INFORMATION:** Choose benefit selection and enter the effective date of coverage.

④ **SUBSCRIBER INFORMATION:** Enter all information requested for the subscriber. In most situations, the employee is the subscriber.

⑤ **REQUIRED SIGNATURES:**
Form must be signed and dated by the **subscriber** of the plan and an **authorized group administrator**.

⑥ **SPOUSE or CIVIL UNION PARTNER INFORMATION:**
The first row is for entering spouse or civil union partner information. If adding spouse or civil union partner outside of open enrollment, please attach supporting documents (i.e., marriage certificate, loss of coverage letter from other carrier, etc.)

⑦ **DEPENDENT INFORMATION:**
Enter all information for dependent(s). If additional rows are needed, please attach another sheet. If adding dependent(s) outside of open enrollment, please attach supporting documents (i.e., court order, birth certificate, etc.)

To ensure proper processing, all required fields must be completed and proper documentation submitted. Mail, fax or email completed forms with necessary documentation to:

UHA Employer Services
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Toll-free fax: (877)222-3198

Email: ES@uhahealth.com

You can also conveniently submit changes for employee information through **UHA's Online Enrollment Services.** Member enrollments take approximately one business day. Please note that retroactive changes **cannot** be added through the Online Enrollment Services System.

To sign up, complete the **Online Employer Access Authorization and Certification Form** (uhahealth.com/uploads/forms/form_online_agreemt.pdf) or contact us for more information.

If you have any further questions contact Employer Services.
Phone: (808) 532-4007; Toll-free phone: (800) 458-4600 Ext. 299; ES@uhahealth.com

Enrolling a New Spouse

A newly married spouse or Civil Union partner can be enrolled for coverage effective on the first day of the month following marriage or Civil Union. For example:

> If David Jones is married on March 14, he must enroll the spouse by April 14 (within 31 days). Spouse will be covered effective April 1 (1st of month following marriage) if the spouse is enrolled by April 14.

The Group Administrator must send in a Member Enrollment Form within 31 days of marriage, Civil Union, or entry into the United States. A copy of the marriage certificate, certified Civil Union license, or visa showing the stamped date of entry is required to verify eligibility. A newly married spouse or partner to a new Civil Union will not be allowed to enroll until the next open enrollment period if the request is not received within 31 days of marriage, Civil Union, or entry into the United States. No retroactive enrollment is allowed.

Enrolling Children

A child may be enrolled if all of the following requirements are met:

- The child is a:
  - Natural-born child
  - Legally adopted child
  - Stepchild
  - Child placed for adoption
  - Child for whom the member is the court-appointed guardian,
- The child is under 26 years of age

Enrolling Newborns or Newly Adopted Children

Newborn or newly adopted children may be enrolled within 31 days of the birth or adoption placement. The member is responsible for notifying the employer who will then submit a Member Enrollment form to notify UHA. If the child is not enrolled within 31 days of birth or adoption, he or she cannot be enrolled until the next open enrollment period.

When to Use the Member Enrollment Form

The Member Enrollment Form should be used for the following situations:

- New enrollment of an employee and dependents
- Reinstatement with break in coverage
- Part-time to full-time work status changes
- Adding a Spouse, Civil Union partner, and dependents
- Adding Dependents
- Reinstating an employee with **no** break in coverage

When to Use the Member Change Form

The UHA Member Change Form should be used for employees already enrolled and who wish to make the following types of status changes to their enrollment:

- Open Enrollment changes if the employee is already enrolled in a UHA plan
- Changing the selection of benefits options
- Correcting an employee's Social Security Number (SSN) or adding a dependent's SSN
- Transferring an employee(s) to another division
- Updating employee information such as a change of address, change of phone number, or name change

UHA
HEALTH INSURANCE

Member Change Form

Review Member Change Instructions on the next page
before filling out this form.

You can also manage your employee's information through UHA's Online Enrollment Services! *See instructions for details.*

SUBSCRIBER INFORMATION

Fill in all requested information:

1

Subscriber's Member ID: _____ - _____ Last Name: _____ First Name: _____

TRANSFER TO NEW DIVISION?

If the subscriber is transferring to a different division, enter the old and new divisions:

2

Old Group/Division #: _____ / _____
New Group/Division #: _____ / _____
Effective Date: ____ / ____ / _____

CHANGE PLAN?

Enter the new medical coverage:

3

Medical Plan: ☐ UHA 600 ☐ UHA 3000
Other Benefits: ☐ Drug ☐ Vision ☐ Dental
☐ *Pediatric Dental

*Pediatric Dental coverage for small groups only (1 - 50 Employees)

UPDATE SUBSCRIBER INFORMATION?

Check one or more boxes to indicate the information being updated.

☐ NAME ☐ ADDRESS ☐ EMAIL ☐ PHONE # ☐ SOCIAL SECURITY # ☐ GENDER

4

Social Security #: ___ - ___ - ____ Gender: ☐ Female ☐ Male
Last Name:
First Name:
Mailing Address:
City: State: Zip Code:
Physical Address:
☐ same as mailing City: State: Zip Code:
Contact Number: ___ - ___ - ____ E-mail Address:

UPDATE DEPENDENT INFORMATION?

Complete only if spouse, civil union partner, or dependent child information needs to be updated.

Select the box: ☐ NAME ☐ SOCIAL SECURITY CORRECTION ☐ GENDER

5

Member ID: _____ - ___ Social Security #: ___ - ___ - ____
Last Name:
First Name:
Birth Date: ___ / ___ / ____ Gender: ☐ Female ☐ Male
Physical Address:
☐ same as mailing City: State: Zip Code:

6

REQUIRED SIGNATURE

The Group Administrator for the Member Group certifies by signature below that the information provided above is the most current and accurate information and the information complies with the Enrollee eligibility and termination requirements in the contract between UHA and Member Group. Eligibility requirements include that the subscriber is a bona fide "regular employee" as defined by the Hawaii Prepaid Healthcare Act (HRS Chapter 393) and any dependent is an Eligible Dependent of the subscriber. The Group Administrator understands that UHA may terminate coverage for any ineligible Enrollee upon confirmation of ineligibility.

If UHA finds enrollment of Enrollee(s) to be based on False Statements, coverage for the Member Group and/or the Enrollee(s) may be retroactively terminated. For retroactive termination, UHA shall return all premiums paid for the time period after the termination date and the Member Group and/or ineligible Enrollee(s) shall return any benefit payments made by UHA for the same time period.

Under penalty of perjury, the Group Administrator certifies that the social security number shown on this form is correct for the subscriber and/or dependent (or they are waiting for a number to be issued).

Group Administrator Signature: _____ **Date:** _____

NOTE: Verifiable digital signatures with date stamp and name of signor accepted as well as certain electronic signatures.

Prepared By: (Print Name) _____ Contact Number: _____

EMP_ENR-0211-102020

Member Change Instructions

① **SUBSCRIBER INFORMATION:**
Provide the subscriber's member ID and full name.
One subscriber per form.

② **TRANSFER TO NEW DIVISION:**
Enter the old group/division number.
Provide new group/division number and effective date of change.

③ **CHANGE PLAN:**
Check off one or more items to change pertaining to the subscriber mentioned on this form.
Provide all information requested.

④ **UPDATE SUBSCRIBER INFORMATION:**
Check off one or more items to change pertaining to the subscriber mentioned on this form.
Provide all information requested.

⑤ **UPDATE DEPENDENT INFORMATION:** Check off one or more items to change pertaining to the spouse, civil union partner, or dependent child mentioned on this form. Provide all information requested.

⑥ **GROUP ADMINISTRATOR SIGNATURE:**
Form must be signed and dated by an authorized group administrator. Capitalized words in this section are defined in the Agreement for Group Health Plan, which is the contract between UHA and the Member Group.

