EXEMPTIONS FROM COVERAGE

Exempt Employees

The following categories of employees can claim an exemption from coverage:

1) those covered by a Federally established health insurance or prepaid health care plan, such as Medicare, Medicaid or medical care benefits provided for military dependents and military retirees and their dependents;
2) those covered as dependents under a qualified health care plan;
3) those who are recipients of public assistance or covered by a State Office Building, #2

Our phone number is: 808-974-6464

For more information, please visit our website at: http://hawaii.gov/labor/dcd

Auxiliary aids and services are available upon request. Please call the above listed telephone numbers, (808) 586-8847 (TTY), or 1-888-569-6859 (TTY neighbor islands). A request for a reasonable accommodation(s) should be made no later than ten working days prior to the needed accommodation(s).

It is the policy of the Department of Labor and Industrial Relations that no person shall on the basis of race, color, sex, marital status, religion, creed, ethnic origin, national origin, age, disability, ancestry, arrest/court record, sexual orientation, and National Guard participation be subjected to discrimination, excluded from participation in, or denied the benefits of the department's services, programs, activities, or employment.

STATE OF HAWAII
Department of Labor and Industrial Relations

残疾补偿委员会

为了解提供雇主和雇员对残疾补偿委员会一般理解的更多信息，请参阅该法律（第393章，HRS）。

残疾补偿委员会

原于1974年由联邦雇员退休收入保障法（ERISA），残疾补偿委员会于1981年10月重新生效，1983年1月1日。残疾补偿委员会要求夏威夷雇主为合格雇员提供健康保险，以确保雇员在高成本医疗和医院护理下因非工作相关的疾病或伤害而得到保护。

排除的就业

服务从健康保险中排除，但排除的类别包括：1) 工作不足20小时者；2) 联邦、州和县的雇员；3) 农业季节性工人；4) 保险或房地产销售人员支付给佣金；5) 个人工作与子女、女儿或遗孀；以及6) 儿童年龄21岁以下为父亲或母亲的工作者。（详细列表请参阅第393-5章。）

确保覆盖

雇主可能获得健康保险：1) 购买并提供健康保险服务的雇主或护理合同提供者；2) 购买并提供自我健康保险合同；3) 签署并提供集体谈判协议；4) 为健康保险提供者或护理机构提供支付。

资格

所有或部分保险，每人每月工资至少8667次，夏威夷州的雇主应向雇员提供健康保险。健康保险的目的是确保雇员在合同日期 EGIBILITY FOR ENROLLMENT

雇主工作20小时或更长时间，每月工资至少8667次，夏威夷州的雇主应向雇员提供健康保险。健康保险的目的是确保雇员在合同日期

EXEMPTIONS FROM COVERAGE

Exempt Employees

The following categories of employees can claim an exemption from coverage:

1) those covered by a Federally established health insurance or prepaid health care plan, such as Medicare, Medicaid or medical care benefits provided for military dependents and military retirees and their dependents;
2) those covered as dependents under a qualified health care plan;
3) those who are recipients of public assistance or covered by a State-legislated health care plan governing medical assistance; and
4) those who are followers of religious groups who depend upon prayer or other spiritual means for healing.

"Employer Notification to Employer" (Form HC-5)

To claim an exemption or individual waiver, an employee must complete and submit Form HC-5 to the employer. The employer retains the original and gives a copy to the employee. The employer sends a copy to the Department of Labor and Industrial Relations only when the employee selects exemption #3(b) or individual waiver #4 or upon request by the Director. The exemption/waiver notification is binding for one year and must be renewed every December 31.
CONCURRENT EMPLOYMENT

An employee who works concurrently for two or more employers is required to designate the principal and secondary employer and file notification (Form HC-5) with the employers for subsequent filing with the Department of Labor and Industrial Relations. The principal employer shall be the employer who pays the employee the most wages; only in cases where the employer who does not pay the most wages employs the employee for at least 35 hours per week does the employee determine which of the employers shall be the principal employer. The designated principal employer is required to provide coverage pursuant to the law.

