Understanding the ACA Reporting Requirements

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Warner Norcross + Judd

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

Overview of Reporting Requirements

Why Are There Reporting Requirements?

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

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

"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 2017 subject to reporting requirement for 2018

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

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

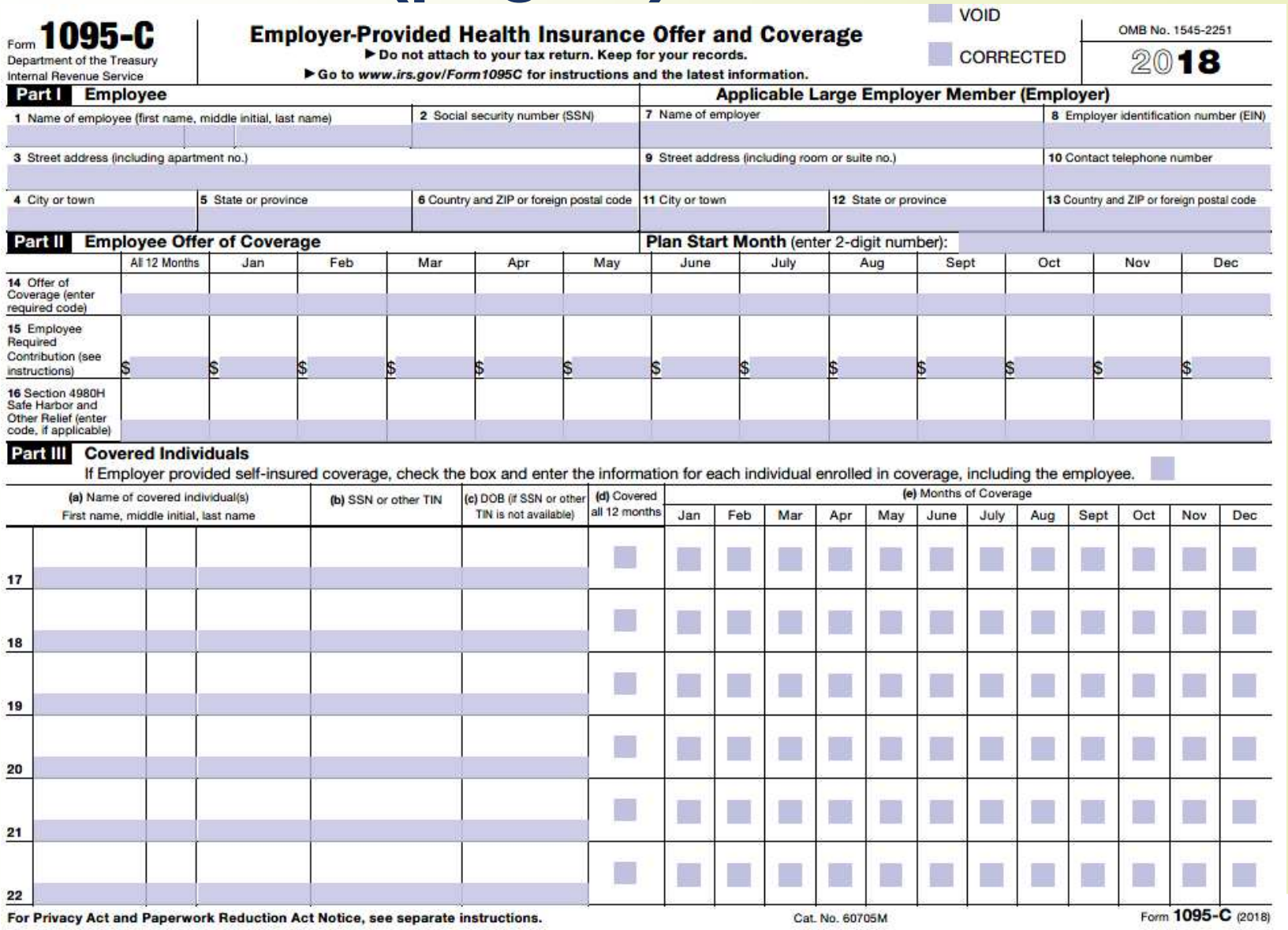
Penalties for Failure to Offer Coverage

- The “A” Penalty--Failure to offer coverage to at least 95% of full-time workforce:
  - $2,320 x (number of full-time employees - 30)
- The “B” Penalty--Offer coverage, but some full-time employees qualify for subsidized coverage through exchange
  - $3,480 x number of full-time employees who qualify for subsidized coverage

IRS Penalty Enforcement

- IRS started issuing enforcement letters for 2015 employer mandate compliance in late 2017
- 2016 enforcement letters coming soon
- Most penalties resulted from reporting errors
- IRS has been easy to work with to resolve penalty assessments

2018 1095-C (page 1)



Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

VOID
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OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)
2 Social security number (SSN)
3 Street address (including apartment no.)
4 City or town
5 State or province
6 Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer
8 Employer identification number (EIN)
9 Street address (including room or suite no.)
10 Contact telephone number
11 City or town
12 State or province
13 Country and ZIP or foreign postal code

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)													
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																
18																
19																
20																
21																
22																

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

2018 1095-C (page 2)

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, the issuer of the insurance or the sponsor of the plan providing the coverage will furnish you information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, the provider of that coverage will furnish you information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.

Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

Additional information. For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, the premium tax credit, and the employer shared responsibility provisions, see *www.irs.gov/Affordable-Care-Act/Individuals-and-Families* or call the IRS Healthcare Hotline for ACA questions (1-800-919-0452).

Part I. Employee

Lines 1–6. Part I, lines 1–6, reports information about you, the employee.

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

Lines 7–13. Part I, lines 7–13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14–16

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

1A. Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).

1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.

1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.

1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

1I. Reserved.

1J. Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).

1K. Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest-cost self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, see IRS.gov.

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, see the additional covered individuals on Part III, Continuation Sheet(s).

2018 1095-C (page 3)

Form 1095-C (2018) Page **3**

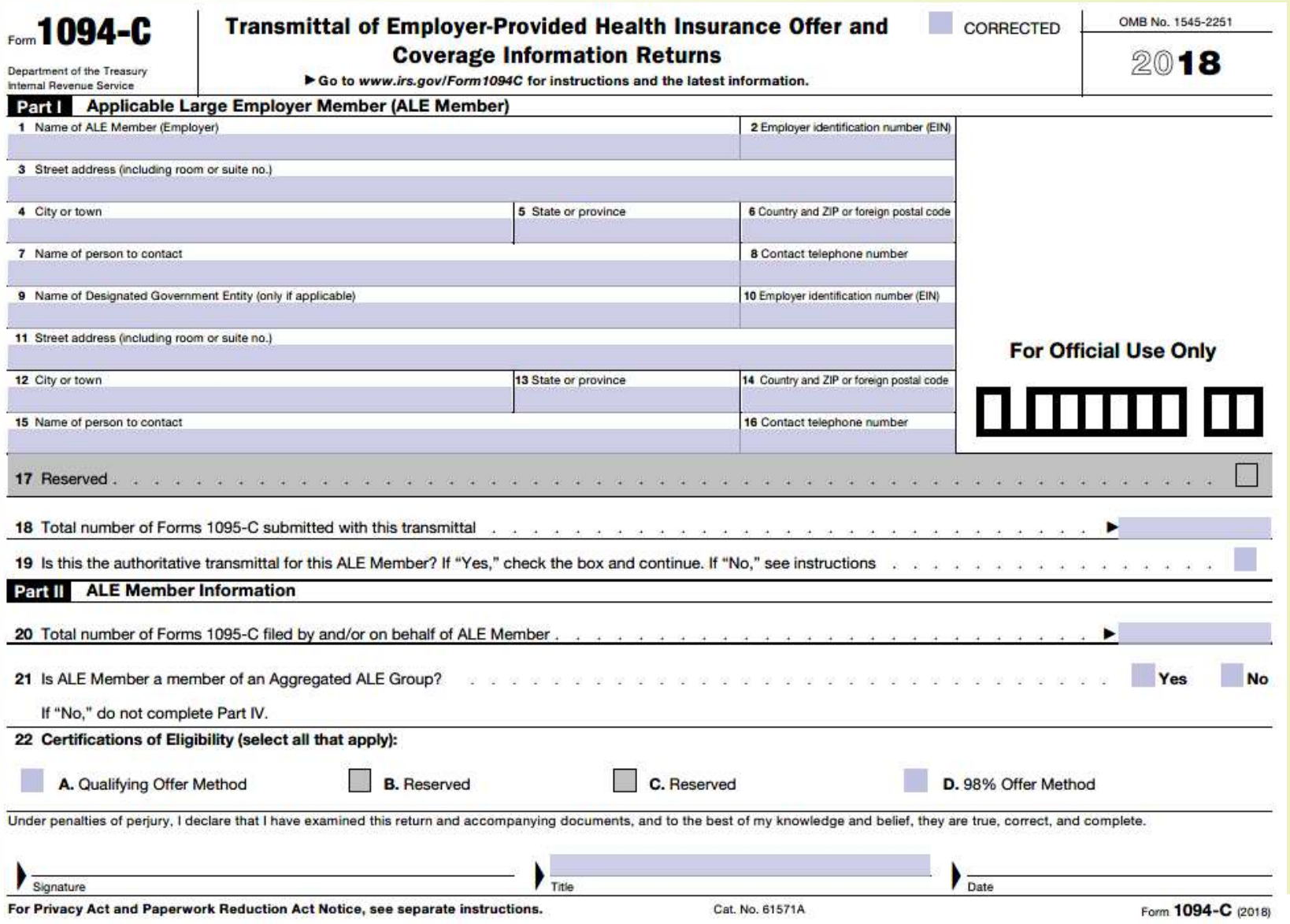
Name of employee (first name, middle initial, last name) | Social security number (SSN)

Part III **Covered Individuals** — Continuation Sheet

	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
29				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
31				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
32				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
33				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
34				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Form **1095-C** (2018)

2018 1094-C (page 1)



Form **1094-C**

Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

▶ Go to *www.irs.gov/Form1094C* for instructions and the latest information.