***To** ensure proper processing, all required fields must be completed and proper documentation submitted. Mail, fax or email completed forms with necessary documentation to:*

UHA Employer Services
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Toll-free fax: (877)222-3198

Email: ES@uhahealth.com

You can also conveniently submit changes for employee information through **UHA's Online Enrollment Services**. Termination of employees and dependents takes approximately one business day. Please note that retroactive terminations **cannot** be added through the Online Enrollment Services System.

To sign up, complete the **Online Employer Access Authorization and Certification Form** (uhahealth.com/uploads/forms/form_online_agreemt.pdf) or contact us for more information.

If you have any further questions contact Employer Services.
Phone: (808) 532-4007; Toll-free phone: (800) 458-4600 Ext. 299; ES@uhahealth.com

Termination of Coverage

You may submit termination forms for an employee and/or their dependents at any time. Possible reasons for terminating coverage (disqualifying events) include:

- The employee no longer is employed with your company
- A reduction of employee's hours to fewer than 20 hours a week
- The employee is on leave of absence (at the employer's discretion)
- Death of employee
- Voluntary cancellation by employee who has dual health insurance coverage.

Completed termination forms must be received prior to the end of the month in which an employee or their dependent(s) no longer meet the eligibility criteria set forth in the Medical Benefits Guide. Coverage will end on the last day of the month following proper notification to UHA. **No retroactive terminations or mid-month terminations are allowed.**

For example: John Smith does not wish to cover his wife under his health plan starting April 1. The Member Termination form was submitted late to UHA on April 5, so coverage for the spouse cannot be terminated until April 30, and the Employer will be responsible for premiums for the spouse for the month of April. If the Member Termination form was received on March 29, the spousal coverage would have been terminated on March 31.

Please enter the termination date as the end of the month.

For example: If termination should be July 31, do not enter August 1. If the termination form shows August 1, coverage will be terminated on August 31, even if the form was received in July.

The **Member Termination Form** is used to terminate all benefit coverage for the employee and his/her spouse, Civil Union partner, and dependents. When an employee's coverage is terminated, coverage for dependents is automatically terminated as well.

- Once an employee is enrolled and voluntarily terminates coverage or the coverage for dependents, re-enrollment will not be allowed until the next open enrollment period.

- However, if the employee terminates coverage because coverage was to be provided through a spouse/Civil Union partner's program and later experiences a status change, UHA permits re-enrollment on the first day of the month following the status change.

Please use the Member Termination Form to terminate dependent eligibility (such as the eligibility of a spouse, Civil Union partner and/or child) if the employee remains eligible. Please enter the termination date for each dependent.

UHA HEALTH INSURANCE

Member Termination Form

Review Member Termination Instructions on the next page **before** filling out this form.

You can also manage your employee's information through UHA's Online Enrollment Services! *See instructions for details.*

INSTRUCTIONS: Use this form to terminate benefit plans for subscribers and/or their family members.

①

Group Name: ____ Group/Division #: ____ / ____

Prepared By: ____ Contact Number: ____ Page: ____ of ____

MEMBERS

List the members that are no longer eligible for benefits. * By selecting a "Subscriber" option, it will terminate plan for the whole family.

②

Check ONE: ☐ **Subscriber*** ☐ **Spouse/Civil Union Partner** ☐ **Dependent Child**

Member ID: ____ - ____ Plan Term Date: ____ / ____ / ____ (Last day of the month)

Last Name: ____

First Name: ____

Check ONE: ☐ **Subscriber*** ☐ **Spouse/Civil Union Partner** ☐ **Dependent Child**

Member ID: ____ - ____ Plan Term Date: ____ / ____ / ____ (Last day of the month)

Last Name: ____

First Name: ____

Check ONE: ☐ **Subscriber*** ☐ **Spouse/Civil Union Partner** ☐ **Dependent Child**

Member ID: ____ - ____ Plan Term Date: ____ / ____ / ____ (Last day of the month)

Last Name: ____

First Name: ____

Check ONE: ☐ **Subscriber*** ☐ **Spouse/Civil Union Partner** ☐ **Dependent Child**

Member ID: ____ - ____ Plan Term Date: ____ / ____ / ____ (Last day of the month)

Last Name: ____

First Name: ____

The Group Administrator for the Member Group certifies by signature below that the information provided above is the most current and accurate information and the information complies with the Enrollee eligibility and termination requirements in the contract between UHA and Member Group. Eligibility requirements include that the subscriber is a bona fide "regular employee" as defined by the Hawaii Prepaid Healthcare Act (HRS Chapter 393) and any dependent is an Eligible Dependent of the subscriber. The Group Administrator understands that UHA may terminate coverage for any ineligible Enrollee upon confirmation of ineligibility. If UHA finds enrollment of Enrollee(s) to be based on False Statements, coverage for the Member Group and/or the Enrollee(s) may be retroactively terminated. For retroactive termination, UHA shall return all premiums paid for the time period after the termination date and the Member Group and/or ineligible Enrollee(s) shall return any benefit payments made by UHA for the same time period.

③ **Group Administrator Signature:** ____ **Date:** ____

NOTE: Verifiable digital signatures with date stamp and name of signor accepted as well as certain electronic signatures.

Prepared By: (Print Name) ____ Contact Number: ____

EMP_ENR-0187-102220

Member Termination Instructions

① **GROUP INFORMATION:**
Enter the group name and the eight-digit group/division number.
Provide the name of the person preparing this form and contact phone number.
If multiple pages are being submitted, indicate the page number(s).

② **TERMINATION INFORMATION:**
One subscriber per row.
For each row, provide a subscriber member ID and full name.
Select the member that will be terminated from the plan.

- Selecting the subscriber will terminate the plan for the whole family.
- If terminating spouse, civil union partner, or dependent, make the appropriate selection and provide the member's full name.

Provide the month and year of the termination. Termination will fall on the last day of the month selected.

③ **GROUP ADMINISTRATOR SIGNATURE:**
Form must be signed and dated by an authorized group administrator. Capitalized words in this section are defined in the Agreement for Group Health Plan, which is the contract between UHA and the Member Group.

To ensure proper processing, all required fields must be completed and proper documentation submitted. Mail, fax or email completed forms with necessary documentation to:

UHA Employer Services
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100

Toll-free fax: (877)222-3198

Email: ES@uhahealth.com

You can also conveniently submit changes for employee information through **UHA's Online Enrollment Services**. Termination of employees and dependents takes approximately one business day. Please note that retroactive terminations **cannot** be added through the Online Enrollment Services System.

To sign up, complete the **Online Employer Access Authorization and Certification Form** (uhahealth.com/uploads/forms/form_online_agreemt.pdf) or contact us for more information.

If you have any further questions contact Employer Services.
Phone: (808) 532-4007; Toll-free phone: (800) 458-4600 Ext. 299; ES@uhahealth.com

Group Terminations Notice Provision

An employer group may cancel its contract with UHA upon 60 days prior written notice to UHA. Please refer to your group contract for your notice provision. **No retroactive terminations will be accepted**.

Group Contract Terminated for Non-payment of Premiums

A group will be terminated for non-payment of premiums. UHA will notify the Group in writing of its delinquency and if delinquency continues, UHA will terminate the Group. When a Group terminates, coverage for all of its employees and COBRA-covered employees is terminated.

A group canceled for non-payment of premiums may be reinstated based upon approval and upon payment of all outstanding premiums and any applicable fees.

Termination due to Fraud

UHA retains the right to rescind or terminate a Group's contract if coverage for the Group or any Enrollee(s) was obtained through fraud, intentional misrepresentation of a material fact by the Group, intentional omission of any material fact or Group's failure to promptly notify UHA that an Enrollee or Group is no longer eligible or in compliance with the Underwriting Rules. The Enrollee and/or Group will be given a thirty (30) days notice prior to prospective or retrospective termination of coverage.

