


A Better Partnership*



**Warner
Norcross & Judd^{LLP}**
ATTORNEYS AT LAW

ACA Reporting


August 18, 2015
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Overview


- Overview of Reporting Requirements
 - ◆ Why have reporting
 - ◆ Status of forms
 - ◆ Penalties
- ACA Reporting Examples
 - ◆ On-going full time employees
 - ◆ Newly-hired employees
 - ◆ Other situations

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Overview of Reporting Requirements

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Why Are There Reporting Requirements?

- Employer pay or pay penalties
- Individual mandate
- Federal subsidies

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Reporting Requirements

- Reporting coverage under the plan (§ 6055).
 - ◆ Applies to all medical plans (regardless of size)
 - ◆ For insured plans: insurers will report (1095-B)
 - ◆ For multiemployer plans: plan will report (1095-B)
 - ◆ For employers with self-insured plans: employer will report (1095-C, part III).
- Reporting on full-time employees (§ 6056).
 - ◆ Applies to all "Applicable Large Employers."
 - ◆ Reports key information used for calculating penalties and determining affordability

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"Applicable Large Employer"

- Are you an "ALE" subject to the 6056 reporting requirement?
 - ◆ An employer that employed an average of at least 50 FTEs on business days during the preceding year.
 - ◆ Includes all "common law" employees

Employers who average 50 or more FTEs per month in 2014 subject to reporting requirement for 2015.

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Identifying Full-Time Employees

- “Full-time”
 - ◆ Average at least:
 - > 30 hours of service per week; or
 - > 130 hours of service per month
- Includes:
 - ◆ Hours while working; and
 - ◆ Other hours for which the employee is paid or entitled to pay

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Identifying Full-Time Employees

- Use same method as for employer responsibility compliance:
 - ◆ Monthly (after the fact); or
 - ◆ Use of look-back measurement periods
 - > Standard measurement periods for on-going employees (typically 12-months).
 - > Initial measurement periods for newly-hired part-time, seasonal and variable hour employees.

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Penalties for failure to offer coverage

- The “A” Penalty--Failure to offer coverage to at least 95%¹ of full-time workforce:
 - ◆ \$2,080 x number of full-time employees - 30*
- The “B” Penalty—Offer coverage, but some full-time employees qualify for subsidized coverage through exchange
 - ◆ \$3,000 x number of full-time employees who qualify for subsidized coverage

¹2015 transitional rule: 70%

*2015 transitional rule: subtract 80

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Reporting Forms

- 2014 forms & instructions (final)
 - ♦ <http://apps.irs.gov/app/picklist/list/formsPublications.html>
- 2015 forms & instructions (drafts)
 - ♦ 1094-C: <http://www.irs.gov/pub/irs-dft/f1094c--dft.pdf>
 - ♦ 1095-C: <http://www.irs.gov/pub/irs-dft/f1094c--dft.pdf>
 - ♦ instructions: <http://www.irs.gov/pub/irs-dft/i109495c--dft.pdf>
 - ♦ 1094-B: <http://www.irs.gov/pub/irs-dft/f1094b--dft.pdf>
 - ♦ 1095-B: <http://www.irs.gov/pub/irs-dft/f1095b--dft.pdf>
 - ♦ Instructions: <http://www.irs.gov/pub/irs-dft/i109495b--dft.pdf>

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2015 1095-C (page 1)

The image shows the top portion of the 2015 Form 1095-C, 'Employer-Provided Health Insurance Offer and Coverage'. It includes the title, form number (1095-C), and a table for reporting health insurance coverage for each month of the year. A large watermark is overlaid on the form.

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2015 1095-C (page 2)

The image shows the bottom portion of the 2015 Form 1095-C, including the 'Controlled Individuals' section and the bottom header area. A large watermark is overlaid on the form.