CORRECTED

OMB No. 1545-2251

2018

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)
2 Employer identification number (EIN)
3 Street address (including room or suite no.)
4 City or town
5 State or province
6 Country and ZIP or foreign postal code
7 Name of person to contact
8 Contact telephone number
9 Name of Designated Government Entity (only if applicable)
10 Employer identification number (EIN)
11 Street address (including room or suite no.)
12 City or town
13 State or province
14 Country and ZIP or foreign postal code
15 Name of person to contact
16 Contact telephone number

For Official Use Only

17 Reserved . . . . . ☐

18 Total number of Forms 1095-C submitted with this transmittal . . . . . ▶

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions . . . . . ☐

Part II ALE Member Information

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member . . . . . ▶

21 Is ALE Member a member of an Aggregated ALE Group? . . . . . ☐ Yes ☐ No

If "No," do not complete Part IV.

22 **Certifications of Eligibility (select all that apply):**

☐ **A.** Qualifying Offer Method ☐ **B.** Reserved ☐ **C.** Reserved ☐ **D.** 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

▶ Signature ▶ Title ▶ Date

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2018)

2018 1094-C (page 2)

Form 1094-C (2018) Page 2

Part III ALE Member Information—Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Section 4980H Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Reserved
		Yes	No				
23	All 12 Months	☐	☐			☐	
24	Jan	☐	☐			☐	
25	Feb	☐	☐			☐	
26	Mar	☐	☐			☐	
27	Apr	☐	☐			☐	
28	May	☐	☐			☐	
29	June	☐	☐			☐	
30	July	☐	☐			☐	
31	Aug	☐	☐			☐	
32	Sept	☐	☐			☐	
33	Oct	☐	☐			☐	
34	Nov	☐	☐			☐	
35	Dec	☐	☐			☐	

Form **1094-C** (2018)

2018 1094-C (page 3)

Form 1094-C (2018) Page 3

Part IV Other ALE Members of Aggregated ALE Group

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

	Name	EIN		Name	EIN
36			51		
37			52		
38			53		
39			54		
40			55		
41			56		
42			57		
43			58		
44			59		
45			60		
46			61		
47			62		
48			63		
49			64		
50			65		

Form **1094-C** (2018)

When to Report?

- Reporting to Individuals (1095-B and 1095-C)
  - By January 31st following end of calendar year
    - ➢ No extension from this date
- Transmittal Forms to IRS (1094-B or 1094-C)
  - By February 28th of year following calendar year (if paper)
  - Deadline extended until March 31st if filed electronically
    - ➢ Deadline for 2018 filings is April 1, 2019 because March 31, 2019 falls on the weekend
    - ➢ Must be filed electronically if required to file at least 250 forms
    - ➢ Automatic 30-day extension available
- Annual Filing Obligation

Penalties for Noncompliance

- Failure to file with IRS or furnish statements to individuals
  - $260 for each statement, annual cap of $3,218,500
  - Intentional disregard of filing requirements: fine doubles and no annual cap
- No “good faith effort” relief

Reporting for

On-Going Full-Time Employees

On-Going Full-Time Employees

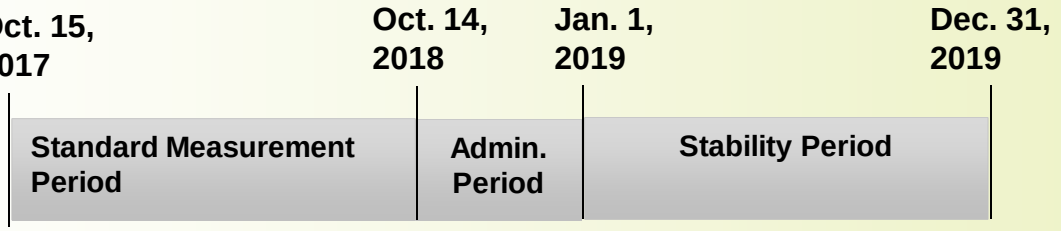
Reporting Issues:

- 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

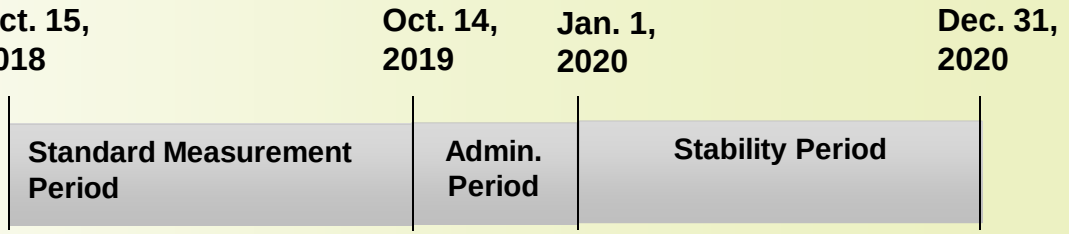
On-Going Employee Measurement Periods

Year 1

Year 2



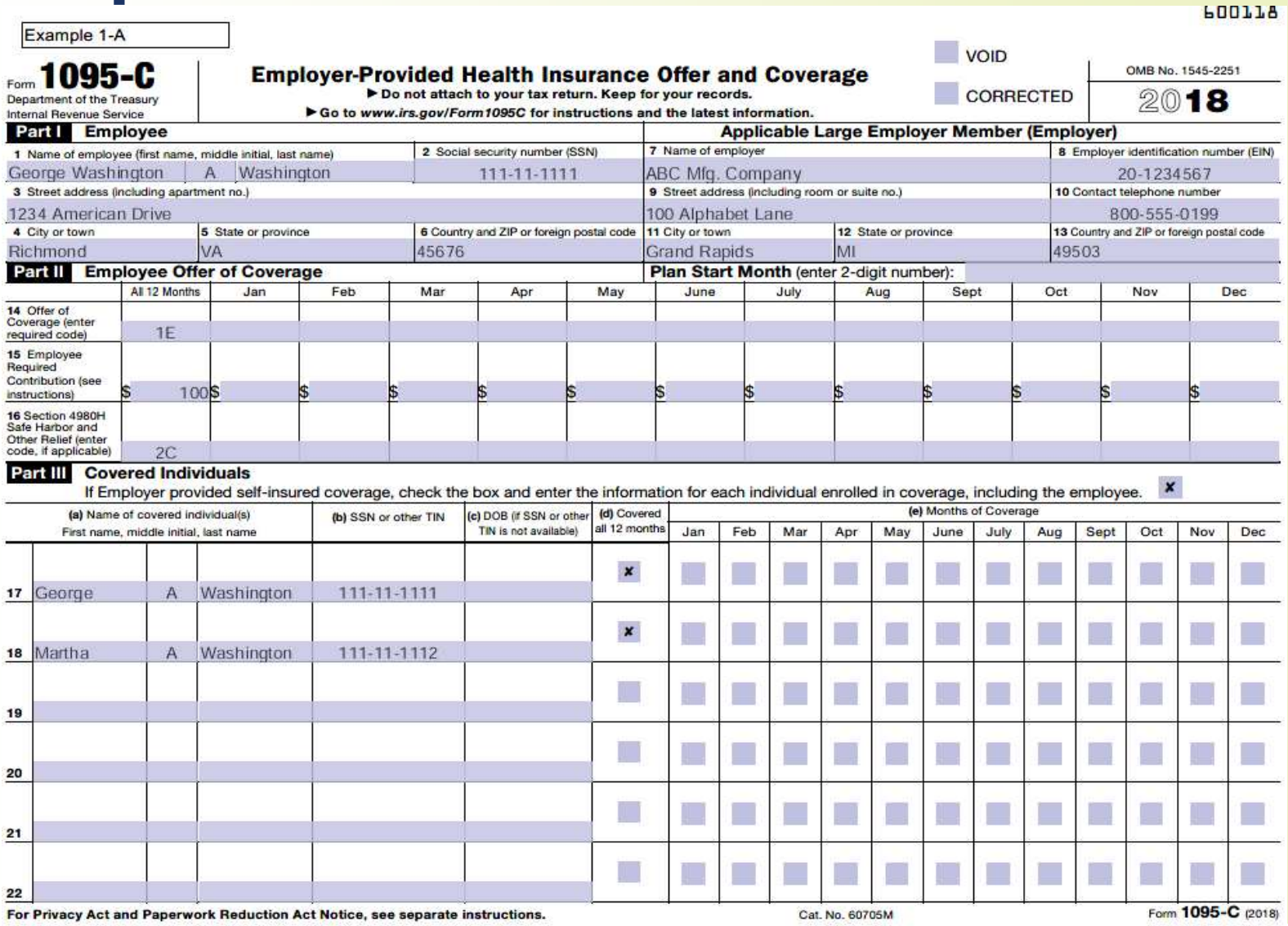
Year 3



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

Example 1-A



Example 1-A

600118

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)			2 Social security number (SSN)
George Washington	A	Washington	111-11-1111
3 Street address (including apartment no.)			
1234 American Drive			
4 City or town	5 State or province		6 Country and ZIP or foreign postal code
Richmond	VA		45676

Applicable Large Employer Member (Employer)

7 Name of employer			8 Employer identification number (EIN)
ABC Mfg. Company			20-1234567
9 Street address (including room or suite no.)			10 Contact telephone number
100 Alphabet Lane			800-555-0199
11 City or town	12 State or province		13 Country and ZIP or foreign postal code
Grand Rapids	MI		49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 100	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

