Health Insurance Responsibility Disclosure Worksheet

Please complete and return to Schwartz Payroll Dept. by Nov. 25

Company Name:

Does the employer offer group health insurance? ____ **YES** _____ **NO**

- ✓ **If no, then no further information is needed.**
- ✓ **If Yes**, provide the following information about the employer's next upcoming Plan Year. If plan information for the upcoming Plan Year is not available, provide information for the current Plan Year.

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1. What is the minimum number of scheduled hours per week that the employer requires an employee to work to be considered eligible for health plan benefits? _____
2. What is the time period (in months) that a new employee must work before he or she is eligible for health plan benefits? _____ months
3. Does the employer determine employee eligibility for health plan benefits according to employment based categories for different groups of employees? ____ **YES** _____ **NO**
4. Does the employer offer different health plan benefits/rates for health plan benefits according to employment based categories for different groups of employees? ____ **YES** _____ **NO**
5. Part 1: Mark Yes next to the employment based categories that the employer utilize in the grid below.
6. Part 2: For each category that is marked Yes, describe how the employer defines the category and the eligibility requirements for health plan benefits.

Category	YES, we use	Defined as:	Eligibility for benefits:
Regular Full-time			
Regular Part-time			
Management			
Non-Management			
Temporary Full-time			
Temporary Part-time			

Category	YES, we use	Defined as:	Eligibility for benefits:
Exempt			
Non-Exempt			
Salaried			
Hourly			
Wage Based			
Intern			
Union			
Non-Union			
Other			

7. Does the employer employ any union members who receive Group Health Insurance through a union rather than through the employer? ____ **YES** _____ **NO**
8. If applicable, list the unions from which the employer's unionized employees receive group health insurance.

   _____ _____

   _____

9. Only if necessary, please add any additional information not otherwise captured in the above questions to explain the employer's group health insurance offerings and/or eligibility requirements.

   _____

   _____

10. What are the start and end dates for the Open Enrollment Period for your Health Insurance:
    a. Start Date _____
    b. End Date _____
11. What are the start and end dates for the Plan Year for your Health Insurance:
    a. Start Date _____
    b. End Date _____
12. Name of the health insurer and Name of the health plan _____
13. Plan group number _____
14. Do the benefits provided under the health insurance plan satisfy the minimum creditable coverage requirements of 956 CMR 5.03(1)(a)? ____ **YES** _____ **NO**
15. Does the employer offer its employees wellness credits that may reduce the employee contribution to the premium for this plan? ____ **YES** _____ **NO**

16. Enter the date on which the following costs and coverage information became or will become effective for this plan. _____

17. Which levels of coverage are offered by this plan?
    a. Individual ____ **YES** _____ **NO**
    b. Employee Plus One ____ **YES** _____ **NO**
    c. Employee Plus Children ____ **YES** _____ **NO**
    d. Family ____ **YES** _____ **NO**

18. For each Level of Coverage offered by this plan, complete the following information:

    a. Plan's Total monthly Cost
        i. Individual _____
        i. ii. Employee Plus One _____
        ii. iii. Employee Plus Children _____
        iii. iv. Family _____
    b. Employee's Monthly Contribution
        i. Individual _____
        i. ii. Employee Plus One _____
        ii. iii. Employee Plus Children _____
        iii. iv. Family _____
    c. Employer's Monthly Contribution
        i. Individual _____
        ii. Employee Plus One _____
        iii. Employee Plus Children _____
        iv. Family _____
    d. In-Network Annual Deductibles
        i. Individual _____
        i. ii. Employee Plus One _____
        ii. iii. Employee Plus Children _____
        iii. iv. Family _____
    e. Annual Out of Pocket Max Expenses
        i. Individual _____
        1. ii. Employee Plus One _____
        2. iii. Employee Plus Children _____
        3. iv. Family _____

Please complete and return to Schwartz & Schwartz Payroll Dept. by Nov. 25:

Email: **Payroll@schwartzaccountants.com**

Fax: **781.998.8137**

Mail: **8 Cedar Street Suite 54, Woburn, MA 01801**