Eligibility Audits

UHA reserves the right to conduct audits of Member Groups for compliance with the terms of the Agreement for Group Health Plan, including but not limited to membership eligibility, enrollment and group participation requirements. Member Group shall promptly provide to UHA within ten (10) business days, any records requested by UHA to determine compliance with this Agreement.

Member Group shall prepare and maintain accurate and complete records demonstrating eligibility of all Enrollees in accordance with UHA's Underwriting Rules. Such records shall be retained and produced upon request to UHA at any time during the term of this Agreement and for three (3) years following termination of this Agreement. Such records shall include but not be limited to Member Group's (a) General Excise Tax License and Department of Labor number, (b) payroll records reflecting each Eligible Employee's date of hire, pay and hours worked, (c) records reflecting the FICA tax deductions for each Eligible Employee, (d) records reflecting the health plan enrollment status of all employees, including any signed waiver forms in compliance with HRS § 393-21, (e) records demonstrating each Enrolled Employee's coverage under Unemployment Insurance, Workers Compensation Insurance, and Temporary Disability Insurance, and (f) if any exemption from the above requirements is claimed as to any Eligible Employee, then records demonstrating a valid legal and factual basis for statutory exemption from any of the above requirements.

UHA Provider Network

Using Participating Providers

The payment made by this plan and the **Co-payment** amount that the member must pay depend on the category of provider from whom services are received. A **Provider** may be "**Participating**" with UHA or "**Non-Participating**."

Participating means that a **Physician, Hospital**, or other licensed health care provider has signed a contract with UHA to provide benefits under this plan. The contract requires that the provider collect only:
(a) the **Eligible Charge** paid by UHA for the **Covered Services** delivered
(b) the applicable co-payment
(c) billed charges for non-covered services
(d) the applicable state excise tax, based on the eligible charge

Participating providers also agree to participate in and abide by UHA's credentialing, quality improvement and utilization management programs.

There are many participating providers throughout Hawaii. Please refer to the UHA Participating Physicians and Health Care Provider Directory for a listing. If a Directory was not received at the time of the enrollment, please call Customer Services and one will be sent without charge. This listing may have changed since the date of printing, therefore, it is always a good idea to check with the provider to make sure he or she is still participating with this plan. A Directory is also available on UHA's website at uhahealth.com.

It is also important to understand that a specific physician or other provider may be a participating provider at one office location, but be Non-Participating at another location. Additionally, a hospital may be a participating hospital, but some of the physicians or other individual licensed providers who practice at that hospital may not be participating providers with UHA. It is always a good idea to verify that each provider is participating with UHA before you receive services, in order to help minimize health care costs.

Using Non-Participating Providers

A **Non-Participating Provider** is any health care provider who does not have a contract with us to participate with the selected UHA plan, including out-of-state providers.

Visits to a provider that is not participating with UHA are permissible. UHA will pay the eligible charge for covered services less the co-payment or **Coinsurance**, and the payment will be made directly to the subscriber of the plan. The total charge will then be paid to the provider (which includes any difference between UHA's payment and the total **Actual Charge**) plus the applicable taxes for each service. UHA has no contract with non-participating providers to guarantee the amount of charges assessed. UHA does not recognize assignment of benefits to nonparticipating providers. At our sole discretion, however, we will make payments directly to nonparticipating hospitals for **Inpatient** services.

Please note: Participating providers may refer services to a non-participating provider and that may incur a higher out-of-pocket expense. For example, a participating provider may refer to a Non-Participating specialist for additional care. Requesting a referral

to a participating provider may help minimize health care costs.

Out of State Policy

The service area for UHA is the State of Hawaii.

We have a special arrangement with a mainland contractor to help members control their health care expenses in the event of a travel emergency. A travel emergency is a medical emergency that occurs while traveling outside of the Service Area. For example, a member suffers a broken limb while vacationing in Las Vegas.

For more information on the Out-of-State Policy, please refer to your MBG.
For more information on participating and non-participating providers, please refer to your MBG.

Using your Member Identification Card

Members should make sure to show a UHA Identification Card when they receive services from any provider.

SAMPLE UHA IDENTIFICATION CARD
(ID card sample is for illustration only and may look different)

UHA automatically prepares UHA Identification Cards for all employees covered under your health plan once enrollment forms are received and processed. A UHA Identification Card will be mailed to the employee within five (5) business days of receipt of a completed enrollment form. Each covered dependent will receive a card listing the employee's name and the dependent's name(s).

The UHA Identification Card lists:

1. Your company's group number
2. The name of the covered person
3. The identification number of the covered person
4. Benefit coverage

Providers often contact UHA to verify eligibility and benefits; therefore it is important that the insured person present their current UHA Identification Card to their provider (doctor, hospital, pharmacy, etc.) of services. Please remember that the UHA Identification Card is for informational purposes only and does not guarantee coverage. Coverage is determined based on eligibility and plan benefits.

Employers and/or employees are responsible to repay UHA for services paid by UHA as a result of a retroactive termination.

- **For replacement of lost UHA Identification Cards:**

  1. Contact the UHA Customer Services Department:

     On Oahu ..... **(808) 532-4000**

     Neighbor Islands.....**1-800-458-4600**

  2. Members may download the Request for UHA Identification Card form from our website and submit it to UHA Employer Services as instructed on the document. Members may print a temporary Member ID Card from the Online Member Portal. Members can register for access to the Online Member Portal at portal.uhahealth.com/Member/Account/registeruser

Dental Identification Card

Separate Dental Identification Cards are generated by **Hawaii Dental Service (HDS)** for employees that obtain dental coverage through their employers.
Please note that dental coverage is a separate rider and is not included in the MBG.

Paying Claims

In order for UHA to pay for a covered service, all of the following payment determination criteria must be met:

- The service must be listed as a covered benefit and not be excluded as a benefit by the member's UHA plan
- The service must be medically necessary for the diagnosis or treatment of the member's illness or injury
- the service must be provided in an appropriate setting and at an appropriate level of care
- When required under the member's UHA plan, the service must be prior authorized

The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not in itself mean that the service or supply meets these payment criteria, even if the service or supply is listed as a covered service in the member's UHA plan.

For more information on filing and paying medical claims, please refer to the MBG.