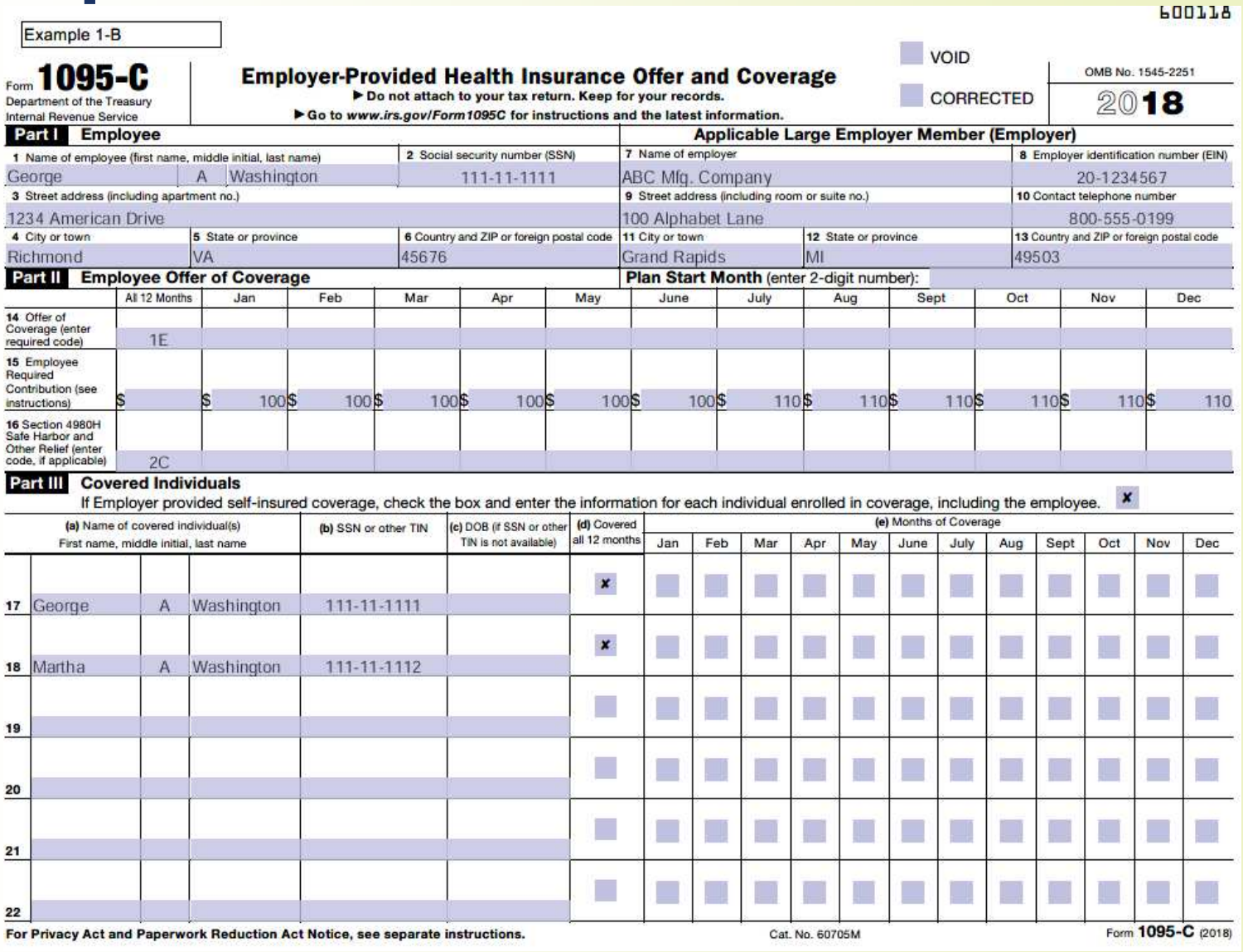
	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
							Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	George	A	Washington	111-11-1111		☒												
18	Martha	A	Washington	111-11-1112		☒												
19																		
20																		
21																		
22																		

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

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

Example 1-B



Example 1-B

600118

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

☐ VOID
☐ CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
George A Washington	111-11-1111
3 Street address (including apartment no.)	
1234 American Drive	
4 City or town	5 State or province	6 Country and ZIP or foreign postal code
Richmond	VA	45676

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ABC Mfg. Company	20-1234567
9 Street address (including room or suite no.)	10 Contact telephone number
100 Alphabet Lane	800-555-0199

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
Grand Rapids	MI	49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100	$ 110	$ 110	$ 110	$ 110	$ 110	$ 110
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
							Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	George	A	Washington	111-11-1111		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18	Martha	A	Washington	111-11-1112		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

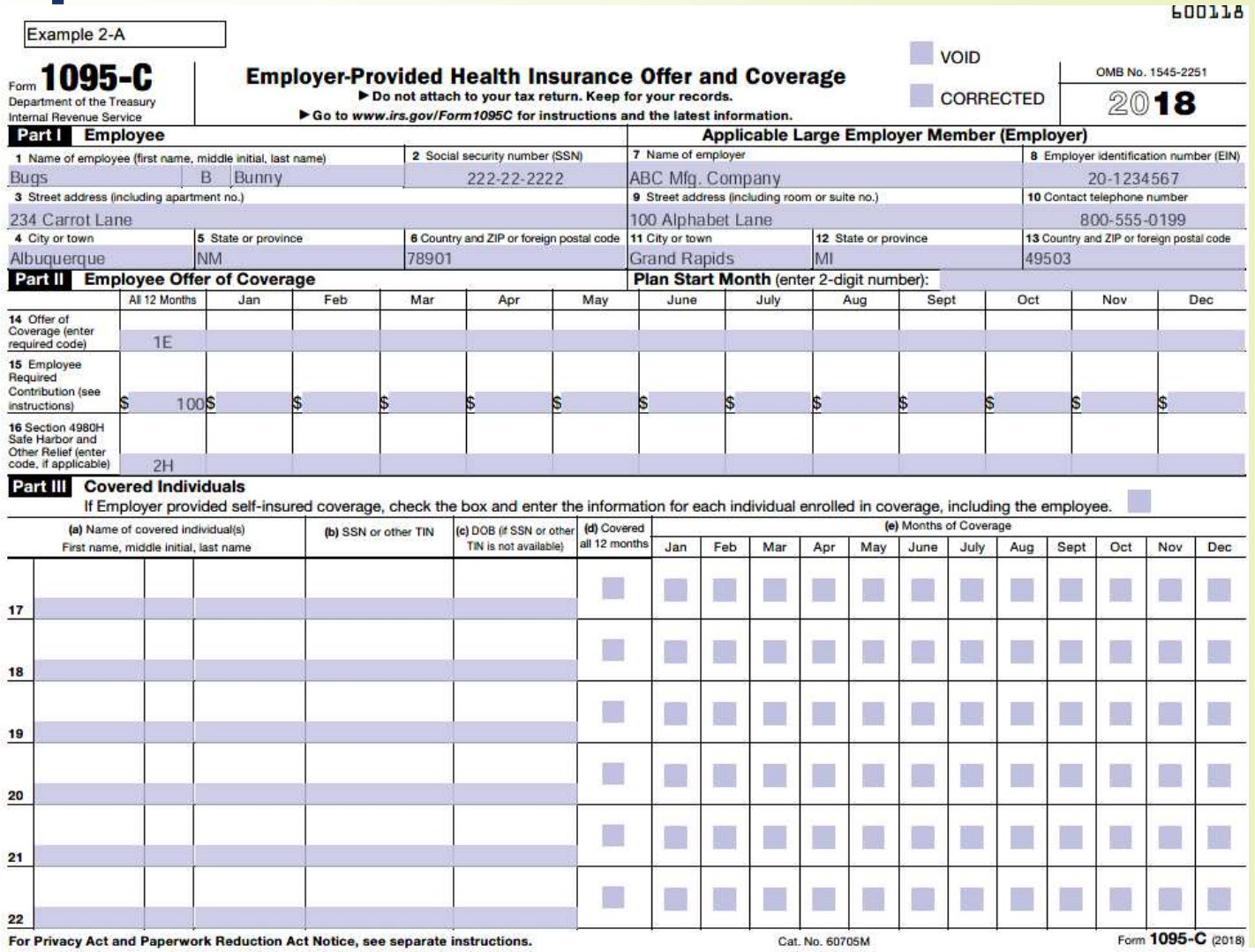
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

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 x 130 hrs = $1,300; $1,300 x .0956 = $124.28
- Plan year: January 1 – December 31

Example 2-A



Example 2-A

600118

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)			2 Social security number (SSN)
Bugs	B	Bunny	222-22-2222
3 Street address (including apartment no.)			
234 Carrot Lane			
4 City or town	5 State or province		6 Country and ZIP or foreign postal code
Albuquerque	NM		78901

Applicable Large Employer Member (Employer)

7 Name of employer			8 Employer identification number (EIN)
ABC Mfg. Company			20-1234567
9 Street address (including room or suite no.)			10 Contact telephone number
100 Alphabet Lane			800-555-0199
11 City or town	12 State or province		13 Country and ZIP or foreign postal code
Grand Rapids	MI		49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 100	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

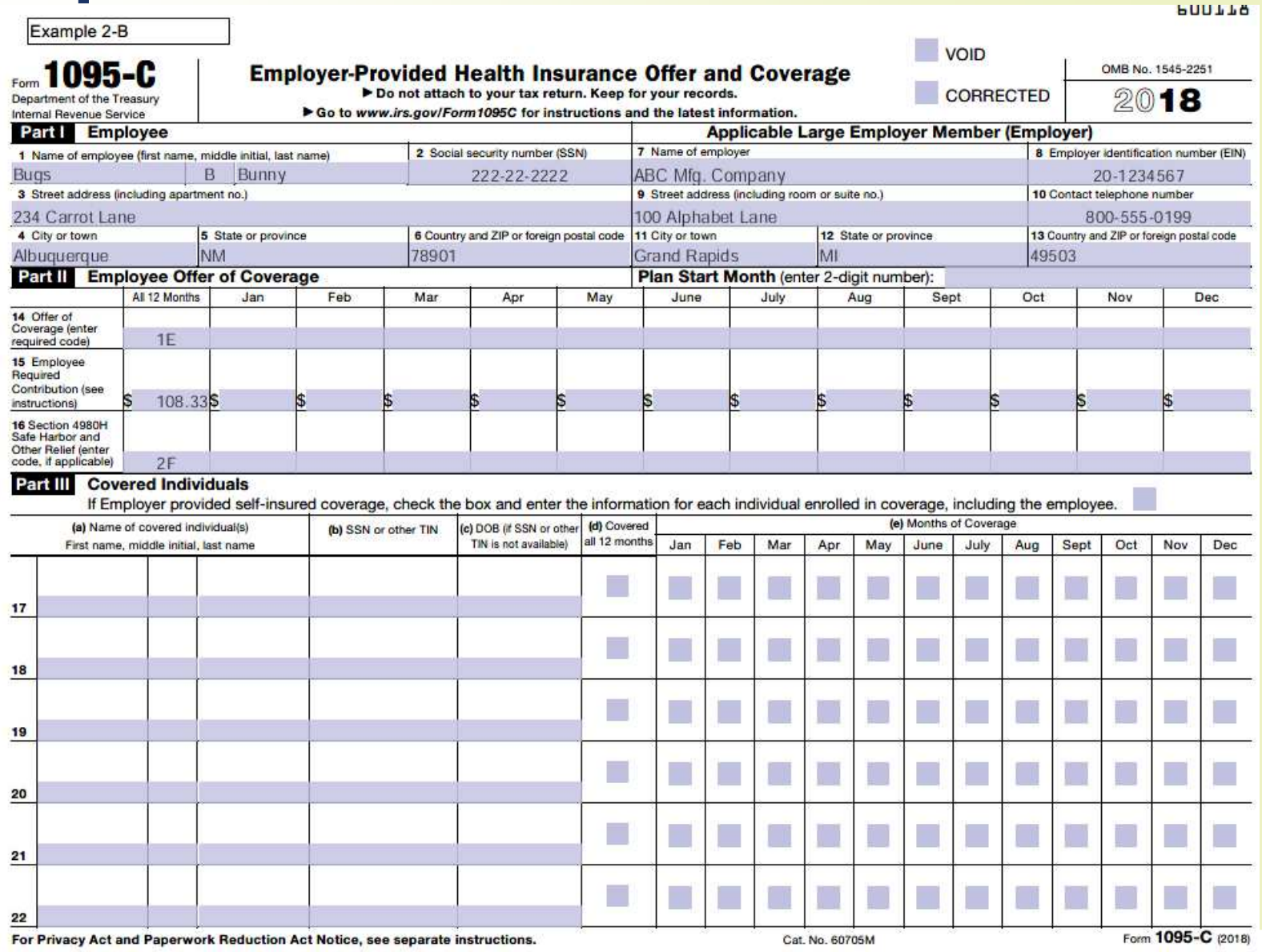
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																
18																
19																
20																
21																
22																

