UHA
HEALTH INSURANCE

Premium Summary Billing Statement

SAMPLE A

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

Group Number: 099010001

Statement Date: 12/10/2014
Payment is due by: 01/01/2014
Billing Period: 01/01/2014 to 01/31/2014

Billing Summary:

Amounts outstanding from the prior month:	$1,800.00	
Less: Payments received:	$1,800.00	
Adjustments:	$0.00	
Other Fees:	$0.00	
Total Unpaid amount from prior periods:		$0.00
*Total Current Monthly ACA Fee		$31.50
Total Retro Monthly ACA Fee		$0.00
Total Current Month and Retroactive Charges	(see detail statement)	$1,800.00
Total Amount Due:		**$1,831.50**

+ **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 to UHA Employer Services, 700 Bishop St., Suite 300, Honolulu, HI, 96813, or fax it to (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 this billing.

+ 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.

* The Monthly ACA Fee includes a reinsurance fee of $5.25 per member per month to be paid to the Department of Health and Human Services (HHS) reinsurance program. Additional fees such as PCORI and/or Health Insurance Industry Tax are included in your medical premium.

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

Detach here and return bottom portion with your payment

Group Number: 099010001 Payment is due by: 01/01/2014

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: $1,831.50

AMOUNT ENCLOSED:

EMP_PBC-0070-101613

20141210009901000129590000183150 3

UHA

Premium Invoice

Detail Premium Statement for:

SAMPLE BILL - A
SAMPLE A - 600
Group and Division #: 9901000106
Benefits: Plan 600

SAMPLE A

Invoice Date: 12/10/2013
Current Billing Period: 01/01/2014 to 01/31/2014

MemberID	Name	Contract Type	Med	Drug	Vision	HDS Dental	Member Count	ACA Fee	Total
UHA 600 - 9901000106									
Current Charges:									
990100103	AFAMILY, SUBSCRIBER	F	$600.00	$150.00	$30.00	$120.00	3	$15.75	$915.75
990100101	ASINGLE, SUBSCRIBER	S	$200.00	$50.00	$10.00	$40.00	1	$5.25	$305.25
990100102	ATWOPARTY, SUBSCRIB	T	$400.00	$100.00	$20.00	$80.00	2	$10.50	$610.50
	Subtotal:		$1,200.00	$300.00	$60.00	$240.00	6	$31.50	$1,831.50

UHA 600 Totals:	Summary of Contracts for Plan:	1	Single	Medical	$1,200.00	HDS Dental	$240.00
		1	Two Party	Drug	$300.00	ACA Fee	$31.50
		1	Family	Vision	$60.00		
						UHA 600 Total:	**$1,831.50**

Current Billing Period Totals:	Summary of Contracts for Plan(s):	1	Single	Medical	$1,200.00	HDS Dental	$240.00
		1	Two Party	Drug	$300.00	ACA Fee	$31.50
		1	Family	Vision	$60.00		
						Total Current Month and Retroactive Charges:	**$1,831.50**

PREMIUM BILL RECONCILIATION

Note: Use this section for corrections to the Current Billing Period ONLY
For questions regarding eligibility changes, terminations, or additions, call Enrollment at (808) 532-4007 from Oahu, or (800) 458-4600, ext. 299 from the neighbor islands.

Terminations:

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

Additions: (Completed Enrollment Forms MUST be attached)

Employee Name	Social Security #	Effective Date	Amount
			.
			.
		Total Additions:	.
		Payment Amount Submitted:	.

Group Administrator Signature: _____ Date _____

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

UHA
HEALTH INSURANCE

Premium Summary Billing Statement

SAMPLE B

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

Group Number: 099020002

Statement Date: 12/10/2014
Payment is due by: 01/01/2014
Billing Period: 01/01/2014 to 01/31/2014

Billing Summary:

Amounts outstanding from the prior month:	$2,400.00	
Less: Payments received:	$1,800.00	
Adjustments:	$0.00	
Other Fees:	$0.00	
Total Unpaid amount from prior periods:		$600.00
*Total Current Monthly ACA Fee		$31.50
Total Retro Monthly ACA Fee		($10.50)
Total Current Month and Retroactive Charges	(see detail statement)	$1,200.00
Total Amount Due:		**$1,821.00**

+ **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 to UHA Employer Services, 700 Bishop St., Suite 300, Honolulu, HI, 96813, or fax it to (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 this billing.

