Health Insurance Information Sheet

Section A.

Medicare

Contact:

http://www.medicare.gov/

Section B.

Medicaid

Contact:

http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/vermont.html

http://ovha.vermont.gov/

2015 Subsidy Estimator: http://info.healthconnect.vermont.gov/subsidy_estimator

Section C.

TLC BCBS

Contact: TLC office (802) 735-1123

TLC Contribution per month:

Please choose a BCBS plan by going to:
1) www.tlcnursing.com
2) Employee Resources
3)Employee Benefits
4) Click on BSBC logo for plan information

PCA/Caregivers: $150
LNA's: $125
LPN's/RN's: $85

**Once you have chosen a plan please call the office so we may add information to BCBS

Section D.

Vermont Health Connect (exchange)

Contact: VT Health Connect 1(855) 899-9600

http://info.healthconnect.vermont.gov/Get_Started

2015 Subsidy Estimator: http://info.healthconnect.vermont.gov/subsidy_estimator

Health Insurance Eligibility Worksheet

******PLEASE READ******

Once you have completed the Health Insurance Worksheet, please fill out the new Health Declaration form reflecting your answer from the Worksheet

	NO		YES	
A. I am 65 years old or over.	☐	Continue	☐	STOP! ***You qualify for MEDICARE Please see Section A. on info sheet**

B. You are eligible for subsidized healthcare according to:

NO ☐ YES ☐ STOP! ***You qualify for MEDICAID Please see Section B. on info sheet**

		Number of people in your household					
		1	**2**	**3**	**4**	**5**	**6**
	You may qualify for **lower premiums AND lower out-of-pocket costs for Marketplace insurance** if your yearly income is between...	$11,670-$29,175	$15,730-$39,325	$19,790-$49,475	$23,850-$59,625	$27,910-$69,775	$31,970-$79-925
	If your state **is** expanding Medicaid: You may qualify for **Medicaid coverage** if your yearly income is below...	$16,105	$21,707	$27,310	$32,913	$38,516	$44,119

C. Have you worked at least 30 hours/week within the last 90 days?

NO ☐ YES ☐ STOP! ***You qualify for TLC BCBS plan. Please see Section C. on info sheet**

D. If you have answered 'NO' to all of the questions on the worksheet, please go to http://info.healthconnect.vermont.gov/Get_Started for more information on insurance plans through the exchange.

For more information regarding where to look: Please see Section D. on info sheet

THIS FORM MUST BE COMPLETED ANNUALLY BY ALL EMPLOYEES

Vermont Department of Labor

DECLARATION OF HEALTH CARE COVERAGE

Employer: This form is ONLY to be completed by employees if you offer to pay a portion of a health care plan that provides hospital and physicians services to at least some of your employees. You are required to maintain these documents together in a file in the event of an audit (for a minimum of three years).

Employer's Legal Name: TLC

Print Employee's Full Name: _____

Employee ID or Social Security Number: _____ DOB _____

EMPLOYEE TO COMPLETE: *The purpose of this form is to obtain information regarding your health care coverage. The information certified on this form will be used solely for the purposes of determining if your employer must pay Health Care Contributions, as required under 21 V.S.A., Section 2003. Return to employer when complete.*

I AM OFFERED AND AM ELIGIBLE FOR HEALTH CARE COVERAGE BY MY EMPLOYER:

☐ I have elected to accept the health care coverage offered and provided by my employer.

I AM OFFERED AND AM ELIGIBLE FOR HEALTH CARE COVERAGE BY MY EMPLOYER BUT HAVE ELECTED NOT TO ACCEPT THE COVERAGE OFFERED (√ *appropriate box*):

☐ I have Health Care Coverage that includes hospital and physicians services from another source other than Medicaid or Vermont Health Benefit Exchange (VHBE): (Specify Below) _____	☐ I have no health care. ☐ I have Medicaid. ☐ I am a full time employee and have health care as an individual through the Vermont Health Benefit Exchange.

I AM NOT ELIGIBLE FOR HEALTH CARE COVERAGE OFFERED BY MY EMPLOYER: (√ *appropriate box*):

☐ I am a part-time employee who works less than 30 hours per week **AND** I have coverage from a source other than Medicaid that offers hospital and physicians services. ☐ I am a seasonal employee who expects to work for this employer 20 or fewer weeks during this calendar year **AND** I have coverage from a source other than Medicaid that offers hospital and physicians services. ☐ I have Health Care Coverage that includes hospital and physicians services: (Specify) _____ Employer Note: these individuals will need to be included in your uncovered hours, if you do not offer your plan to **ALL** of your full-time employees.	☐ I am a part-time or seasonal employee and I do not have health care coverage OR I am covered by Medicaid. ☐ I have no health care.

NOTE to Employee: If at some point within the next year your health care coverage changes, you are required to complete another declaration.

☐ I certify the above information is accurate and true to the best of my knowledge and belief.

_____ _____

Employee Signature Date

Employer – Retain this document on file for THREE YEARS

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