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2015 1094-C (page 1)

...1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns 120114

DRAFT AS OF June 16, 2015 DO NOT FILE

Part I Applicable Large Employer Master HCE Member

Part II ALE Member Information

17. Total number of Forms 1098-C submitted with this transmittal

18. Is this the individual responsible for this ALE Member? If "Yes," check the box and provide, if this form instructions require, the applicable information.

19. Total number of Forms 1098-C filed by and/or on behalf of ALE Member

20. Is ALE Member a member of an Aggregated ALE Group?

21. Certification of Eligibility (enter all that apply)

22. For Multiple ALE Members, see separate instructions.

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2015 1094-C (page 2)

120214

DRAFT AS OF June 16, 2015 DO NOT FILE

Part III ALE Member Information Matrix

	18 All Full-Time Employees	19 All Part-Time Employees	20 All Aggregated Group Members	21 Section 500(c)(29) Members
22 All 12 Months				
23 Jan				
24 Feb				
25 Mar				
26 Apr				
27 May				
28 Jun				
29 Jul				
30 Aug				
31 Sept				
32 Oct				
33 Nov				
34 Dec				

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2015 1094-C (page 3)

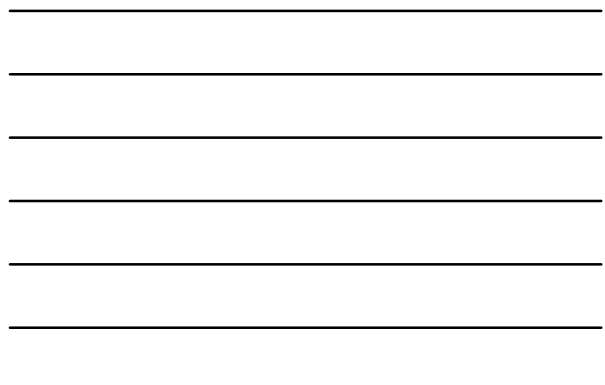
120315

DRAFT AS OF June 16, 2015 DO NOT FILE

Part IV Other ALE Members of Aggregated ALE Group

25	Name	EM	Name	EM
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
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50				

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When to Report?

- Reporting to Individuals (1095-B and 1095-C)
 - ♦ By January 31st following end of calendar year
- Transmittal Forms to IRS (1094-B or 1094-C)
 - ♦ By February 28th of year following calendar year (if paper)
 - ♦ Deadline extended until March 31 if filed electronically
 - > Must be filed electronically if required to file at least 250 forms
- Annual Filing Obligation

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Penalties for Noncompliance

- Failure to file with IRS or furnish statements to individuals
 - ♦ \$250 for each statement, annual cap of \$3,000,000
 - ♦ Intentional disregard of filing requirements: \$500 per statement, no annual cap.
- Transition Relief - 2016
 - ♦ Must file at least incorrect or incomplete information
 - ♦ No relief if no good faith effort or failure to timely file

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Reporting for On-Going Full-Time Employees

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On-Going Full-Time Employees

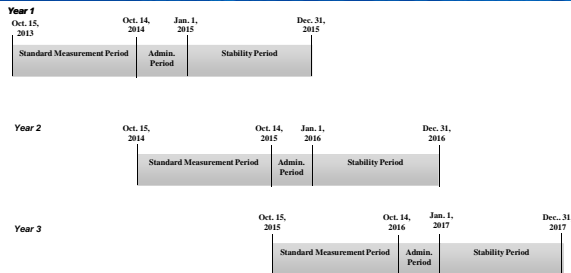
- Reporting Issues:
 - ♦ Month-to-month method:
 - > Employee counts as full-time any month that he or she works 130 or more hours
 - ♦ Look-back measurement method:
 - > Employee counts as full-time during stability period that follows standard measurement period.