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* The Monthly ACA Fee includes a reinsurance fee of $5.25 per member per month to be paid to the Department of Health and Human Services (HHS) reinsurance program. Additional fees such as PCORI and/or Health Insurance Industry Tax are included in your medical premium.

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

- Detach here and return bottom portion with your payment -

Group Number: 099020002 Payment is due by: 01/01/2014

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: $1,821.00

AMOUNT ENCLOSED: **Auto Pay**

EMP_PBC-0070-101613

201412100099020002295900001821004

UHA

Premium Invoice

Detail Premium Statement for:

SAMPLE BILL - B
SAMPLE B - 3000
Group and Division #: 9902000203
Benefits: UHA 3000

SAMPLE B

Invoice Date: 12/10/2013
Current Billing Period: 01/01/2014 to 01/31/2014

MemberID	Name	Contract Type	Med	Drug	Vision	HDS Dental	Member Count	ACA Fee	Total
UHA 3000 - 9902000203									
Current Charges:									
990200203	BFAMILY, SUBSCRIBER	F	$600.00	$150.00	$30.00	$120.00	3	$15.75	$915.75
990200201	BSINGLE, SUBSCRIBER	S	$200.00	$50.00	$10.00	$40.00	1	$5.25	$305.25
990200202	BTWOPARTY, SUBSCRIB	T	$400.00	$100.00	$20.00	$80.00	2	$10.50	$610.50
	Subtotal:		$1,200.00	$300.00	$60.00	$240.00	6	$31.50	$1,831.50
Retro Adjustments:									
990200292	ZTWOPARTY, SUBSCRIB	T	($400.00)	($100.00)	($20.00)	($80.00)	-2	($10.50)	($610.50)
	Subtotal:		($400.00)	($100.00)	($20.00)	($80.00)	-2	($10.50)	($610.50)

UHA 3000 Totals:	Summary of Contracts for Plan:	1	Single	Medical	$800.00	HDS Dental	$160.00
		1	Two Party	Drug	$200.00	ACA Fee	$21.00
		1	Family	Vision	$40.00		
						UHA 3000 Total:	**$1,221.00**

Current Billing Period Totals:	Summary of Contracts for Plan(s):	1	Single	Medical	$800.00	HDS Dental	$160.00
		1	Two Party	Drug	$200.00	ACA Fee	$21.00
		1	Family	Vision	$40.00		
						Total Current Month and Retroactive Charges:	**$1,221.00**

PREMIUM BILL RECONCILIATION

Note: Use this section for corrections to the Current Billing Period ONLY
For questions regarding eligibility changes, terminations, or additions, call Enrollment at (808) 532-4007 from Oahu, or (800) 458-4600, ext. 299 from the neighbor islands.

Terminations:

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

Additions: (Completed Enrollment Forms MUST be attached)

Employee Name	Social Security #	Effective Date	Amount
			.
			.
		Total Additions:	.
		Payment Amount Submitted:	.

Group Administrator Signature: _____ Date _____

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

UHA
HEALTH INSURANCE

Premium Summary Billing Statement

SAMPLE C

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

Group Number: 099030003

Statement Date: 12/10/2014
Payment is due by: 01/01/2014
Billing Period: 01/01/2014 to 01/31/2014

Billing Summary:

Amounts outstanding from the prior month:	$2,700.00	
Less: Payments received:	$2,700.00	
Adjustments:	$0.00	
Other Fees:	$0.00	
Total Unpaid amount from prior periods:		$0.00
*Total Current Monthly ACA Fee		$31.50
Total Retro Monthly ACA Fee		($15.75)
Total Current Month and Retroactive Charges	(see detail statement)	$900.00
Total Amount Due:		**$915.75**

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* The Monthly ACA Fee includes a reinsurance fee of $5.25 per member per month to be paid to the Department of Health and Human Services (HHS) reinsurance program. Additional fees such as PCORI and/or Health Insurance Industry Tax are included in your medical premium.