Filing Drug & Vision Claims

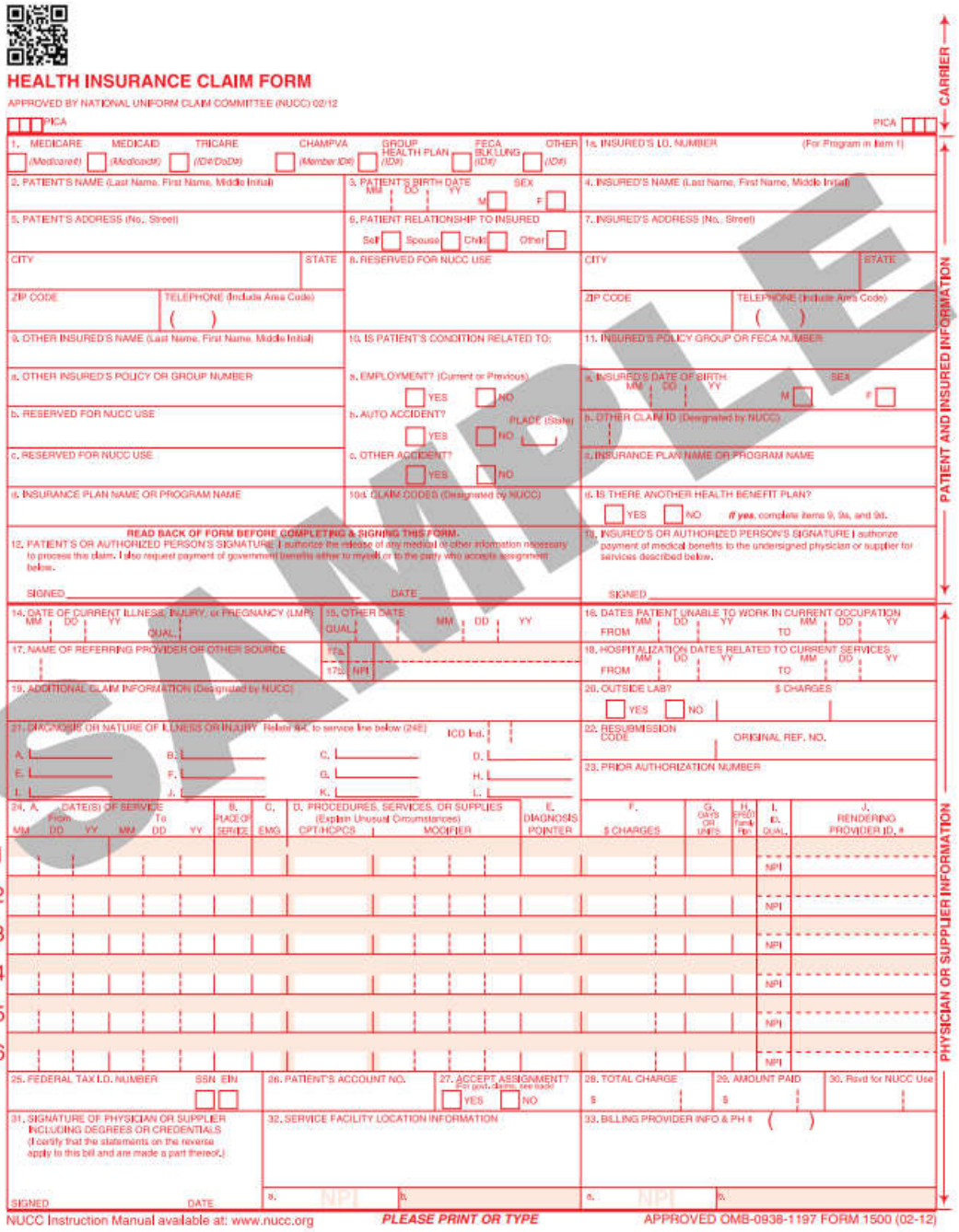
How to File a Drug Claim

1. Present UHA prescription identification card to the provider of services.
2. Participating providers will electronically file claims on behalf of the member, and payment is made to provider.
3. When drugs are purchased from a Non-Participating Provider, or if you paid out of pocket for your drugs, you can submit your receipts for reimbursement via fax to Express Scripts at 877-329-3760. There is a direct member reimbursement form (DMR) located on the Express Scripts website that you may send with your receipts that will ensure timely reimbursement. You should note that the reimbursement is likely to be less than if you used a participating pharmacy.
4. Claims must be filed within ninety (90) days from the date the drug is purchased.

How to File a Vision Claim

1. Present UHA member identification card to the provider of services.
2. Ask the provider of service to file a claim (CMS-1500) on behalf of the member.
3. Participating providers will file claims on behalf of the member, and payment is made to provider.
4. When services are received from a Non-Participating Provider, members should send UHA a copy of the itemized receipt / invoice along with a copy of your UHA medical card.
5. Claims must be filed within one (1) year after the date of service.
6. Please allow 15 – 20 days for processing.

SAMPLE CLAIM FORM



Third Party Liability (TPL)

Third party liability situations occur when a member is injured or become ill and:

- the injury or illness is caused or alleged to have been caused by someone else and the member has or may have the right to recover damages or receive payment in connection with the illness or injury, or
- the member has or may have the right to recover damages or receive payment from someone else for the member's injury or illness, without regard to fault.

When third party liability situations occur, UHA's Plan will provide benefits only as set forth in the Rules described in the MBG. **For more information on TPL, please refer to the MBG.**

Important Health Care Laws

Prepaid Health Care (PHC) Act

Originally enacted in 1974, the Hawaii PHC Act was the first in the nation to set minimum standards of health care benefits for workers. Employers, excluding Federal, State and City government and other categories specifically excluded by the law (sections **393-3(8)**, **393-5** and **393-6**) are required to provide Hawaii employees who suffer a disability due to non-work related illness or injury with adequate medical coverage for non-work related illness or injury, protecting them from the high cost of medical and hospital care.

Employers must provide health care coverage to employees who work at least twenty (20) hours per week for four (4) consecutive weeks. Coverage commences after four (4) consecutive weeks of employment or the earliest time thereafter at which coverage can be provided by the health care plan contractor, which is usually the first of the month. For more information on the Hawaii PHC Act, visit the State of Hawaii Department of Labor & Industrial website at hawaii.gov/labor.

HIPAA

The Health Insurance Portability and Accountability Act (HIPAA) provide rights and protections for participants and beneficiaries in group health plans. HIPAA includes protections for coverage under group health plans that limit exclusions for preexisting conditions; prohibits discrimination against employees and dependents based on their health status; and allows a special opportunity to enroll in a new plan to individuals in certain circumstances. HIPAA may also provide the right to purchase individual coverage if group health plan coverage is not available and COBRA or other continuation coverage has been exhausted. For more information on HIPAA, visit the U.S. Department of Labor website at dol.gov.

COBRA

The Consolidated Omnibus Budget Reconciliation Act (COBRA) gives workers and their families who lose their health benefits the right to choose to continue group health benefits provided by their group health plan for limited periods of time under certain circumstances such as voluntary or involuntary job loss, reduction in the hours worked, transition between jobs, death, divorce, and other life events. Qualified individuals may be required to pay the entire premium for coverage up to 102 percent of the cost to the plan.

COBRA generally requires that group health plans sponsored by employers with 20 or more employees in the prior year offer employees and their families the opportunity for a temporary extension of health coverage (called continuation coverage) in certain instances where coverage under the plan would otherwise end.

COBRA outlines how employees and family members may elect continuation coverage. It also requires employers and plans to provide notice. See Section IV regarding COBRA Services Provided by UHA. For more information on the COBRA law, visit the U.S. Department of Labor website at dol.gov.

Employee Retirement Income Security Act of 1974 (ERISA)

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans.

ERISA requires plans to provide participants with plan information including important information about plan features and funding; provides fiduciary responsibilities for those who manage and control plan assets; requires plans to establish a grievance and appeals process for participants to get benefits from their plans; and gives participants the right to sue for benefits and breaches of fiduciary duty.

For more information on ERISA, visit the U.S. Department of Labor website at dol.gov.

Uniformed Services Employment and Reemployment Rights Act

The Uniformed Services Employment and Reemployment Rights Act were signed into law on October 13, 1994. This law requires employers to offer up to 24 months of continuation coverage to employees who take military leave, and their dependents. The law is very similar to COBRA, with two important differences. First, it applies to all employers - COBRA generally exempts employers that have fewer than 20 employees. Second, if the military leave is longer than 31 days, employers can charge up to 102 percent of the premium. If the leave is shorter than 31 days, employers can only charge up to the active employee share of the premium.

UHA does not provide administrative services related to USERRA. UHA will include the employee on the billing statement but the employer is responsible for billing the employee for the premiums. You should consult with your attorney or legal advisor if you have any questions about the applicability of this act to you as an employer.

Patient Protection and Affordable Care Act (PPACA)

The Patient Protection and Affordable Care Act (PPACA), also known as the Affordable Care Act (ACA) is a United States federal statute that was signed into law on March 23, 2010. The changes implemented by the ACA are focused on reducing the uninsured population and decreasing healthcare costs.

Qualified Medical Child Support Order (QMCSO)

Any claim for benefits with respect to a child covered by a Qualified Medical Child Support Order ("QMCSO") may be made by the child or by the child's custodial parent or court-appointed guardian. Any benefits otherwise payable to the member with respect to any such claim shall be payable to the child's custodial parent or court-appointed guardian.

For more information about how UHA handles QMCSO's, please contact Employer Services at 532-4007 or 1-800-458-4600 ext. 299 when calling from the Neighbor Islands.