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Ongoing Employee Measurement Periods



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Example 1-A

- Full-time employee who worked all year and was covered all year
 - ♦ Offer of coverage meets minimum value
 - ♦ Offer of coverage to spouse and dependents
 - ♦ Monthly cost of individual coverage: \$100
 - ♦ Employee elects to cover spouse
 - ♦ Plan year: January 1 – December 31

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Example 1-A

Example 1-A
1095-C **Employer-Provided Health Insurance Offer and Coverage** VOID CORRECTED **14**

Employer Information
 Employer Name: **ABC Mfg. Company**
 Employer EIN: **111-11-1111**
 Employer Address: **123 Main Street, Anytown, MD 21001**
 Employer Phone: **410-555-0100**

Employee Information
 Employee Name: **George Washington**
 Employee ID: **111-11-1111**
 Employee Address: **456 Elm Street, Anytown, MD 21001**
 Employee Phone: **410-555-0100**

Employee Offer and Coverage

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Offered	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Accepted	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Cost	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0

Covered Individuals

Individual	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
George Washington	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Martha Washington	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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Example 1-B

- Full-time employee who worked all year and was covered all year
 - ♦ Offer of coverage meets minimum value
 - ♦ Offer of coverage to spouse and dependents
 - ♦ Monthly cost of individual coverage: \$100
 - ♦ Employee elects to cover spouse
 - ♦ Plan year: **July 1 – June 30**
 - > **Increase in employee contribution on July 1**

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Example 1-B

Example 1-B
1095-C **Employer-Provided Health Insurance Offer and Coverage** VOID CORRECTED **14**

Employer Information
 Employer Name: **ABC Mfg. Company**
 Employer EIN: **111-11-1111**
 Employer Address: **123 Main Street, Anytown, MD 21001**
 Employer Phone: **410-555-0100**

Employee Information
 Employee Name: **George Washington**
 Employee ID: **111-11-1111**
 Employee Address: **456 Elm Street, Anytown, MD 21001**
 Employee Phone: **410-555-0100**

Employee Offer and Coverage

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Offered	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Accepted	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Cost	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0	\$100.0

Covered Individuals

Individual	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
George Washington	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Martha Washington	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

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Example 2-A

- Full-time employee who worked all year, was offered but declined coverage.
 - ♦ Offer of coverage meets minimum value
 - ♦ Offer of coverage to spouse and dependents
 - ♦ Employee works 40 hours per week.
 - ♦ Monthly cost of individual coverage: \$100
 - > Deductions taken twice a month: \$50 per check
 - ♦ Affordability safe harbor: rate of pay method
 - > Employee makes \$10 per hour
 - > $\$10 \times 130 \text{ hrs} = \$1,300$; $\$1,300 \times .095 = \113.75
 - ♦ Plan year: January 1 – December 31



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Example 2-A

The screenshot shows Form 1095-C with the following details:

- Form ID: 1095-C
- Employer Name: ABC COMPANY
- Employer EIN: 12-3456789
- Plan Name: ABC COMPANY
- Plan Year: 2015
- Table 1: Monthly Premiums for Individual

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Individual	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50



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Example 2-B

- Full-time employee who worked all year, was offered but declined coverage.
 - ♦ Offer of coverage meets minimum value
 - ♦ Offer of coverage to spouse and dependents
 - ♦ Employee works 40 hours per week.
 - ♦ Cost of individual coverage: \$50 per pay period
 - > 26 pay periods during calendar year.
 - > \$1,300 annual cost
 - ♦ Affordability safe harbor: W-2 method
 - > \$19,500 taxable income for year
 - > $\$19,500 \times .095 = \$1,852.50$
 - ♦ Plan year: January 1 – December 31




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Reporting for Newly-Hired Employees


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Newly Hired Employees

- Issues:
 - ◆ Month-to-month method:
 - > Employee counts as full-time any month that he or she works 130 or more hours
 - ◆ Look-back-measurement method:
 - > If expected to work full-time:
 - Until completes a standard measurement period, count as full-time during months he or she works 130 or more hours
 - > If part-time, variable hour or seasonal: initial measurement period of up to 12 months

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New Variable Hour Employee

New Employee Initial Determination

March 6, 2014 March 5, 2015 May 1, 2015 April 31, 2016

Initial measurement period	Admin. Period	Stability Period
----------------------------	---------------	------------------