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

- Detach here and return bottom portion with your payment -

Group Number: 099030003 Payment is due by: 01/01/2014

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: $915.75

AMOUNT ENCLOSED:

EMP_PBC-0070-101613

201412100099030003295900000915751

UHA

Premium Invoice

Detail Premium Statement for:

SAMPLE BILL - C
SAMPLE C - 3000
Group and Division #: 9903000303
Benefits: UHA 3000

SAMPLE C

Invoice Date: 12/10/2013
Current Billing Period: 01/01/2014 to 01/31/2014

MemberID	Name	Contract Type	Med	Drug	Vision	HDS Dental	Member Count	ACA Fee	Total
UHA 3000 - 9903000303									
Current Charges:									
990300303	CFAMILY, SUBSCRIBER	F	$600.00	$150.00	$30.00	$120.00	3	$15.75	$915.75
990300301	CSINGLE, SUBSCRIBER	S	$200.00	$50.00	$10.00	$40.00	1	$5.25	$305.25
990300302	CTWOPARTY, SUBSCRIB	T	$400.00	$100.00	$20.00	$80.00	2	$10.50	$610.50
	Subtotal:		$1,200.00	$300.00	$60.00	$240.00	6	$31.50	$1,831.50
Retro Adjustments:									
990300392	XFAMILY, SUBSCRIBER	F	($600.00)	($150.00)	($30.00)	($120.00)	-3	($15.75)	($915.75)
	Subtotal:		($600.00)	($150.00)	($30.00)	($120.00)	-3	($15.75)	($915.75)

UHA 3000 Totals:	Summary of Contracts for Plan:	1	Single	Medical	$600.00	HDS Dental	$120.00
		1	Two Party	Drug	$150.00	ACA Fee	$15.75
		1	Family	Vision	$30.00		
						UHA 3000 Total:	**$915.75**

Current Billing Period Totals:	Summary of Contracts for Plan(s):	1	Single	Medical	$600.00	HDS Dental	$120.00
		1	Two Party	Drug	$150.00	ACA Fee	$15.75
		1	Family	Vision	$30.00		
						Total Current Month and Retroactive Charges:	**$915.75**

PREMIUM BILL RECONCILIATION

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

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

Additions: (Completed Enrollment Forms MUST be attached)

Employee Name	Social Security #	Effective Date	Amount
			.
			.
		Total Additions:	.
		Payment Amount Submitted:	.

Group Administrator Signature: _____ Date _____

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

UHA
HEALTH INSURANCE

Premium Summary Billing Statement

SAMPLE D

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

Group Number: 099040004

Statement Date: 12/10/2014
Payment is due by: 01/01/2014
Billing Period: 01/01/2014 to 01/31/2014

Billing Summary:

Amounts outstanding from the prior month:	$2,000.00	
Less: Payments received:	$2,000.00	
Adjustments:	$0.00	
Other Fees:	$0.00	
Total Unpaid amount from prior periods:		$0.00
*Total Current Monthly ACA Fee		$126.00
Total Retro Monthly ACA Fee		$63.00
Total Current Month and Retroactive Charges	(see detail statement)	$6,000.00
Total Amount Due:		**$6,189.00**

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

Detach here and return bottom portion with your payment

Group Number: 099040004 Payment is due by: 01/01/2014

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: $6,189.00

AMOUNT ENCLOSED: **Auto Pay**

EMP_PBC-0070-101613

201412100099040004295900006189005

UHA

Premium Invoice

Detail Premium Statement for:

SAMPLE BILL - D
SAMPLE D - 3000
Group and Division #: 9904000403
Benefits: UHA 3000