Medicare Part D Notice – Notification of Creditable Coverage

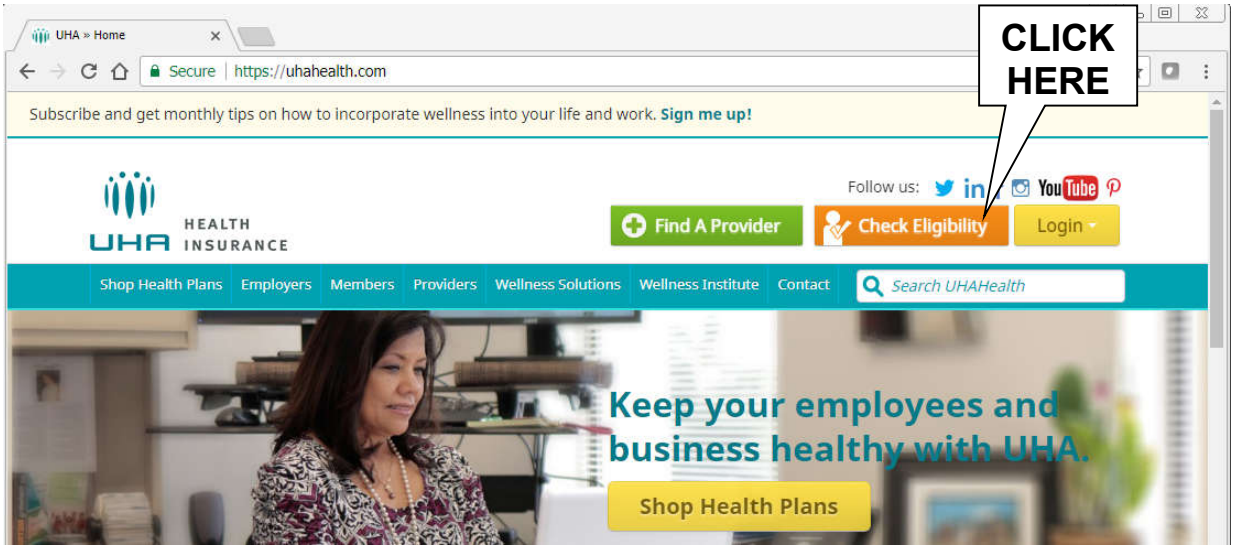
If your company offers a group-sponsored drug plan to Medicare-eligible individuals, you are required under the Medicare Modernization Act (MMA) to provide a Creditable Coverage notice to all of your Medicare-eligible beneficiaries.

Most entities (Employer Groups) that currently provide prescription drug coverage to Medicare Part D eligible individuals must disclose to the Centers for Medicare & Medicaid Services (CMS) whether the coverage is "creditable prescription drug coverage" (Disclosure Notice). A disclosure is required whether the entities' coverage is primary or secondary to Medicare. Entities that must comply with these provisions are listed at the CMS website.

For more information, please visit uhahealth.com/page/medicare-part-d.

Online Eligibility Verification

For your convenience, you may check the status of an employee's eligibility on our website at uhahealth.com.



COBRA Services

On April 7, 1986, Congress enacted the Consolidated Omnibus Budget Reconciliation Act (COBRA). This law requires employers with 20 or more employees that sponsor group health plans to offer employees and their families the opportunity for temporary extension of health coverage at group rates in certain instances where coverage under the health plan would otherwise end.

COBRA Services Provided by UHA

Employer groups eligible to receive UHA COBRA services are required to have a minimum of 20 employees. Interested groups should call the UHA Employer Services Department - COBRA Section for more information.

Every group health plan that provides COBRA should have a Group Administrator who may be the employer, an individual employed by the company, or an independent administrator. **While UHA is prepared to assist employers with their efforts to comply with COBRA, the final responsibility to meet the requirements of this law lies with the employer**. UHA does not serve as a Group Administrator, regardless of your election for UHA to perform collection and/or notification services. Employers should consult with their own legal counsel regarding questions about COBRA.

To assist Group Administrators, UHA offers the following COBRA services:

1. Collection of COBRA premiums
   Payments may be submitted through:
   - Mail
   - Direct Deposit
   - Credit Card
   - Automatic Deduction**

   **Written termination must be received by the 25th of the month to timely stop any deductions for the following month.
2. Notification to COBRA subscribers regarding

   - Ineligibility because of dual coverage
   - Rate and/or benefits change
   - Termination due to expiration of coverage period , non-payment, or premium delinquency

3. Monthly listing of Active COBRA members

   As a courtesy, UHA sends a payment reminder to all COBRA members monthly.

   UHA charges COBRA subscribers a 2% administration fee as allowed under COBRA regulations.

   If you elect to have UHA provide COBRA services, you must provide the following documents to qualified COBRA members:

   - COBRA Continuation Coverage Election Forms

General COBRA Information

A qualifying event is defined as an event that results in a loss of coverage which entitles qualified beneficiaries to COBRA benefits. The following are qualifying events and the corresponding maximum length of COBRA coverage:

1. Termination for reasons other than "gross misconduct": 18 months
2. Retirement: 18 months
3. Reduction in hours: 18 months
4. Left Employment: 18 months
5. Leave of absence: 18 months
6. Disability under the Social Security Act: 29 months
7. Divorce/legal separation: 36 months
8. Death of employee (dependents may continue coverage): 36 months
9. Loss of dependent child status under the health plan rules: 36 months
10. Subscriber/dependent becomes eligible for Medicare: 36 months

COBRA coverage does not extend to domestic partners nor to reciprocal beneficiaries who are not related by blood. COBRA does apply to Civil Unions.

Guidelines for COBRA Coverage

Please follow these guidelines for COBRA coverage:

- Timely submission of the completed COBRA Continuation Coverage Election Form with premium payment is essential. Current COBRA regulations require coverage to be elected within 60 days from the date of the qualifying event. Payment of the first premium must be made within 45 days from the election date. Employer at their option may pay COBRA premiums, but most employers choose to have the qualified beneficiary pay monthly premiums. UHA will not provide COBRA coverage if payment is not received within 45 days from the election date.

- Premiums may not exceed 102% of the applicable premium amount. Premiums may be increased to 150% only for the 19th through the 29th month of COBRA coverage if coverage is extended to 29 months because of an individual's disability at the time of termination. A Notice of Award letter from the Social Security Administration will be required prior to the 18th month of coverage to continue extended COBRA eligibility due to disability.

- COBRA coverage will terminate for the following reasons:
  - Coverage as an employee or as a dependent under any group health plan that does not contain any exclusions or limitations for any pre-existing conditions which you, your spouse or dependents may have;
  - Payment is not made on time;
  - The COBRA member meets the maximum length of coverage for their qualifying COBRA event;
  - The group terminates their group plan;
  - Coverage under Medicare (if Medicare becomes effective following COBRA coverage effective date).

If your company would like a COBRA eligibility listing from UHA, please contact the UHA Employer Services Department Enrollment Section.

UHA HEALTH INSURANCE
700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4007
800.458.4600 ext. 299
F 877.222.3198
uhahealth.com

Print Form

COBRA CONTINUATION COVERAGE ELECTION FORM

SECTION 1 – Notification (To be completed by the Designated Employer Representative)

1. Date of Notice: _____
2. UHA Benefits Termination Date: _____
3. Name: _____
4. Employee Name (if different): _____
5. Social Security Number: _____
6. **IMPORTANT: Employers MUST have 20 or more employees to offer COBRA when an employee's group coverage ends. This form must be completed and returned with the enrollee's first month's premium payment (if electing COBRA coverage) to the Designated Employer Representative at: _____ no later than _____. If mailed, it must be post-marked no later than this date. Member will NOT be enrolled until payment is received by UHA.**
7. Qualifying COBRA Event: (CHECK ONE BOX BELOW):

EVENT	MAXIMUM LENGTH OF COVERAGE
☐ End of Employment ☐ Retirement ☐ Reduction in hours of employment	Eighteen (18) Months
☐ Divorce/Legal Separation ☐ Death of Employee ☐ Loss of dependent child status ☐ Medicare Enrollment of Spouse/Parent	Thirty-Six (36) Months
☐ Certified Disabled by the Social Security Act (Notice of Award issued by SSA must be attached)	Twenty-Nine (29) Months

8. Date of Qualifying Event: _____ (Mo/Day/Year)
9. Date COBRA Coverage to Begin: _____ (Mo/Day/Year)
10. Current Monthly Rates: Single: $ _____ Two Party: $ _____ Family: $ _____
11. Group Name: _____
12. UHA Group / COBRA Division Number: _____
13. Designated Employer Representative: _____
14. Designated Phone #: _____

SECTION 2 – Election of COBRA Benefits (To be completed by the Covered Employee and/or Spouse and Dependents)
Check one below, sign and return.