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

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 x .0956 = $1,864.20
  - Plan year: January 1 – December 31

Example 2-B



Example 2-B

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
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VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
Bugs B Bunny	222-22-2222
3 Street address (including apartment no.)	
234 Carrot Lane	
4 City or town	5 State or province	6 Country and ZIP or foreign postal code
Albuquerque	NM	78901

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ABC Mfg. Company	20-1234567
9 Street address (including room or suite no.)	10 Contact telephone number
100 Alphabet Lane	800-555-0199
11 City or town	12 State or province	13 Country and ZIP or foreign postal code
Grand Rapids	MI	49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 108.33	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2F												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

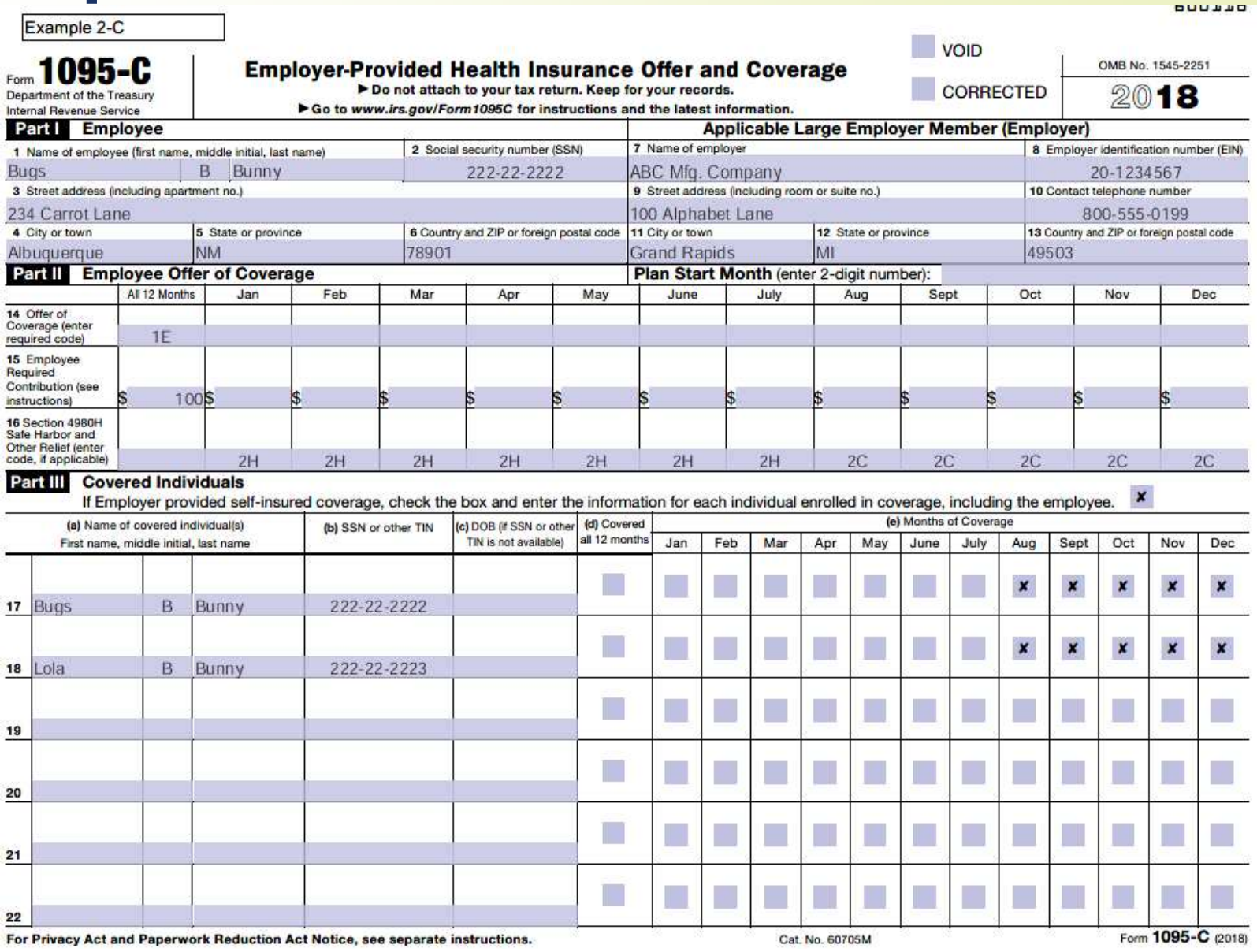
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																
18																
19																
20																
21																
22																

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

Example 2-C

- Full-time employee who declined coverage but experiences mid-year status change
  - 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
  - Gets married on 7/15/18
  - Plan year: January 1 – December 31

Example 2-C



Example 2-C

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
Bugs B Bunny	222-22-2222
3 Street address (including apartment no.)	
234 Carrot Lane	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code
Albuquerque	NM	78901

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ABC Mfg. Company	20-1234567
9 Street address (including room or suite no.)	**10** Contact telephone number
100 Alphabet Lane	800-555-0199
11 City or town	**12** State or province	**13** Country and ZIP or foreign postal code
Grand Rapids	MI	49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$ 100	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2C	2C	2C	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
							Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	Bugs	B	Bunny	222-22-2222		☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☒	☒	☒
18	Lola	B	Bunny	222-22-2223		☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☒	☒	☒
19						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

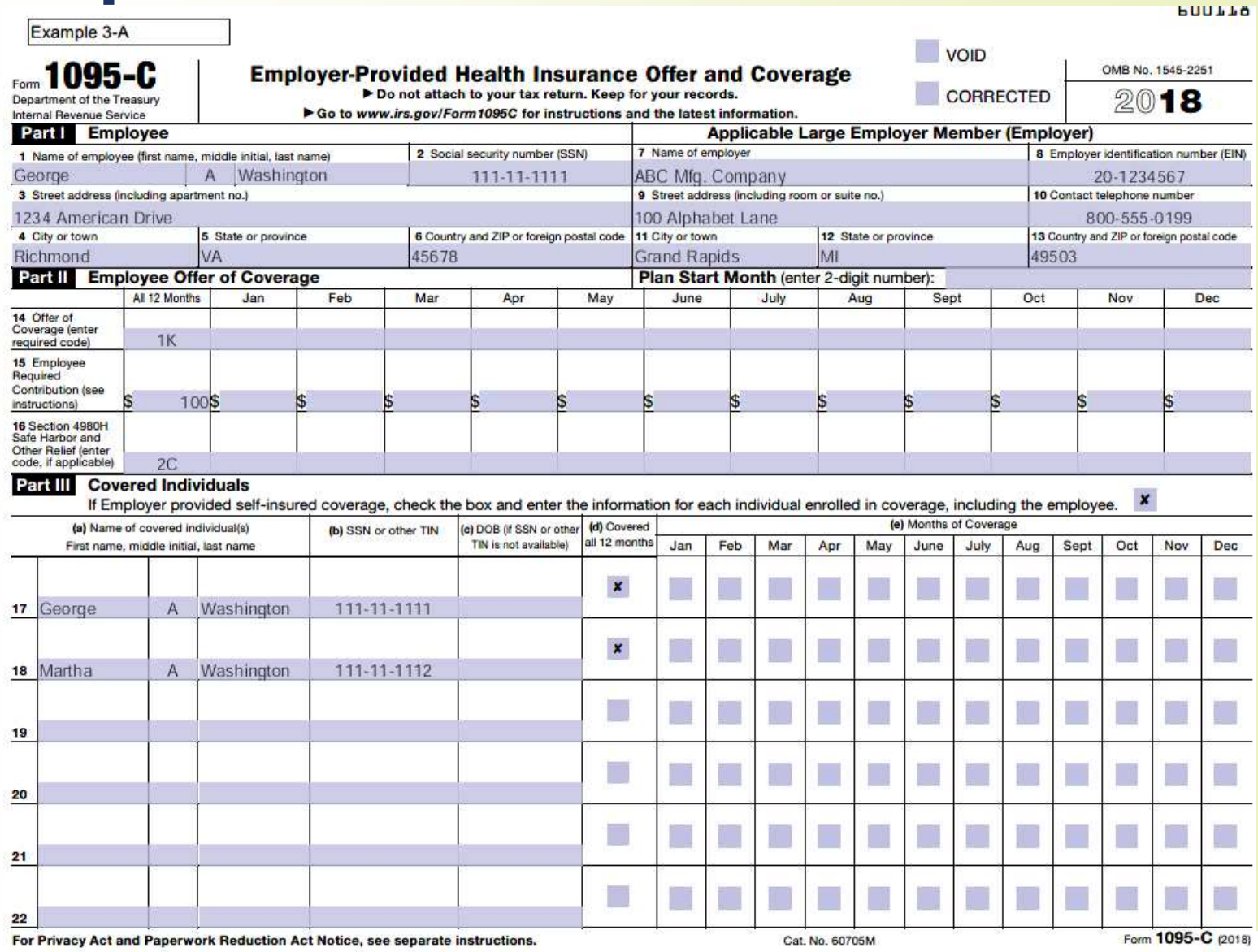
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