SAMPLE D

Invoice Date: 12/10/2013
Current Billing Period: 01/01/2014 to 01/31/2014

MemberID	Name	Contract Type	Med	Drug	Vision	HDS Dental	Member Count	ACA Fee	Total
UHA 3000 - 9904000403									
Current Charges:									
990400412	FAMILY2, G SUB2000	F	$350.00	$120.00	$30.00	$0.00	3	$15.75	$515.75
990400409	NEWFAMILY2, K SUB2000	F	$350.00	$120.00	$30.00	$0.00	3	$15.75	$515.75
990400410	NEWSINGLE2, L SUB2000	S	$150.00	$40.00	$10.00	$0.00	1	$5.25	$205.25
990400411	NEWTWOP2, M SUB2000	T	$200.00	$80.00	$20.00	$0.00	2	$10.50	$310.50
990400407	SINGLE2, H SUB2000	S	$150.00	$40.00	$10.00	$0.00	1	$5.25	$205.25
990400408	TWOPARTY2, J SUB2000	T	$200.00	$80.00	$20.00	$0.00	2	$10.50	$310.50
	Subtotal:		$1,400.00	$480.00	$120.00	$0.00	12	$63.00	$2,063.00
Retro Adjustments:									
990400412	NEWFAMILY2, K SUB2000	F	$350.00	$120.00	$30.00	$0.00	3	$15.75	$515.75
990400410	NEWSINGLE2, L SUB2000	S	$150.00	$40.00	$10.00	$0.00	1	$5.25	$205.25
990400411	NEWTWOP2, M SUB2000	T	$200.00	$80.00	$20.00	$0.00	2	$10.50	$310.50
	Subtotal:		$700.00	$240.00	$60.00	$0.00	6	$31.50	$1,031.50

UHA 3000 Totals: Summary of Contracts for Plan:

2	Single	Medical	$2,100.00	HDS Dental	$0.00
2	Two Party	Drug	$720.00	ACA Fee	$94.50
2	Family	Vision	$180.00		

UHA 3000 Total: $3,094.50

MemberID	Name	Contract Type	Med	Drug	Vision	HDS Dental	Member Count	ACA Fee	Total
UHA 600 - 9904000406									
Current Charges:									
990400403	FAMILY6, A SUB600	F	$350.00	$120.00	$30.00	$0.00	3	$15.75	$515.75
990400406	NEWFAMILY6, D SUB600	F	$350.00	$120.00	$30.00	$0.00	3	$15.75	$515.75
990400404	NEWSINGLE6, E SUB600	S	$150.00	$40.00	$10.00	$0.00	1	$5.25	$205.25
990400405	NEWTWOP6, F SUB600	T	$200.00	$80.00	$20.00	$0.00	2	$10.50	$310.50
990400401	SINGLE6, B SUB600	S	$150.00	$40.00	$10.00	$0.00	1	$5.25	$205.25
990400402	TWOPARTY6, C SUB600	T	$200.00	$80.00	$20.00	$0.00	2	$10.50	$310.50
	Subtotal:		$1,400.00	$480.00	$120.00	$0.00	12	$63.00	$2,063.00
Retro Adjustments:									
990400406	NEWFAMILY6, D SUB600	F	$350.00	$120.00	$30.00	$0.00	3	$15.75	$515.75
990400404	NEWSINGLE6, E SUB600	S	$150.00	$40.00	$10.00	$0.00	1	$5.25	$205.25
990400405	NEWTWOP6, F SUB600	T	$200.00	$80.00	$20.00	$0.00	2	$10.50	$310.50
	Subtotal:		$700.00	$240.00	$60.00	$0.00	6	$31.50	$1,031.50

UHA

Premium Invoice

Detail Premium Statement for:

SAMPLE BILL - D
SAMPLE D - 600
Group and Division #: 9904000406
Benefits: Plan 600

SAMPLE D

Invoice Date: 12/10/2013
Current Billing Period: 01/01/2014 to 01/31/2014

MemberID	Name	Contract Type	Med	Drug	Vision	HDS Dental	Member Count	ACA Fee	Total
UHA 600 Totals:		Summary of Contracts for Plan:	2	Single	Medical	$2,100.00	HDS Dental		$0.00
			2	Two Party	Drug	$720.00	ACA Fee		$94.50
			2	Family	Vision	$180.00			
							UHA 600 Total:		**$3,094.50**
Current Billing Period Totals:		Summary of Contracts for Plan(s):	4	Single	Medical	$4,200.00	HDS Dental		$0.00
			4	Two Party	Drug	$1,440.00	ACA Fee		$189.00
			4	Family	Vision	$360.00			
							Total Current Month and Retroactive Charges:		**$6,189.00**

PREMIUM BILL RECONCILIATION

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Terminations:

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

Additions: (Completed Enrollment Forms MUST be attached)

Employee Name	Social Security #	Effective Date	Amount
			.
			.
		Total Additions:	.
		Payment Amount Submitted:	.

Group Administrator Signature: _____ Date _____

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