☐ **I (We) elect to continue coverage in the UHA Health Plan as indicated below and will be responsible for paying the full cost of the coverage.**

15. List the individuals to be included in the UHA Health Plan continuation coverage:

A. RELATIONSHIP TO EMPLOYEE	B. GENDER (M or F)	C. LAST NAME	FIRST	MIDDLE INITIAL	D. SOCIAL SECURITY #	E. BIRTH DATE (Mo./Day/Yr.)	F. CERTIFIED DISABLED BY SSA (Y or N)
EMPLOYEE							
SPOUSE							
DEPENDENT CHILD							
DEPENDENT CHILD							
DEPENDENT CHILD							

Checks payable to UHA. See attached UHA COBRA Payment Procedures for instructions. Payment is due the first of each month. If payment is not received, coverage will be cancelled. **The monthly COBRA rates are subject to change based on contracted changes with the employer's group plan.**

I hereby certify that above information is accurate and complete. I have read, understand and agree to all the provisions listed under "Election to accept COBRA" on the reverse side of this COBRA Enrollment Form. (SIGN AND RETURN AS STATED IN #6 ABOVE WITH YOUR FIRST MONTH'S PAYMENT).

X _____ Signature of COBRA Enrollee (or Guardian) | _____ Date | _____ Phone (Home) | _____ Phone (Work/Other)

_____ Print Name and Relationship to individual(s) listed above | _____ Mailing Address

☐ **I do not wish to continue my coverage under the UHA Health Plan, for myself and/or my dependents, if any. (SIGN & RETURN AS STATED IN #6 ABOVE)**

X _____ Signature | _____ Print Name and Relationship to individual(s) listed above | _____ Date

EMP_ENR-0213-092520

HOW TO COMPLETE THIS FORM

SECTION 1 – Notification (To be completed by the Designated Employer Representative)
Note: The designated employer representative must inform the Enrollee of their COBRA election rights

1. **Date of Notice:** Date the Qualified Beneficiary is notified of his/her COBRA rights.
2. **UHA Benefits Termination Date:** The Date that the covered employee and/or spouse and dependents will no longer be eligible for coverage under the group's plan for active subscribers (Normally the end of the month following the qualifying event).
3. **Name:** Name of the Qualified Beneficiary who is eligible for COBRA coverage.
4. **Employee Name:** If different from #3, the name of the employee.
5. **Social Security Number:** The 9-digit number under which COBRA benefits are to be paid (For example, the SSN of a child who is currently enrolling under COBRA, who may have been previously covered under a parent's SSN).
6. **Return and completion instructions:** Return address for the Designated Employer Representative and date the COBRA Enrollee must return the UHA COBRA Continuation Coverage Election Form and first month's premium payment (if electing COBRA coverage) to the Designated Employer Representative. The return date should be 60 days from the date of the Qualifying event or 60 days from the Date of Notice, whichever is later.
7. **Qualifying COBRA Event:** Check one. *For covered employees, spouses or dependent children:* Termination of employment for reasons other than "gross misconduct,' Retirement from employment, Reduction in hours of employment or Certified disabled by Social Security Act (SSA). *For spouses or dependent children:* Divorce/Legal Separation of a spouse from a covered employee, Death of a covered employee, Loss of dependent child status or Covered employee's coverage under Medicare.
8. **Date of Qualifying Event:** The Date that the qualifying event occurred.
9. **Date COBRA Coverage to Begin:** The Date that the covered employee and/or spouse and dependents will be eligible to receive COBRA benefits (COBRA regulations do not allow a break in coverage. Coverage must and shall begin immediately following the termination from the group's plan for active subscribers).
10. **Current monthly COBRA Rates:** Current monthly COBRA rates provided by UHA, which represents 102% of the applicable premium. For individuals determined to be disabled (See #7 above) the COBRA rate for the additional 11 months of continued COBRA coverage may be increased to 150% of the applicable premium.
11. **Group Name:** Name of the Group or company.
12. **UHA Group / COBRA Division Number:** UHA group number and applicable COBRA division number.
13. **Designated Employer Representative:** Name of the designated Employer Representative completing the UHA COBRA Continuation Coverage Election Form.
14. **Designated Phone Number:** Phone number of the designated Employer Representative completing the UHA COBRA Continuation Coverage Election Form.

SECTION 2 – Election of COBRA Benefits (To be completed by the Covered Employee and/or Spouse and Dependents)
Election to accept COBRA: Check the election box to accept continuation of coverage. This also indicates that the person checking the box accepts the following:

- Responsibility to pay for the full cost of the coverage
- Coverage will be terminated if payment is not received
- Coverage will be cancelled if payment is not received by the first of the month. Coverage will be reinstated retroactively to the beginning of the month once payment is received in full within the current month. (See COBRA Payment Procedures)
- COBRA rate changes based upon contracted changes in benefits and rates of the employer group plan

15. **Individuals to be enrolled:** Who will be enrolled in COBRA, including their A) Relationship to employee, B) Gender, C) Full Name, D) Social Security Number, E) Birth date, F) Social Security Disability

Signature of COBRA Enrollee: Signature of the person enrolling in COBRA or their legal guardian, including phone number and mailing address.
Election to decline COBRA: Check box if you or your dependents will not be enrolling in COBRA.
Signature: Signature of the person qualified for COBRA to decline coverage or their legal guardian.

COBRA ENROLLEE: Return your completed form along with your first month's premium payment (if you are choosing COBRA coverage) to the Designated Employer Representative at the address listed on #6 above. All payments after the initial payment should be sent directly to UHA (see payment procedure below).
DESIGNATED EMPLOYER REPRESENTATIVE: Please submit completed form and initial payment (if applicable) to the address listed on #3 below.

UHA COBRA PAYMENT PROCEDURES

MONTHLY PREMIUM PAYMENT

1. The COBRA Enrollee is responsible to pay for their COBRA coverage. **They will not have eligibility until payment for the current month is received in full. The COBRA monthly billing rates, which represents 102% of the group plan's premium, are subject to change upon the former employer group's contracted renewal.**
2. A COBRA monthly billing statement will be mailed to you after the initial payment is received. UHA's COBRA monthly billing statement is sent as a courtesy reminder of when payment is due. **Payment is due whether or not a billing statement is received.**
3. Payment stub with check made payable to UHA should be sent to: **UHA – COBRA**
   700 Bishop Street, Suite 300
   Honolulu, HI 96813
4. Payment can also be made by Electronic Funds Transfer (EFT) or Credit card. EFT forms are available on our website, uhahealth.com. Please contact UHA Enrollment Services at (808) 532-4000 ext. 299 for more information regarding credit card payments or any other questions. Notification to terminate your automatic deduction is required by the 25th of the month. Should UHA be notified after this date and payment is deducted, a refund will be processed which may take up to two weeks.
5. **Coverage will be cancelled until full payment for the month is received. UHA does not accept postdated checks or checks for an amount less than the premiums owed.**
6. Coverage will be terminated if an enrollee's check is returned and proper payment is not received by the end of the current month (see #5 above).
7. If coverage is cancelled and payment remains past due beyond the last day of the month due, coverage cannot be reinstated and the account will remain cancelled.