On-going employee year 1

Nov. 1, 2014 Oct. 31, 2015 Jan. 1, 2016 Dec. 31, 2016


Standard measurement period	Admin. Period	Stability Period
-----------------------------	---------------	------------------

On-going employee year 2

Nov. 1, 2015 Oct. 31, 2016 Jan. 1, 2017 Dec. 31, 2017

Standard Measurement period	Admin. Period	Stability Period
-----------------------------	---------------	------------------

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Limited Non-Assessment Periods

- Applies to certain waiting periods.
 - ♦ First calendar month of hire (if not hired on first day of month)
 - ♦ First three full calendar months of employment
 - ♦ For part-time, variable hour and seasonal employees, during initial measurement period and administrative period but only if "otherwise eligible for coverage."

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Example 3-A

- Newly Hired Employee
 - ♦ Hired to work a **full-time** schedule.
 - ♦ Date of hire: April 15, 2015
 - ♦ Eligible for minimum value coverage for employee, spouse and dependents on July 1, 2015.
 - ♦ \$100/month for single coverage
 - ♦ Employee enrolls in single coverage.

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Example 3-A

Example 3-A
1095-C Employee-Provided Health Insurance Offer and Coverage
Form 1095-C (2014)
14

Employer Name: ABC Company
Employer ID Number: 123456789
Plan Name: ABC Company Health Plan
Plan Year: 2015
Plan Start Date: 01/01/2015
Plan End Date: 12/31/2015

Month	1	2	3	4	5	6	7	8	9	10	11	12
Employee	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Spouse												
Dependent 1												
Dependent 2												

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Example 3-B

- Newly Hired Employee
 - ♦ Hired to work a variable/part-time schedule.
 - > Employer uses look-back measurement method
 - > Uses initial measurement period starting on first day of month following or coinciding with date of hire.
 - ♦ Date of hire: March 15, 2015.
 - ♦ Eligible for minimum value coverage for employee, spouse and dependents on May 1, 2016 if averages at least 30 hours of service per week.

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Example 3-B

- No need to issue a 1095-C to this employee.
 - ♦ Is not classified as a FT employee during any month in 2015.
 - ♦ Is not enrolled in coverage during any month in 2015.

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Example 3-C

- Newly Hired Employee
 - ♦ Hired to work a variable/part-time schedule.
 - > Employer uses look-back measurement method
 - > Uses initial measurement period starting on first day of month following or coinciding with date of hire.
 - ♦ Date of hire: March 15, 2014.
 - ♦ Eligible for minimum value coverage for employee, spouse and dependents on May 1, 2015 if averages at least 30 hours of service per week.
 - > Employee averages over 30 hours of service per week and enrolls in single coverage.
 - ♦ \$100/month for single coverage

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Example 3-C

Example 3-C **1095-C** **Employer-Provided Health Insurance Offer and Coverage**

Employer: ABC Co. (123456789) | State: CA | L00518

Applicable Large Employer (ALE) | 14

Offer Date: 1/1/2015 | ALE Name: ABC Co. | ALE ID: 123456789
 EIN: 987654321 | ALE Address: 1234 Main St, City, CA 90001

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Minimum hours worked	0	0	0	0	0	0	0	0	0	0	0	0
Hours worked	35	35	35	20	20	20	20	20	20	20	20	20

Individual	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
John Doe	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>



Example 3-D

- Newly Hired Employee
 - Hired to work a part-time schedule.
 - Employer uses look-back measurement method
 - Uses initial measurement period starting on first day of month following or coinciding with date of hire.
 - Date of hire: March 15, 2015.
 - Works 25 hrs per week March, April, May.
 - Works 35 hrs per week June, July, August, Sept.
 - Works 20 hrs per week October, November, December
 - Employee classified as not eligible for coverage