An employee's determination of principal employer is binding for one year or until change of employment occurs. Whenever an employee elects to make a change with respect to the status of each, notification (Form HC-5) must be filed. (For complete details, refer to Section 393-6 of the law.)

The employer is prohibited from coercing, interfering, or influencing an employee in making a determination of principal employer.

PREMIUM PAYMENTS

The employer may elect to pay the entire premium amount or share the cost with the employee. The employer must pay at least one-half the premium cost; however, the employee's contribution cannot exceed 1.5% of the employee's monthly wages. In the event the employee's allowable share constitutes less than one-half of the premium, the employer is liable for the entire remaining portion. The employer is permitted to withhold the employee's contribution from the employee's wages.

An employee cannot agree to pay a greater share from wages, except for the purpose of paying for the added cost of providing prepaid health care benefits for the employee's dependents under the same plan.

CONTINUATION OF COVERAGE PROVISION

In the event an employee is disabled and unable to work, the employer is obligated to enable the employee to continue health care coverage by continuing the employee's share of the premium costs for three months following the month during which the employee became disabled, or for the period for which the employer has undertaken payment of employee's regular wages, whichever is longer. The employee must maintain the employee's portion of the premium payments.

HEALTH CARE CONTRACTOR

Type

A prepaid health care contractor may fall in one of three groups: 1) any medical group or organization which provides health care benefits under a prepaid health care plan; 2) any nonprofit organization which defrays or reimburses in whole or in part the expenses of health care under a prepaid health care plan; or 3) any insurer who defrays or reimburses in whole or in part the expenses of health care under a prepaid health care plan.

Selection

The employer selects the health care contractor and the plan type.

HEALTH CARE PLANS

Type

There are two types of health care plans: 1) a plan by which a prepaid health care contractor would furnish health care, and 2) a plan by which the health care contractor would defray or reimburse, in whole or in part, the expenses of health care.

Benefits

To meet standards as prescribed by law, prepaid health care plans must include at least the following benefits: 1) hospital (including inpatient care for at least 120 days of confinement in each calendar year), 2) surgical, 3) medical, 4) diagnostic, and 5) maternity. (For further details, refer to Section 393-7 of the law.)

Plan Approval

All health care plans must be approved as meeting prescribed minimum standards by the State Department of Labor and Industrial Relations. Such determination is made by the director under the advisement of a seven-member prepaid health care advisory council consisting of representatives from the medical and public health professions, from consumer interest, and from people experienced in prepaid health care protection.

PENALTIES

An employer who fails to comply with the coverage provisions of the law shall be subject to a penalty of not less than $25, or $1 for each employee for every day during which such failure continues, whichever sum is greater. If such default extends for 30 days, the employer's business may be closed for as long as the default continues.

An employer, employee, or health care contractor, who willfully fails to comply with any other provision or any rule or regulation, may be fined not more than $200 for each violation.

Furthermore, any person who, after twenty-one days written notice and the opportunity to be heard by the director, is found to have violated any provision of Chapter 393 or rule adopted thereunder for which no penalty is otherwise provided, shall be fined not more than $250 for each offense.

APPEAL

When health care benefits are denied a worker, the employer or the prepaid health care contractor must promptly mail a notice of denial to the worker who then has twenty days in which to request a review by the Department of Labor and Industrial Relations. If the parties are not satisfied by the department's findings, the case will be referred to the Prepaid Health Care Appeals Referee. The decision of the referee shall be final and binding, unless the aggrieved party appeals the decision.

SPECIAL FUND

The Prepaid Health Care Premium Supplementation Fund is established by general fund appropriation and used to defray the cost of providing health care benefits to employers with less than eight workers entitled to and covered under the Prepaid Health Care Act. To qualify for premium supplementation, the employer must meet the criteria outlined in Section 393-45 of the law. The Fund may also reimburse health care expenses to workers of bankrupt employers and non-complaint employers. Benefits paid from the Fund shall be recovered from those defaulting employers.

ADMINISTERING AGENCY

The Disability Compensation Division of the Department of Labor and Industrial Relations administers the Hawaii Prepaid Health Care Law. For further information, please contact the offices listed on the back of this brochure.