BENEFITS

- Benefits for the COBRA Enrollee will be the same as those offered in the group's plan for active subscribers. If the group's plan has any benefit and/or rate changes, COBRA Enrollees will be affected. The group's plan administrator or Designated Employer Representative should notify COBRA Enrollees of any changes.

CLAIMS

- Claims must be submitted using the COBRA Group/Division number and the COBRA enrollee's member ID number. In most cases, medical offices will prepare all claims on behalf of covered persons.

TERMINATION

- COBRA eligibility will terminate for the following reasons:
  - Coverage as an employee or as a dependent under any group health plan that does not contain any exclusions or limitations for any pre-existing conditions which you, your spouse or dependents may have;
  - Payment is not made on time;
  - The COBRA member meets the maximum length of coverage for their qualifying COBRA event;
  - The group terminates their group plan;
  - Coverage under Medicare (if Medicare becomes effective following COBRA coverage effective date).

Billing

How to Read the Premium Statement

Your monthly premium statement will reflect current and prior billing information, including any changes in your group's eligibility that you reported to UHA.

The monthly premium statement consists of two sections:

1. A billing summary page, which shows the prior month balance, payments received on or before the statement date, adjustments, current and retroactive charges, and amount due. Current and retroactive charges are shown in the detailed section of the premium statement. Returned check fees, reinstatement fees and legal fees are reflected on the "Other Fees" line.

2. A detailed premium statement, which includes an alphabetical listing of current eligible employees showing:

- Employee Identification Number
- Name
- Contract Type (**S**ingle, **T**wo-party, **F**amily)
- Rates for each benefit (Medical, Drug, Vision, Dental)
- Total current premiums and total retroactive adjustments

This page also provides a summary by plan type (UHA 3000 or UHA 600).

UHA
HEALTH INSURANCE

Premium Summary Billing Statement

Group Name: SAMPLE BILL
Mailing Address: 700 BISHOP ST #300
HONOLULU, HI 96813

Statement Date: 11/05/2020
Payment is due by: 12/01/2020
Billing Period: 12/01/2020 to 12/31/2020

Group Number: 012340001

Billing Summary:

Amounts outstanding from the prior month:	$8,060.50
Less: Payments received:	$8,060.50
Adjustments:	$0.00
Other Fees:	$0.00

Total Unpaid amount from prior periods:		$0.00
Total Current Month and Retroactive Charges:	(see detail statement)	$8,897.27
Total Amount Due:		$8,897.27

- **Important!** For changes in status, such as (1) new subscriber; (2) addition of dependents; (3) deletion of subscribers or dependents, please send Member Enrollment Form or Member Termination Form by mail: UHA Employer Services, 700 Bishop St. Suite 300, Honolulu, HI 96813, email: es@uhahealth.com or fax: (877) 222-3198. Enrollments and changes are effective on the first of the month after our receipt of notice. Enrollments and changes received after the 1st of the month may not be reflected in ths billing.
- You can also conveniently add or terminate employees and update employee and dependent information online through **UHA's Online Employer Services.** Changes take approximately one business day. To sign up, complete the **Online Employer Access Authorization and Certification Form** (uhahealth.com/uploads/forms/form_online_agreemt.pdf) or contact us for more information.
- Late payments may result in termination of your policy. Premiums are still due and payable for that period.
- For questions regarding payments, call Billing at (808) 532-4000, ext 353 from Oahu, or (800) 458-4600, ext. 353 from the neighbor islands.

For information and forms, see our web site **www.uhahealth.com**

Detach here and return bottom portion with your payment

Group Number: 012340001 Payment is due by: 12/01/2020

BILLING STATEMENT

To ensure proper credit to your account, please indicate Group Number on check.

Make check payable to:

UHA
P.O. Box 29590
Honolulu, HI 96820-1990

TOTAL AMOUNT DUE: $8,897.27

AMOUNT ENCLOSED:

EMP_PBC-0078-111120

2020120100025400012959000008897274

Detail Premium Statement for:

SAMPLE BILL - 3000
Group and Division #:12340001

Benefits: UHA 3000

UHA HEALTH INSURANCE

Premium Invoice

Invoice date: 11/04/2020

Current Billing Period: 12/01/2020 to 12/31/2020

MemberID	Name	Contract Type	Med	Drug	Vision	HDS Dental	A&F Fee	Total
UHA 3000 - 1234000103								
Current Charges								
123000001-01	ASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000002-01	BSINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000003-01	ATWOPARTY, SUBSCRIBER	T	728.22	128.91	10.80	64.77	0.00	932.70
123000004-01	DASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000005-01	EASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000006-01	FASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000007-01	GASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
123000008-01	HASINGLE, SUBSCRIBER	S	383.27	67.85	5.40	32.42	0.00	488.94
	Subtotal:		3411.11	603.86	48.60	291.71	0.00	4355.28
Retro Adjustments								
123000009-01	ISINGLE, SUBSCRIBER	S	(383.27)	(67.85)	(5.40)	(32.42)	0.00	(488.94)
123000010-01	BTWOPARTY SUBSCRIBER	T	1,542.79	277.42	21.28	129.54	0.00	1,971.03
	Subtotal:		1159.52	209.57	15.88	97.12	0.00	1482.09

UHA 3000 - 123400103 Totals:

7 Single	Medical	$4,570.63	HDS Dental	$388.83
1 Two Party	Drug	$813.43	A&F Fee	$0.00
0 Family	Vision	$64.48		
Summary of Contract Types	**Total Current Month and Retroactive Charges:**			**$5,837.37**

UHA 600 - 1234000106

Current Charges								
123000011-01	AFAMILY SUBSCRIBER	F	1,209.65	206.93	16.20	97.17	0.00	1,529.95
123000012-01	BFAMILY, SUBSCRIBER	F	1,209.65	206.93	16.20	97.17	0.00	1,529.95
	Subtotal:		2419.30	413.86	32.40	194.34	0.00	3059.90

UHA 600 - 1234000106 Totals:

0 Single	Medical	$2,419.30	HDS Dental	$194.34
0 Two Party	Drug	$413.86	A&F Fee	$0.00
2 Family	Vision	$32.40		
Summary of Contract Types	**Total Current Month and Retroactive Charges:**			**$3,059.90**

Current Billing Period Totals:

7 Single	Medical	$6,989.93	HDS Dental	$583.17
1 Two Party	Drug	$1,227.29	A&F Fee	$0.00
2 Family	Vision	$96.88		
Summary of Contract Types	**Total Current Month and Retroactive Charges:**			**$8,897.27**

PREMIUM BILL RECONCILIATION

Note: Use this section for corrections to the Current Billing Period ONLY

Detail Premium Statement for:

SAMPLE BILL - 600
Group and Division #:12340001

Benefits: UHA 600

UHA HEALTH INSURANCE

Premium Invoice

Invoice date: 11/04/2020

Current Billing Period: 12/01/2020 to 12/31/2020

MemberID	Name	Contract Type	Med	Drug	Vision	HDS Dental	A&F Fee	Total

Terminations:

Employee Name	Member ID #	Termination Date	Amount
			( )
			( )
		Total Subtractions:	( )

Additions: (Completed Enrollment Forms MUST be attached)

Employee Name	Effective Date	Amount
	Total Subtractions:	( )
	Payment Amount Submitted:	

Group Administrator Signature: _____ Date: _____

Important: Changes will not be processed without authorized signature and date

Submitting Payment

UHA is a prepaid health plan contractor and according to the terms of our contract, **payment is due on or before the first day of each month**. We request that you pay the "Total Amount Due." For any discrepancies or questions, contact our Employer Services department.

Timely payment of monthly premiums ensures that eligibility changes submitted with your payments are processed and reflected on subsequent bills. Late payments may result in denial of benefits.