Example 3-D

Example 3-D **1095-C** **Employer-Provided Health Insurance Offer and Coverage**

Employer: ABC Co. (123456789) | State: CA | L00518

Applicable Large Employer (ALE) | 14

Offer Date: 1/1/2015 | ALE Name: ABC Co. | ALE ID: 123456789
 EIN: 987654321 | ALE Address: 1234 Main St, City, CA 90001

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Minimum hours worked	0	0	0	0	0	0	0	0	0	0	0	0
Hours worked	0	0	25	25	25	35	35	35	35	20	20	20

Individual	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
John Doe	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>





Reporting for Other Situations



Example 4-A

- Full-time summer intern
 - ◆ Hired for the summer
 - > Hired on 5/15/15
 - > Terminated on 8/25/15
 - ◆ Works full-time schedule
 - ◆ Is not eligible to participate in health plan



Example 4-A

1095-C Employer-Provided Health Insurance Offer and Coverage

Employer: ABC Company, 123 45 6789, ABC City, Company, 123 45 6789

Applicable Large Employer (ALE) or Self-insured Small Business (SMB): ALE

Plan Year: 2015

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Offered	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Available	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Enrolled												

Individual: 123 45 6789, ABC City, State, 123 45 6789

Plan: ABC Health Plan, ABC City, State, 123 45 6789

Form 1095-C (2015)





Example 4-B

- Full-time summer intern
 - ♦ Hired for the summer
 - > Hired on 5/15/15
 - > Terminated on 8/25/15
 - ♦ Works full-time schedule
 - ♦ Would be eligible to participate in health plan on 9/1/15



Example 4-B

Example 4-B
1095-C Employer-Provided Health Insurance Offer and Coverage
 Form 1095-C
 14

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Employee	1	1	1	1	1	1	1	1	1	1	1	1
Family member	1	1	1	1	1	1	1	1	1	1	1	1

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Example 5

- Collectively-bargained employee covered under union plan.
 - ♦ Employee hired on 2/15/15, expected to work full-time.
 - ♦ CBA requires employer to contribute \$X per hour worked to a multi-employer plan.
 - > Plan provides affordable, minimum value coverage to eligible employees and their children.
 - > Eligibility based on number of hours for which contributions were made in 2014.
 - ♦ Multiemployer plan does not report to employer the specific months for which employee is eligible.





Example 5

Example 5
1095-C **Employer-Provided Health Insurance Offer and Coverage** VOID CORRECTED **14**
 Form 1095-C (2014) **14**

Part I **Employer Information**
 Employer Name: ABC Company
 Employer EIN: 12-3456789
 Employer Address: 123 Main Street, Anytown, NY 12345
 Employer Phone: (555) 123-4567

Part II **Employee Information**
 Employee Name: John Doe
 Employee ID: 12345
 Employee Address: 456 Elm Street, Anytown, NY 12345
 Employee Phone: (555) 987-6543

Part III **Employer Offer and Coverage**

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Offered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accepted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part IV **Covered Individuals**

Individual	Relationship	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
John Doe	Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jane Doe	Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Example 6-A

- Full-time employee terminates mid-year
 - ♦ Employer uses look-back measurement method to determine full-time status.
 - ♦ Date of termination: 8/15/15
 - ♦ Monthly cost of coverage: \$100
 - ♦ Eligible for minimum value coverage for employee, spouse and dependents through date of termination
 - > Would have been continued to be eligible if had not terminated employment.
 - ♦ \$100/month for single coverage
 - ♦ Employee had enrolled self and spouse in coverage.



