Lost Your Health Insurance?
HERE ARE YOUR OPTIONS

UNITE HERE Local 274's Guide to Getting Health Insurance for Laid-off Hospitality & Food Service Workers

During this pandemic, some workers haven't lost coverage because of their union insurance but many workers rely on employer plans for insurance. Many lost coverage the very day they were laid off because bosses cared more about the bottom line than the health of their employees. **Losing health insurance because of a lay-off or hours reduction is a "qualifying life event"** which means you can get insurance outside of normal open enrollment periods.

You have 3 options to continue having health insurance.
In some cases, you must secure coverage within 60 days of losing insurance, so act fast!

Option 1 - COBRA Coverage

You may receive a letter from your employer giving you the option to enroll in COBRA coverage. Federal law requires that insurers allow you to continue your employer provided insurance for up to 18 months. The problem with COBRA is you are responsible for paying the entire premium; this means paying the share that usually comes out of your check *and* what your boss usually pays. For example, if you usually pay 15% of your healthcare premium and the premium is $500 dollars, this would be your COBRA cost:

COBRA EXAMPLE			
Hypothetical Premium	**Your share at 15% while working**	Employer share while working	**Cobra payment after layoff**
$500	**$75.00**	$425.00	**$500.00**

For most hourly workers, COBRA coverage is unaffordable. Our Union is demanding that COBRA be made affordable in the next federal stimulus package, but for most should explore other options.

Option 2 - Marketplace/Affordable Care Act/Obamacare Coverage

If you can't afford COBRA and don't qualify for Medicaid you have 60 DAYS from the date you lost insurance to get coverage from www.healthcare.gov. If you don't buy a new plan within 60 days of losing coverage you might not be able to get insurance until the Fall of 2020.

The federal healthcare exchanges, commonly known as Obamacare or ACA coverage provides subsidies to low income individuals to buy private insurance from health care companies.

To enroll in Obamacare, start here: **https://www.healthcare.gov/screener/**

How much you pay depends on the kind of plan you buy and the total subsidies you receive based on your income. It is complicated to buy plans on the exchanges. **Call the UNITE HERE Local 274 Helpline at 267-603-1274 if you need help picking a plan.**

Philly UNITEHERE! Local 274

Option 3 – Medicaid

Medicaid is excellent low-cost insurance provided by the state (sometimes referred to as "Health Partners"). You must be below Medicaid income limits to qualify for benefits:

Household Size	Maximum Household Income
1	$16,612
2	$22,491
3	$28,369
4	$34,248
5	$40,127
6	$46,005
7	$51,884
8	$57,762

Your maximum household income is based on an estimate of what you think you'll make this year (*not* what you made last year). It should include the following types of income:

- Federal taxable wages and tips
- Self-employment income
- Unemployment compensation NOT including the $600 weekly bump
- Social Security or SSDI
- Retirement or Pension income
- Alimony if divorced before Jan 1, 2019
- Any investment income including rental payments

For most hospitality and food service workers, ***if you are the sole earner in a household with 2 or more dependents and are laid off, you will likely qualify for Medicaid***. Sole earners with 1 dependent might qualify for Medicaid depending on their hourly rate and how much they worked in 2020.

If you meet the income limits, Medicaid is a good option for coverage while you are out of work. If you think you might apply, **call BENEPHILLY at 1-800-236-2194 to apply by phone** or apply online at:

https://www.compass.state.pa.us/compass.web/Public/CMPHome

Please call the UNITE HERE Local 274 Helpline with any questions about eligibility or for assistance in applying: 267-603-1274.

What happens when I go back to work?

When you go back to work, you need to enroll in the insurance your employer offers if it is available to you. This is true even if your new plan is better than the plan your boss offers.

Why is this all so complicated?

None of this is the ideal way to provide healthcare. We need to keep fighting for quality union insurance everywhere and advocate for real solutions to the American healthcare crisis, such as Medicare for All.

If you need help applying or determining eligibility for Medicaid, choosing a plan on the Marketplace (via the Affordable Care Act/Obamacare) or any other questions about your health insurance, please call and leave a message:

UNITE HERE Local 274 Helpline
267-603-1274

Health Care Terms to Help You Navigate www.healthcare.gov

Co-premium – the amount you pay each month for your insurance plan. You have to pay your co-premium each month regardless of whether you use your insurance.

Deductible - How much you have to pay for health services before your insurance company pays anything (except free preventive services). If your deductible is $3000, you must spend $3000 of your money before insurance kicks in (but some plans offer services with co-pays regardless of deductibles). The money you spend on your co-premium is *not* included in the deductible.

Out of pocket maximum –The most you could spend for covered services in a year, not including your co-premium. After you reach this amount, the insurance company pays 100% for covered services. If your out of pocket maximum is $5000.00 you still have to pay your co-premium each month, but after you spend $5000 on medical costs you won't pay anything for the rest of the year.

Co-Payment/Co-Pay – amount you pay for medical services (often regardless of if you've met your deductible). If you for example have a "$60 co-pay" to see you a specialist, each trip to a specialist will cost you $60

Co-Insurance – similar to co-pay but usually a percentage. If you have a "20% coinsurance" for a surgery that cost $10,000, you'll owe at least $2000 (maybe more if you haven't met your deductible).

HMO - A type of health insurance plan that usually limits coverage to care from doctors who work for a particular network. It generally won't cover out-of-network care except in an emergency. HMOs often provide integrated care and focus on prevention and wellness.

PPO/POS - A type of health plan where you pay less if you use providers in the plan's network. You can use doctors, hospitals, and providers outside of the network without a referral for an additional cost. POS plans require you to get a referral from your primary care doctor in order to see a specialist.

CDHDP/HDP – "High Deductible Plans" have higher deductibles which means insurance doesn't kick in until you've spent a lot of money but often provide a higher level of coverage once you do. The premium can be lower as well but if you have regular healthcare costs CDHDPs can cost more.

Bronze/Silver/Gold/Platinum – Metal levels that determine how much you pay versus the insurance company. They have nothing to do with quality of care and depending on your healthcare needs can be misleading ways to compare insurance.

Philly
UNITEHERE!
Local 274