1. Please make payments payable to "UHA" and enclose the bottom portion of the statement with your payment. To ensure proper credit, please include your group number on the check. Send payments to our lockbox address at:

   UHA
   P.O. Box 29590
   Honolulu, HI 96820-1990

2. For your convenience, you may have funds automatically deducted from your company's checking account to ensure timely payment of premiums. To enroll in the UHA Electronic Funds Transfer (EFT) program, complete the "Authorization Form for Electronic Funds Transfer" which can be found on our website.

3. UHA also offers an Online Bill Pay feature through the Employer Portal. To sign up for either the Employer Portal or Online Bill Pay, complete the "Online Agreement Authorization and Certification Form" which can also be found on our website.

UHA
HEALTH INSURANCE

700 Bishop Street, Suite 300
Honolulu, HI 96813-4100
T 808.532.4000
800.458.4600
F 877.222.3198
uhahealth.com

Print Form

Credit Card Authorization Form

Please note: Credit card payments are only accepted as initial payment for NEW or REINSTATING groups.

Group Name: _____ **Group #:** _____

Amount to be charged*: $ _____
*Payment over $5,000. is subject to approval and an additional credit card processing fee. Please contact your Account Executive or Client Services Liaison/Coordinator for more information.

☐ Master Card ☐ VISA ☐ Discover ☐ JCB

Name as it appears on credit card: _____

Credit Card Number **(LAST 4 DIGITS ONLY)**: ___ ___ ___ ___ 3 Digit CVV Code: _____
(UHA will call cardholder for the full credit card numbers)

Expiration Date: _____/_____ Cardholder Phone Number: ( ) _____ - _____

Credit Card Billing Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Email Address (for receipt to be sent to): _____

Please send completed form:

Via mail:
UHA - Billing Department
700 Bishop Street, Suite 300
Honolulu, HI 96813

Via Email: _____@uhahealth.com

If you have any questions, please contact a Billing Representative at 532-4000, extension 353 or toll free 800-458-4600, extension 353.

For UHA Use Only:
Name of Authorized Person (PRINT): _____

Date: _____/_____/_____
Notes of Contact:

EMP_PBC-0116-070820

UHA HEALTH INSURANCE
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100
T 808.532.4000
800.458.4600
F 877.222.3198
uhahealth.com

Credit Card Authorization Form For COBRA Members

Member Name: _____ **Member ID:** _____

_____ My initials confirm that I am the credit card holder and I authorize UHA Health Insurance to process monthly
(Initials) recurring charges as billed to my credit card information below:

☐ Master Card ☐ VISA ☐ Discover ☐ JCB

Name as it appears on credit card: _____

Credit Card Number **(LAST 4 DIGITS ONLY)**: ____ ____ ____ ____ 3 Digit CVV Code: _____
(UHA will call cardholder for the full credit card numbers)

Cardholder Phone Number: (__) _____ - _____ Expiration Date: _____ /_____

Credit Card Billing Address:

Street: _____

City: _____ State: _____ Zip Code: _____

Email Address (for receipt to be sent to): _____

I have read and agree to the following terms and conditions:

- On the first of each month, UHA will automatically charge my credit card account for the current monthly premium charges.
- Receipt of payment(s) will be emailed each month to the above email upon enrollment.
- UHA has the right to cancel my policy at any time with written notice including:
  - notice given by client to stop automatic charges
  - group policy terminates or
  - client coverage period has been met
- UHA has the right to refuse services upon receiving notice for any credit card problem listed below:
  - credit limit is exceeded
  - credit card is reported lost, stolen, or expired
  - credit card authorization is declined for any reason
- I may cancel this service at any time with at least 15-days advance notice to UHA by mail or email.

Signature: _____ Date: _____/_____ / 20____

Please mail or email completed form to Employer Services Billing Department:

UHA - Billing Department
700 Bishop Street, Suite 300
Honolulu, HI 96813

Via Email: <<Enter POC's email address>>@uhahealth.com

Questions? Speak with an Enrollment Services Representative at: 808-532-4000, extension 299 or Toll free 1-800-458-4600, extension 299 from the neighbor islands.

EMP_ENR-0253-060920

Print Form

UHA HEALTH INSURANCE
700 Bishop Street, Suite 300
Honolulu, HI 96813.4100
T 808.532.4007
800.458.4600
F 877.222.3198
uhahealth.com

Online Employer Access Authorization and Certification Form

Please list authorized Online User(s) after the Authorized Agent Signature

Group Number: _____ Group Name: _____

Phone No.: _____ Email address: _____

By signing below, I certify that:

- I am **currently** an authorized agent of the group named above.
- I permit the below-named Online User to execute on my behalf submission of Online Employer transactions to UHA.
- I agree to accept full responsibility for the accuracy of the information submitted to UHA.
- I also certify that I will maintain on file all subscriber signatures and eligibility related information for transactions processed through UHA's Online Employer Portal, including a signed copy of the UHA enrollment form completed by the subscriber.
- I also understand that the appointment of the below-named Online User shall remain in effect until UHA receives written cancellation from me or my below-named Online User.

Authorized Agent's Name (Print): _____ Title: _____

Authorized Agent Signature: _____ Date: _____

(Agent must already be a Group Administrator, Owner, or Company Officer)

NEW Online User(s): (Print name of the person(s) being provided Online Employer access below)

Name: _____ Title: _____

☐ Check if Third Party Administrator Email address: _____

Access to Entire Group: ☐ Yes ☐ No, only Division Number: _____

Indicate Access Level: ☐ Online Enrollment ☐ Online View Bill ☐ Online View Bill with Pay Bill*
(Please check all that apply)
*ONLY ONE USER MAY HAVE ONLINE VIEW BILL WITH PAY BILL. Contact UHA for a list of current users if necessary.

Name: _____ Title: _____

☐ Check if Third Party Administrator Email address: _____

Access to Entire Group: ☐ Yes ☐ No, only Division Number: _____

Indicate Access Level: ☐ Online Enrollment ☐ Online View Bill ☐ Online View Bill with Pay Bill*
(Please check all that apply)
*ONLY ONE USER MAY HAVE ONLINE VIEW BILL WITH PAY BILL. Contact UHA for a list of current users if necessary.

For questions, contact:
Employer Services
808-532-4007; or toll-free 1-800-458-4600, extension 299

Please submit completed form to:
UHA
Attn: Employer Services Department
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100
Fax: 1-877-222-3198
Email: ES@uhahealth.com

Please allow 1-3 business days for processing.

CLI-0045-100720

Appeal Process for Employers

Employer groups have the right to express concerns about actions taken by UHA that adversely affects them, and to file a formal appeal of decisions made by UHA that relate to member eligibility. UHA will attempt to resolve all concerns and appeals fairly and promptly.

If you are dissatisfied with a decision made by UHA relating to enrollment or termination of employees and/or their dependent(s), you may appeal the decision to:

Appeals Coordinator
UHA
700 Bishop Street, Suite 300
Honolulu, HI 96813

The appeal must be made in writing. The request should include pertinent member or employer group information, a description of the facts related to the appeal, and any supporting documentation for the request. We must receive your written appeal within 60 days of the date UHA informed you of the decision you wish to appeal. We will respond to your appeal within 60 days of our receipt of your appeal. If you contest our decision on any appeal, you must submit the case to binding arbitration. Please refer to the section below, or your group agreement, for additional information.

Employer / UHA Dispute Resolution

As cited in your Standard Agreement for Group Health Plan, any disputes between the parties to the agreement will be settled by binding arbitration under the Arbitration Rules of Dispute Prevention & Resolution, Inc. in Honolulu, Hawaii.. The decision of the arbitrator is binding on both parties. Further details are provided in your Standard Agreement for Group Health Plan.

Topa Financial Center
Bishop Street Tower
700 Bishop Street, Suite 300
Honolulu, HI 96813-4100
T 808.532.4000
1.800.458.4600