Example 6-A

Example 6-A
1095-C **Employer-Provided Health Insurance Offer and Coverage** VOID CORRECTED **14**
 Form 1095-C (2014) **14**

Part I **Employer Information**
 Employer Name: ABC Company
 Employer EIN: 12-3456789
 Employer Address: 123 Main Street, Anytown, NY 12345
 Employer Phone: (555) 123-4567

Part II **Employee Information**
 Employee Name: John Doe
 Employee ID: 12345
 Employee Address: 456 Elm Street, Anytown, NY 12345
 Employee Phone: (555) 987-6543

Part III **Employer Offer and Coverage**

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Offered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Accepted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Part IV **Covered Individuals**

Individual	Relationship	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
John Doe	Self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jane Doe	Spouse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



Example 6-B

- Full-time employee terminates mid-year
 - ◆ Employer uses look-back measurement method to determine full-time status.
 - ◆ Date of termination: 8/15/15
 - ◆ Eligible for minimum value coverage for employee, spouse and dependents through date of termination
 - > Would have been continued to be eligible if had not terminated employment.
 - ◆ \$100/month for single coverage
 - ◆ Employee had enrolled self and spouse in coverage.
 - > Employee elects COBRA for self and spouse
 - > Cheapest single coverage COBRA cost is \$500

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Example 6-B

Example 6-B
1095-C Employer-Provided Health Insurance Offer and Coverage

Employer: General Ford, 370-20-3331
Employee: Brenda Ford, 370-20-3331

Month	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Employee	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Spouse	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dependent 1	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dependent 2	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dependent 3	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Dependent 4	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

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1094-C Examples

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Example 8—page 1

Example 8—Page 1

1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns **120315**
 Form 1094-C (2015) **14**

Part I Employer/Plan Administrator (All Members)
 01 Employer name (Do not check if you are a contractor)
 02 Employer EIN
 03 Plan name
 04 Plan type (e.g., self-insured or fully insured)
 05 Plan year (or other reporting period)
 06 Plan sponsor (Do not check if you are a contractor)
 07 Plan administrator (Do not check if you are a contractor)
 08 Plan website (Do not check if you are a contractor)
 09 Plan description (Do not check if you are a contractor)
 10 Plan type (e.g., self-insured or fully insured)
 11 Plan sponsor (Do not check if you are a contractor)
 12 Plan administrator (Do not check if you are a contractor)

Part II Member Information
 13 Member name (Last, first, and middle initials)
 14 Member ID
 15 Member birth date (MM/DD/YYYY)
 16 Member gender (M or F)
 17 Member Social Security number (Do not check if you are a contractor)
 18 Member address (Street, city, state, and ZIP+4)
 19 Member contact information (Phone and fax)
 20 Member email address (Do not check if you are a contractor)

Part III Member Information - Mobility
 21 Is this the address transmitted for this ALE Member? (If "Yes," check the box and continue. If "No," see instructions)
 22 Is this ALE Member a member of an Aggregated ALE Group?
 23 Certification of Eligibility (only if not applicable)
 24 Date of last update (MM/DD/YYYY)
 25 Signature (Print name)
 26 Title (Print title)
 27 Tax ID (Print tax ID)

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Example 8—page 2

Example 8—Page 2

1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns **120315**
 Form 1094-C (2015) **14**

Part III Member Information - Mobility

MO	IS Member Currently Covered by Employer?		84 Total Time Employee Count for All Members	85 Total Enrollment Count for All Members	86 Aggregated Group Indicator	88 Section 408(b) Transmittal Indicator
	Yes	No				
01	X				X	
02			140	176		
03			140	174		
04			140	176		
05			140	177		
06			140	176		
07			141	176		
08			141	176		
09			141	177		
10			141	177		
11			141	176		
12			142	176		
13			142	176		
14			142	176		

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Example 8—page 3

Example 8—Page 3

1094-C Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns **120315**
 Form 1094-C (2015) **14**

Part IV Other ALE Members of Aggregated ALE Group
 Other ALE Members and Other ALE Members of the Aggregated ALE Group (only if the member is not a member at any time during the calendar year)

Name	EIN	Name	EIN
01 ABC Company	15-1111111	01	
02 ABC Company	15-1111111	02	
03		03	
04		04	
05		05	
06		06	
07		07	
08		08	
09		09	
10		10	
11		11	
12		12	
13		13	
14		14	
15		15	
16		16	
17		17	
18		18	
19		19	
20		20	

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Questions & Answers

Thank you!

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