Conditional Offers of Coverage

Example 3-A

- Full-time employee who worked all year and was covered all year
  - Offer of coverage meets minimum value
  - Offer of coverage to dependents and to spouse so long as spouse not eligible for other group health plan by another employer
  - Monthly cost of individual coverage: $100
  - Employee elects to cover spouse
  - Plan year: January 1 – December 31

Example 3-A



Example 3-A

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)			2 Social security number (SSN)
George	A	Washington	111-11-1111
3 Street address (including apartment no.)			
1234 American Drive			
4 City or town	5 State or province		6 Country and ZIP or foreign postal code
Richmond	VA		45678

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ABC Mfg. Company	20-1234567
9 Street address (including room or suite no.)	10 Contact telephone number
100 Alphabet Lane	800-555-0199
11 City or town	12 State or province / 13 Country and ZIP or foreign postal code
Grand Rapids	MI 49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1K												
15 Employee Required Contribution (see instructions)	$ 100	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

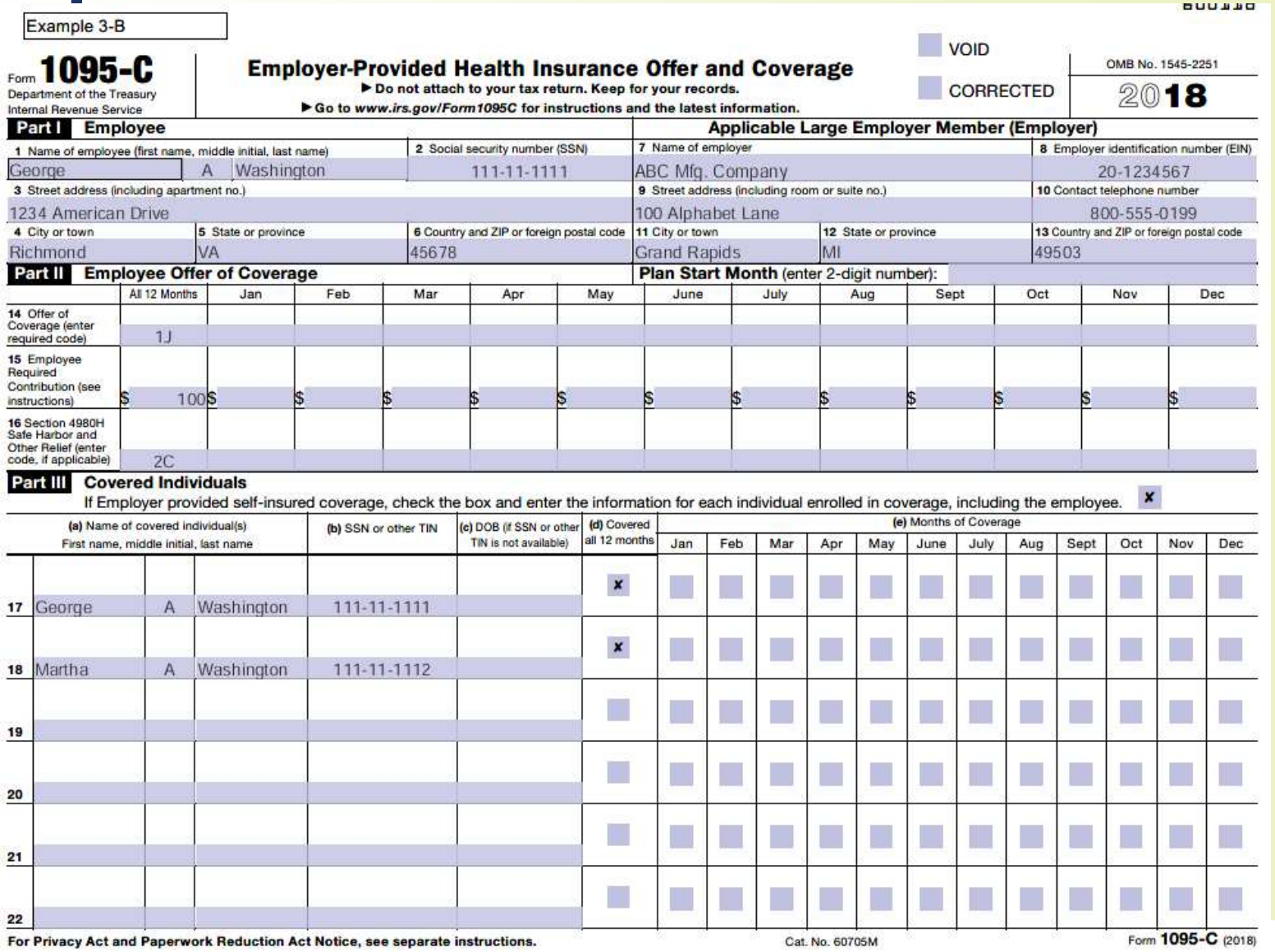
	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	George	A	Washington	111-11-1111		☒												
18	Martha	A	Washington	111-11-1112		☒												
19																		
20																		
21																		
22																		

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

Example 3-B

- Full-time employee who worked all year and was covered all year
  - Offer of coverage meets minimum value
  - Offer of coverage to spouse so long as spouse not eligible for other group health plan by another employer, but no offer of coverage to dependents
  - Monthly cost of individual coverage: $100
  - Employee elects to cover spouse
  - Plan year: January 1 – December 31

Example 3-B



Example 3-B

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
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VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)			2 Social security number (SSN)
George	A	Washington	111-11-1111
3 Street address (including apartment no.)			
1234 American Drive			
4 City or town	5 State or province		6 Country and ZIP or foreign postal code
Richmond	VA		45678

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ABC Mfg. Company	20-1234567
9 Street address (including room or suite no.)	10 Contact telephone number
100 Alphabet Lane	800-555-0199

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
Grand Rapids	MI	49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1J												
15 Employee Required Contribution (see instructions)	$ 100	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2C												

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	George	A	Washington	111-11-1111		☒												
18	Martha	A	Washington	111-11-1112		☒												
19																		
20																		
21																		
22																		

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

Reporting for

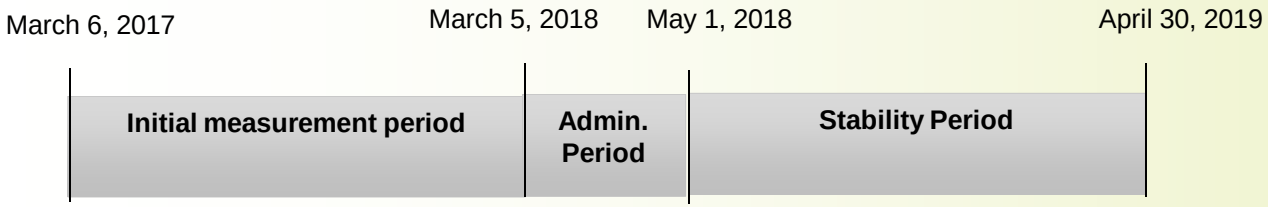
Newly-Hired Employees

Newly Hired Employees

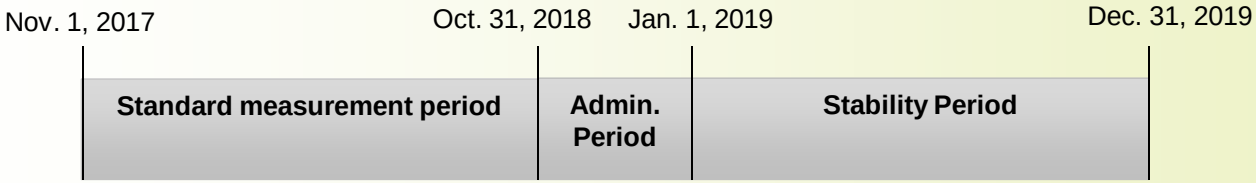
- Issues:
  - Month-to-month method:
    - Employee counts as full-time any month that he or she works 130 or more hours
  - Look-back-measurement method:
    - If expected to work full-time:
      - Until completes a standard measurement period, count as full-time during months he or she works 130 or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

New Variable Hour Employee

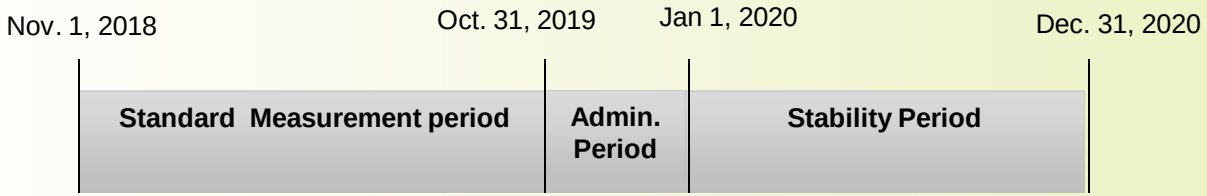
New Employee Initial Determination



On-going Employee Year 1



On-going Employee Year 2



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”

Example 4-A

- Newly Hired Employee
  - Hired to work a full-time schedule
  - Date of hire: April 15, 2018
  - Eligible for minimum value coverage for employee, spouse and dependents on July 1, 2018
  - $100/month for single coverage
  - Employee enrolls in single coverage

Example 4-A

Example 4-A

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
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VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)			2 Social security number (SSN)
John	C	Doe	333-33-3333
3 Street address (including apartment no.)			
456 Unknown Drive			
4 City or town	5 State or province		6 Country and ZIP or foreign postal code
Anywhere	MI		46789

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ABC Mfg. Company	20-1234567
9 Street address (including room or suite no.)	10 Contact telephone number
100 Alphabet Lane	800-555-0199

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
Grand Rapids	MI	49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2D	2D	2D	2C	2C	2C	2C	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ✘

	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
							Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	John	C	Doe	333-33-3333									✘	✘	✘	✘	✘	✘
18																		
19																		
20																		
21																		
22																		

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

Example 4-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, 2018
  - Eligible for minimum value coverage for employee, spouse and dependents on May 1, 2019 if averages at least 30 hours of service per week

