

Do not return this form to the Vermont Department of Taxes. You must retain this form for your records for three years.

VT Form HC-1	HEALTH CARE CONTRIBUTIONS WORKSHEET
Employer FEIN	Quarter / Year

Uncovered Employee Count:

- Did you have 5 or more full-time equivalent (FTE) employees who were all age 18 and older in the previous quarter? ☐ Yes ☐ No
- If you answered **NO**, check this box ☐ to certify no Health Care Fund Contributions will be due for this quarter. Also, check the box on Form WHT-436, Line 6.
 - If you answered **YES**, complete Section 1 **or** 2 below (not both) depending on the health care coverage offered by your company.

Note: For Sections 1 and 2, do not report more than 520 hours for any individual employee, no matter how many actual hours the employee worked during the calendar quarter.

Section 1: Complete this if you **do not** offer to pay any part of the cost of health care coverage for **any** of your employees.

Enter the total number of hours worked by **all** employees you employed during the reporting quarter and continue to "Section 3: Calculations Section," Line A.

Section 1: Total hours of uncovered employees

Section 2: Complete this if you **do** offer to pay part or all of the cost of health care coverage for **any** of your employees.

Enter the total number of hours worked by all employees in each of the following two categories:

- Employees who are offered and eligible for coverage but choose **not** to accept the coverage and have no other health care coverage **or** have Medicaid **or** who are full-time employees and have health care coverage as individuals through the Vermont Health Benefit Exchange.
- Employees who are **not** eligible for the health care coverage offered to any other employees. You may exclude hours worked by a seasonal or part-time employee **as long as** you offer health care coverage to all regular, full-time employees, **and** the employee is covered by a plan other than Medicaid.

Section 2, Line 1: Hours worked by employees offered coverage but did not accept.

Section 2, Line 2: Hours worked by employees not offered coverage.

Section 3: Calculations Section

- A.** Enter the total hours worked by all employees entered in Section 1 **or** the total of Lines 1 and 2 in Section 2. **NOTE:** If the total is a partial hour, round down to the nearest hour. **A.** _____
- B.** Divide the number of hours on Line A by 520. This is your **unadjusted** FTE count. **NOTE:** Round down to the nearest whole number. **B.** _____
- C.** Number of exempted FTEs. **C.** 4
- D.** Subtract Line C from Line B. This is your **adjusted** and reportable FTE count. Enter this amount on Form WHT-436, Line 11. If equal to or less than zero, report -0-. **D.** _____
- E.** Multiply Line D by the appropriate amount shown in the table below. **This is your quarterly Health Care Contribution.** Enter this amount on Form WHT-436, Line 12, even if -0-. **E.** _____

HCC Premium per FTE Exemption (Line E)		
Quarter Ending Date	HCC Premium	Use this HCC Premium amount for the calculation on Line E above.
03/31/2023 - 12/31/2023	\$238.26	
03/31/2024 - 12/31/2024	\$268.24	
03/31/2025 - 12/31/2025	\$296.89	

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