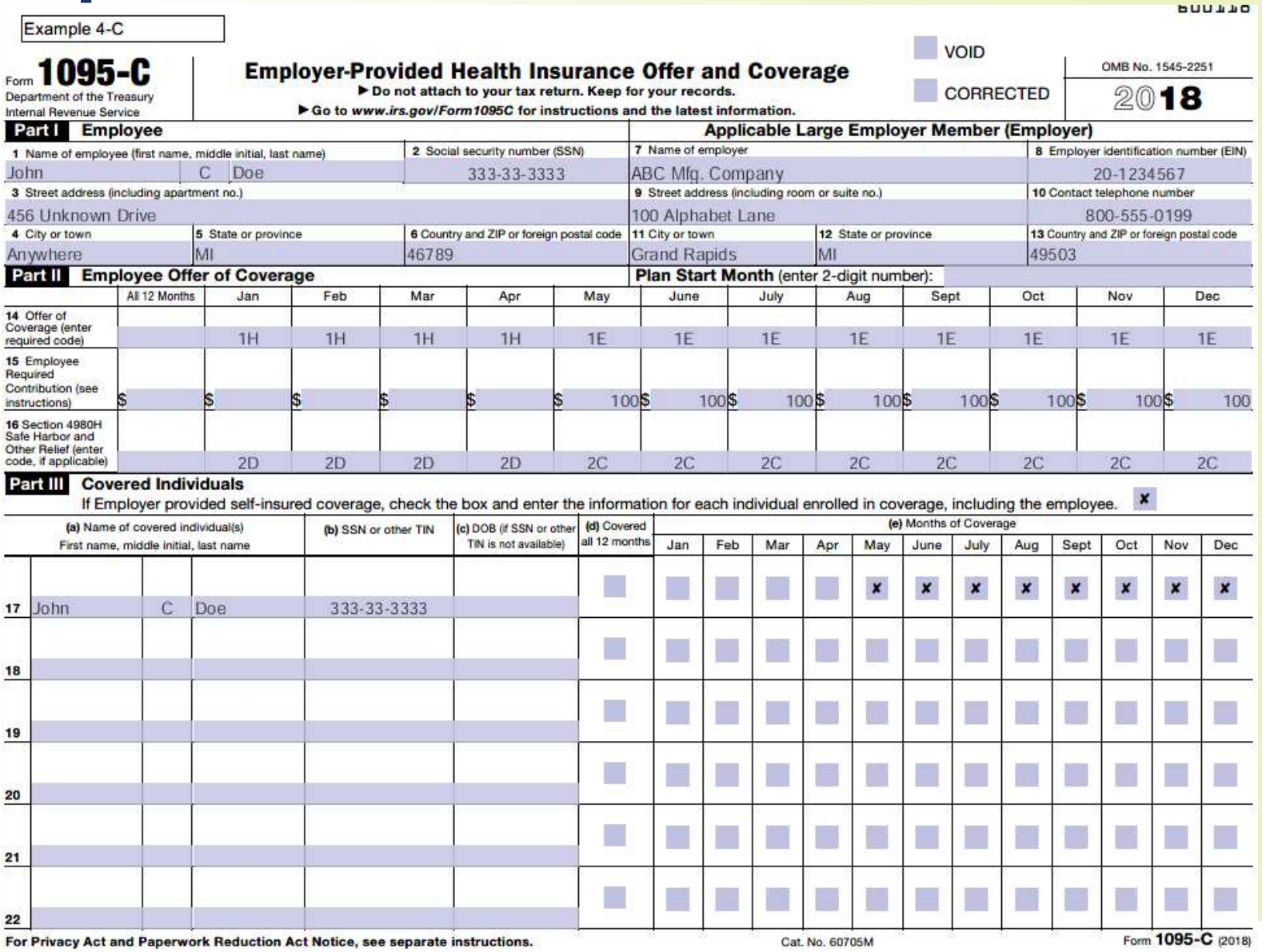
Example 4-B

- No need to issue a 1095-C to this employee
  - Is not classified as a FT employee during any month in 2018
  - Is not enrolled in coverage during any month in 2018

Example 4-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, 2017
  - Eligible for minimum value coverage for employee, spouse and dependents on May 1, 2018 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

Example 4-C



Example 4-C

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
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▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)			2 Social security number (SSN)
John	C	Doe	333-33-3333
3 Street address (including apartment no.)			
456 Unknown Drive			
4 City or town	5 State or province		6 Country and ZIP or foreign postal code
Anywhere	MI		46789

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ABC Mfg. Company	20-1234567
9 Street address (including room or suite no.)	10 Contact telephone number
100 Alphabet Lane	800-555-0199
11 City or town / 12 State or province	13 Country and ZIP or foreign postal code
Grand Rapids / MI	49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2D	2D	2D	2C	2C	2C	2C	2C	2C	2C	2C

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

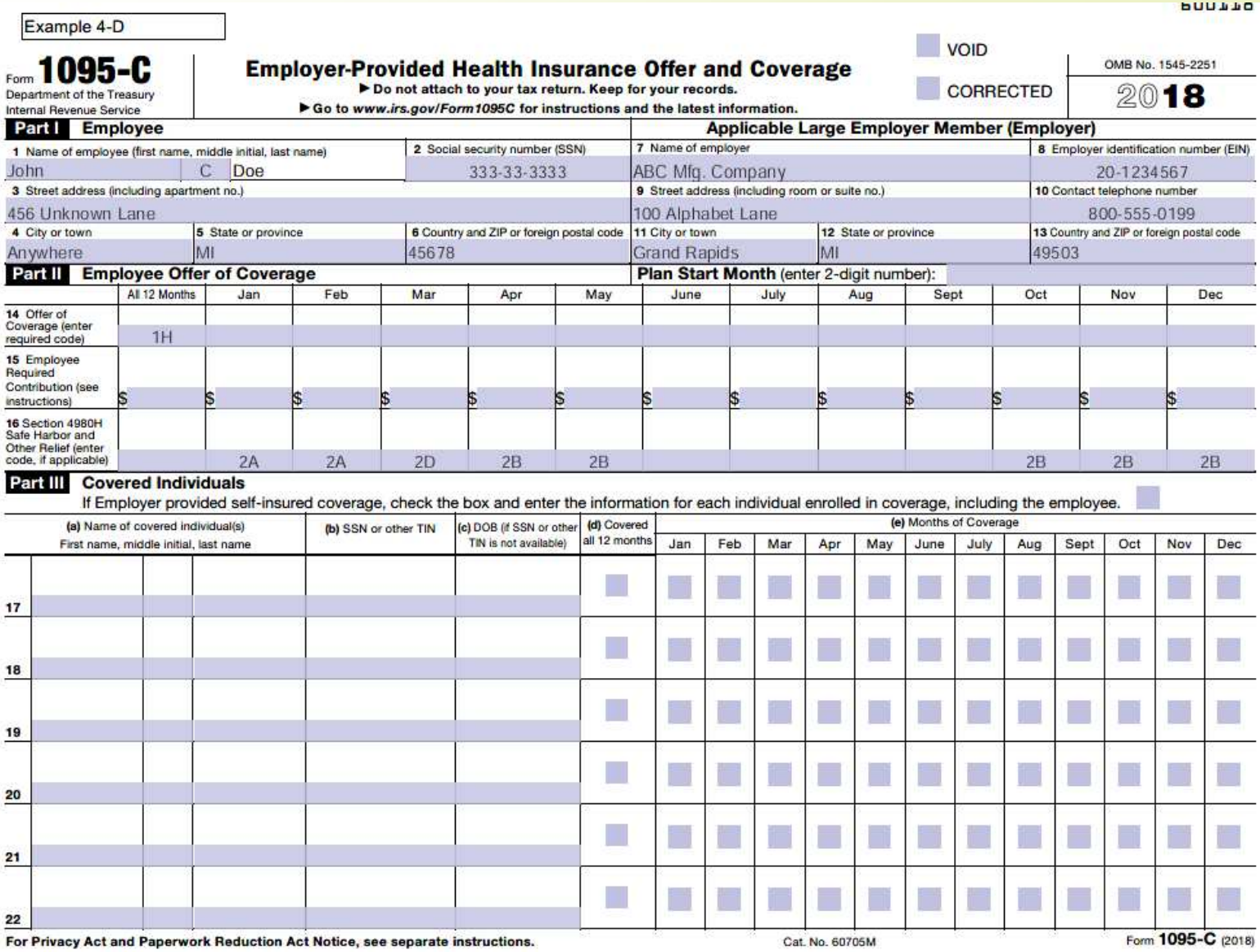
	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
							Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	John	C	Doe	333-33-3333		☐	☐	☐	☐	☐	☒	☒	☒	☒	☒	☒	☒	☒
18						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

Example 4-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, 2018
    - 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 4-D



Example 4-D

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
John C Doe	333-33-3333
3 Street address (including apartment no.)	
456 Unknown Lane	
4 City or town	5 State or province	6 Country and ZIP or foreign postal code
Anywhere	MI	45678

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ABC Mfg. Company	20-1234567
9 Street address (including room or suite no.)	10 Contact telephone number
100 Alphabet Lane	800-555-0199
11 City or town	12 State or province	13 Country and ZIP or foreign postal code
Grand Rapids	MI	49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$	$	$	$	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2B	2B					2B	2B	2B

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																
18																
19																
20																
21																
22																

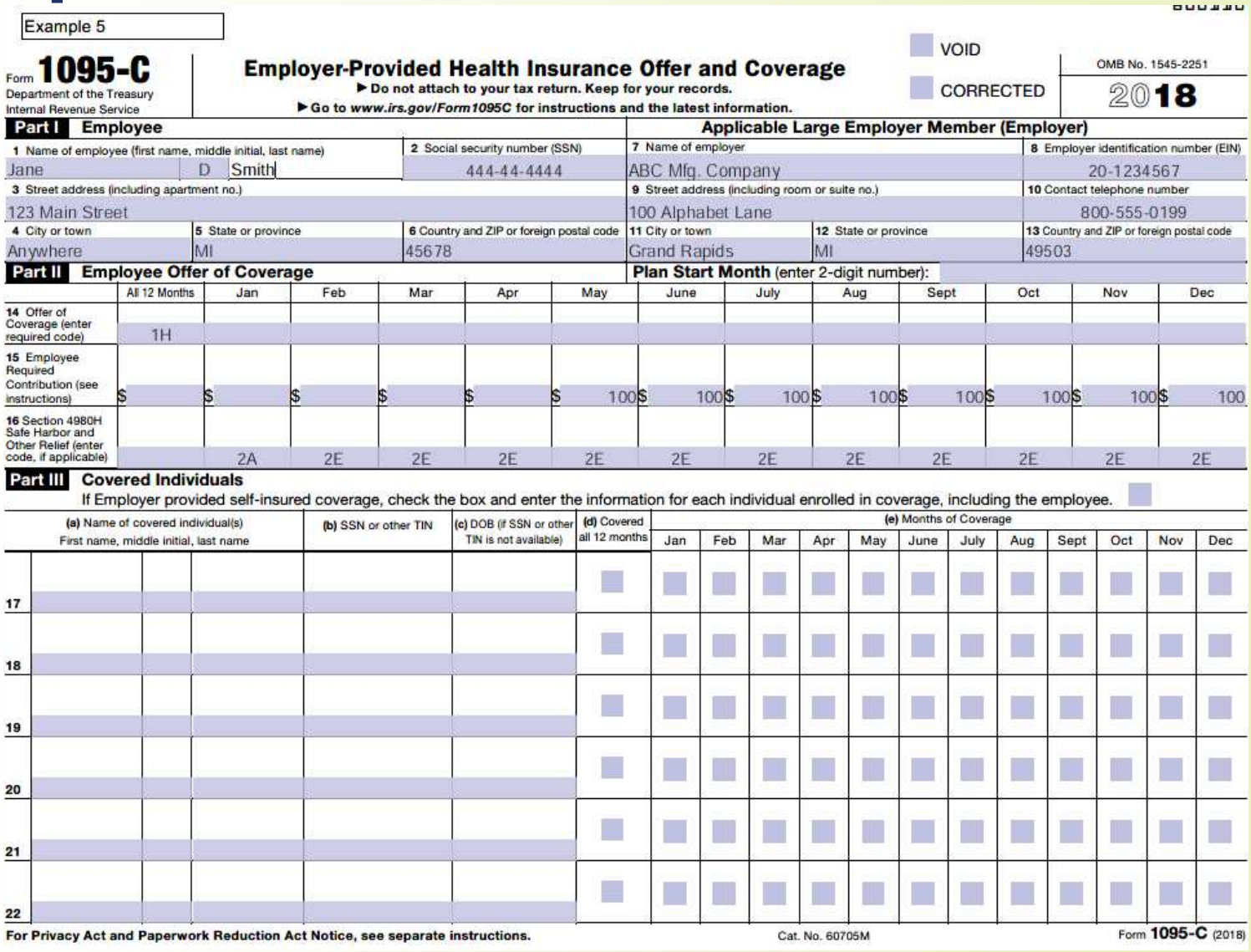
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

Reporting for Other Situations

Example 5

- Collectively-bargained employee covered under union plan
  - Employee hired on 2/15/18, 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 2018
  - Multiemployer plan does not report to employer the specific months for which employee is eligible

Example 5



Example 5

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
Jane D Smith	444-44-4444
3 Street address (including apartment no.)	
123 Main Street	
4 City or town	5 State or province	6 Country and ZIP or foreign postal code
Anywhere	MI	45678

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ABC Mfg. Company	20-1234567
9 Street address (including room or suite no.)	10 Contact telephone number
100 Alphabet Lane	800-555-0199
11 City or town	12 State or province	13 Country and ZIP or foreign postal code
Grand Rapids	MI	49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1H												
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2E	2E	2E	2E	2E	2E	2E	2E	2E	2E	2E

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☐

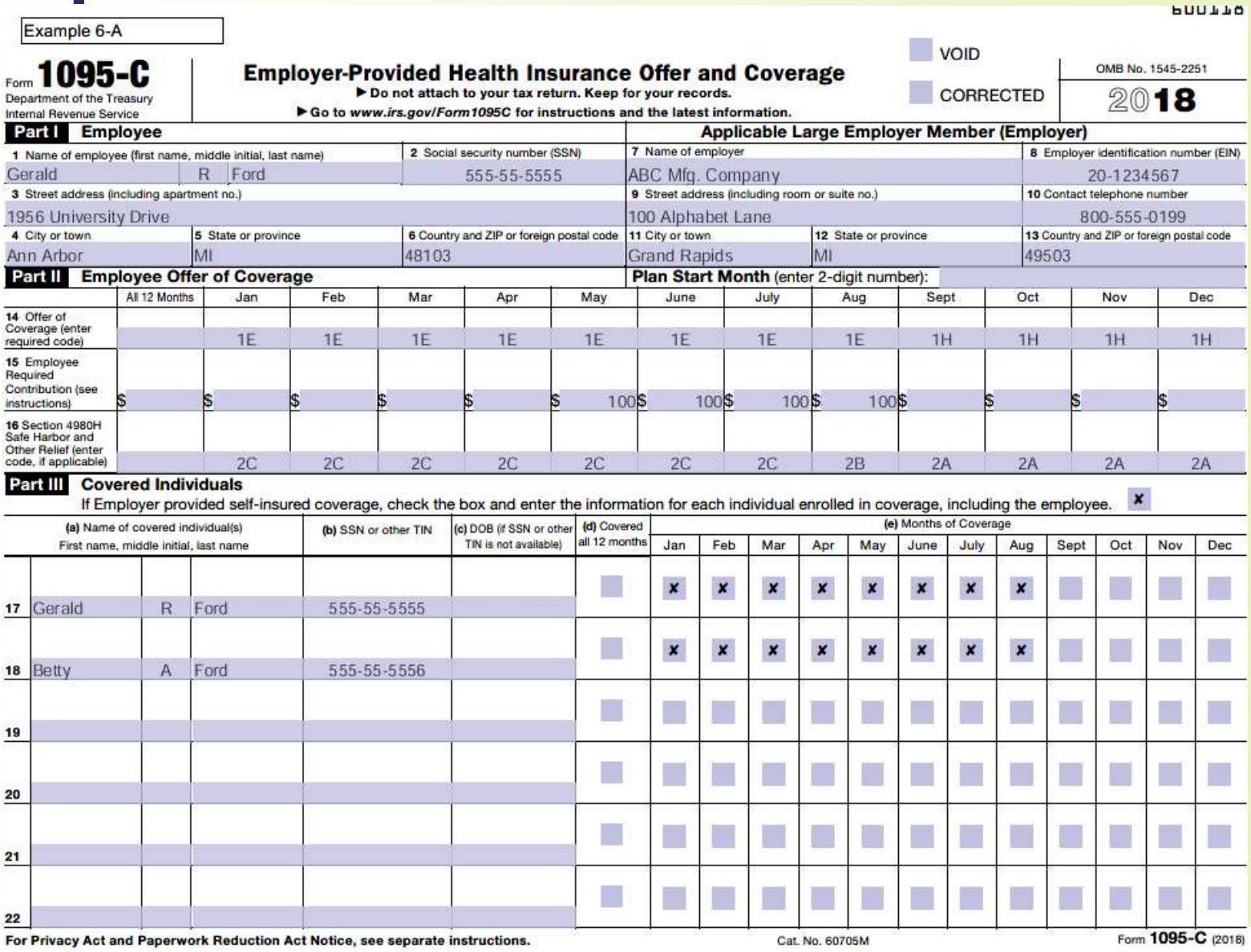
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

Example 6-A

- Full-time employee terminates mid-year
  - Employer uses look-back measurement method to determine full-time status
  - Date of termination: 8/15/18
  - Monthly cost of coverage: $100
  - Eligible for minimum value coverage for employee, spouse and dependents through date of termination
    - ➢ Would have 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

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)			2 Social security number (SSN)
Gerald	R	Ford	555-55-5555
3 Street address (including apartment no.)			
1956 University Drive			
4 City or town	**5** State or province		**6** Country and ZIP or foreign postal code
Ann Arbor	MI		48103

Applicable Large Employer Member (Employer)

7 Name of employer			8 Employer identification number (EIN)
ABC Mfg. Company			20-1234567
9 Street address (including room or suite no.)			**10** Contact telephone number
100 Alphabet Lane			800-555-0199
11 City or town	**12** State or province		**13** Country and ZIP or foreign postal code
Grand Rapids	MI		49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	$	$	$	$	$	$ 100	$ 100	$ 100	$ 100	$	$	$	$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2B	2A	2A	2A	2A

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

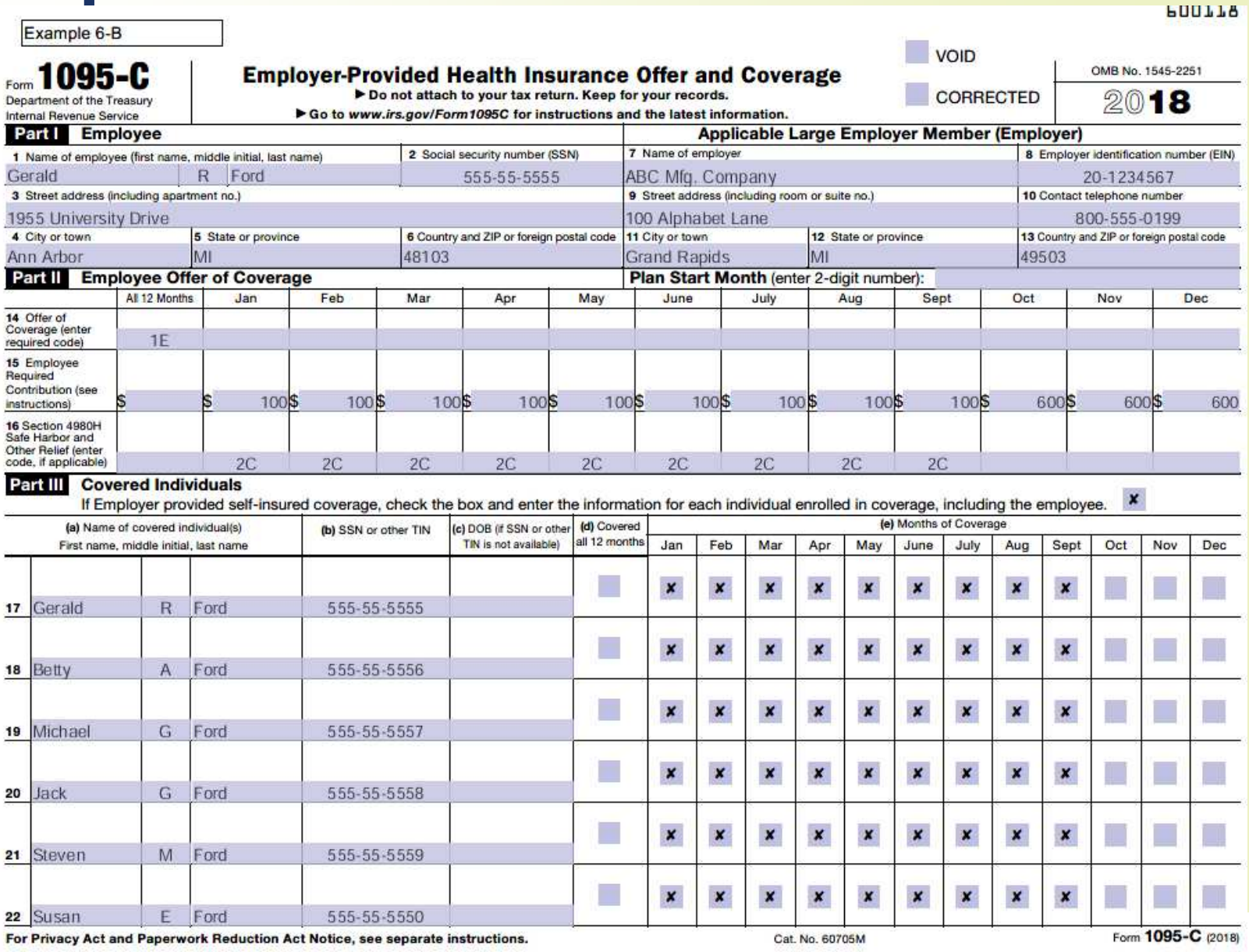
	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
							Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	Gerald	R	Ford	555-55-5555		☐	☒	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐	☐
18	Betty	A	Ford	555-55-5556		☐	☒	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐	☐
19						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22						☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

Example 6-B

- Full-time on-going employee transfers to part-time position mid-year
  - Employer uses look-back measurement method to determine full-time status, but not for eligibility purposes
  - Part-time employees ineligible for coverage
  - Date of part-time transfer: 10/1/18
  - Monthly cost of single coverage: $100
    - Monthly COBRA premium for single coverage: $600
  - Eligible for minimum value coverage for employee, spouse and dependents through date of transfer
  - Employee had enrolled self, spouse and dependents in coverage
  - Employee does not elect COBRA

Example 6-B



Example 6-B

Form **1095-C**
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage
▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

VOID
CORRECTED

OMB No. 1545-2251
2018

Part I Employee

1 Name of employee (first name, middle initial, last name)			2 Social security number (SSN)
Gerald	R	Ford	555-55-5555
3 Street address (including apartment no.)			
1955 University Drive			
4 City or town	5 State or province	6 Country and ZIP or foreign postal code	
Ann Arbor	MI	48103	

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
ABC Mfg. Company	20-1234567
9 Street address (including room or suite no.)	10 Contact telephone number
100 Alphabet Lane	800-555-0199

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
Grand Rapids	MI	49503

Part II Employee Offer of Coverage

Plan Start Month (enter 2-digit number):

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Required Contribution (see instructions)	$	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100	$ 600	$ 600	$ 600
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C			

Part III Covered Individuals

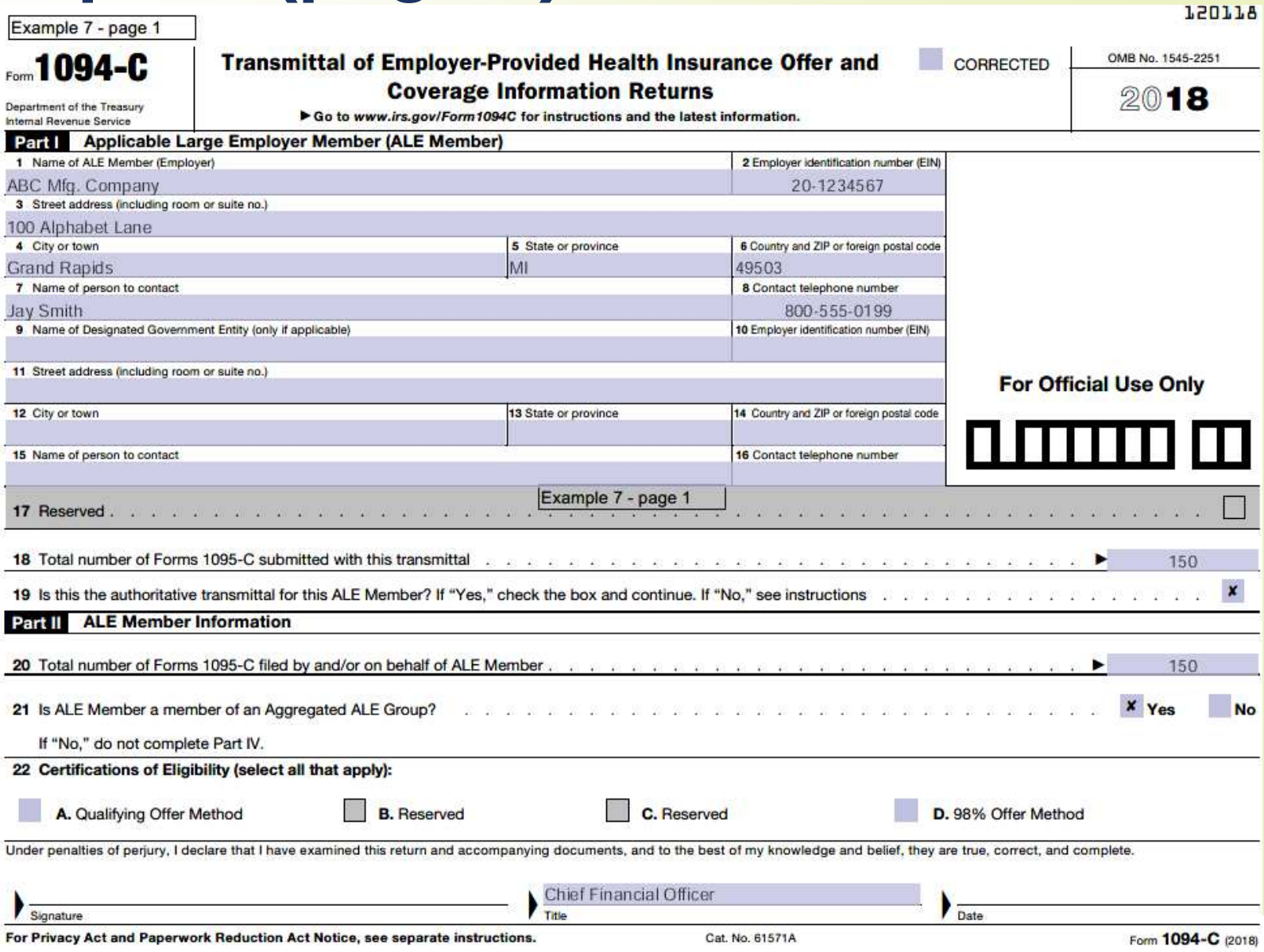
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. ☒

	(a) Name of covered individual(s) First name, middle initial, last name			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
							Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17	Gerald	R	Ford	555-55-5555		☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐
18	Betty	A	Ford	555-55-5556		☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐
19	Michael	G	Ford	555-55-5557		☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐
20	Jack	G	Ford	555-55-5558		☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐
21	Steven	M	Ford	555-55-5559		☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐
22	Susan	E	Ford	555-55-5550		☐	☒	☒	☒	☒	☒	☒	☒	☒	☒	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2018)

1094-C Example

Example 7 (page 1)



Example 7 - page 1

120118

Form **1094-C**

Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

▶ Go to *www.irs.gov/Form1094C* for instructions and the latest information.

☐ CORRECTED

OMB No. 1545-2251

2018

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer) ABC Mfg. Company		2 Employer identification number (EIN) 20-1234567
3 Street address (including room or suite no.) 100 Alphabet Lane		
4 City or town Grand Rapids	5 State or province MI	6 Country and ZIP or foreign postal code 49503
7 Name of person to contact Jay Smith		8 Contact telephone number 800-555-0199
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)
11 Street address (including room or suite no.)		
12 City or town	13 State or province	14 Country and ZIP or foreign postal code
15 Name of person to contact		16 Contact telephone number

For Official Use Only

Example 7 - page 1

17 Reserved . . . . . ☐

18 Total number of Forms 1095-C submitted with this transmittal . . . . . ▶ 150

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions . . . . . ☒

Part II ALE Member Information

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member . . . . . ▶ 150

21 Is ALE Member a member of an Aggregated ALE Group? . . . . . ☒ Yes ☐ No

If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):

☐ **A.** Qualifying Offer Method ☐ **B.** Reserved ☐ **C.** Reserved ☐ **D.** 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

▶ Signature _____ ▶ Chief Financial Officer Title ▶ Date _____

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2018)

Example 7 (page 2)

Example 7 - page 2

Form 1094-C (2018) Page 2

Part III ALE Member Information—Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Section 4980H Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Reserved
		Yes	No				
23	All 12 Months	X				X	
24	Jan			147	165		
25	Feb			147	165		
26	Mar			146	164		
27	Apr			149	167		
28	May			149	167		
29	June			148	170		
30	July			142	164		
31	Aug			142	164		
32	Sept			142	168		
33	Oct			143	169		
34	Nov			143	169		
35	Dec			143	169		

Form **1094-C** (2018)

Example 7 (page 3)

Example 7 - page 3

Form 1094-C (2018) Page 3

Part IV Other ALE Members of Aggregated ALE Group

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

	Name	EIN		Name	EIN
36	XYZ Corporation	11-1111111	51		
37	L&M Company	11-1111112	52		
38			53		
39			54		
40			55		
41			56		
42			57		
43			58		
44			59		
45			60		
46			61		
47			62		
48			63		
49			64		
50			65		

Form **1094-C** (2018)

Questions & Answers

Thank you!

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