Understanding the ACA Reporting Requirements

Norbert F. Kugele Stephanie H. Grant

November 8, 2018



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	5-C	En	ploye			Health					Cove	rage			/OID		-	TOWN DOWN	. 1545-22	
Department of the Internal Revenue S			►Go			ch to your torm 1095C					mation.			(CORR	ECTED	U.	20	18	
Part I Em	ployee	-			×:					Appli	cable L	arge	Emplo	yer M	embe	(Emp	loyer)			
1 Name of emplo	yee (first name,	middle initial, I	last name)		2 Soc	ial security n	umber (SSN	1) 7	Name of 6	mployer						8	Employer	identifica	ation num	ber (EIN
3 Street address	(including apart	ment no.)			9			9	Street add	fress (inc	luding roo	om or sui	te no.)			10	Contact to	elephone	number	}
4 City or town		5 State or pro	vince		6 Coun	try and ZIP or	r foreign pos	ital code 11	City or to	vn		12 St	ate or pro	vince		13	Country an	d ZIP or fo	oreign post	tal code
Part II Em	ployee Off	er of Cove	erage	40		80		P	lan Sta	rt Mo	nth (ent	ter 2-di	git num	ber):	-		500			
	All 12 Months	Jan	F	eb	Mar	Apr	r	May	June		July		Aug	Se	pt	Oct		Nov	1	Dec
14 Offer of Coverage (enter equired code)																				
15 Employee Required Contribution (see														9						
nstructions)	S	S	\$	\$		\$	Ş		6	\$		\$		\$		6	S		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																				
(a) Nam	mployer provine of covered inches, middle initial	dividual(s)	-	verage, o		(c) DOB (if S	SN or other	e informat (d) Covered all 12 month		ach ind	dividual	enrolle		Months	of Cover	age		ee.	Nov	Dec
First nam	ie, middle inidal	last name	+			THE IS HOL	available)		Jan	reb	War	Apr	way	June	July	Aug	Sept	Oct	NOV	Dec
17																				
18																				
19												1				9,,0				
20																				
21										- 1						9				
21																				

2018 1095-C (page 2)

Form 1095-C (2018)

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/1, and the 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.

 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

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

11. Reserved

1.J. 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).

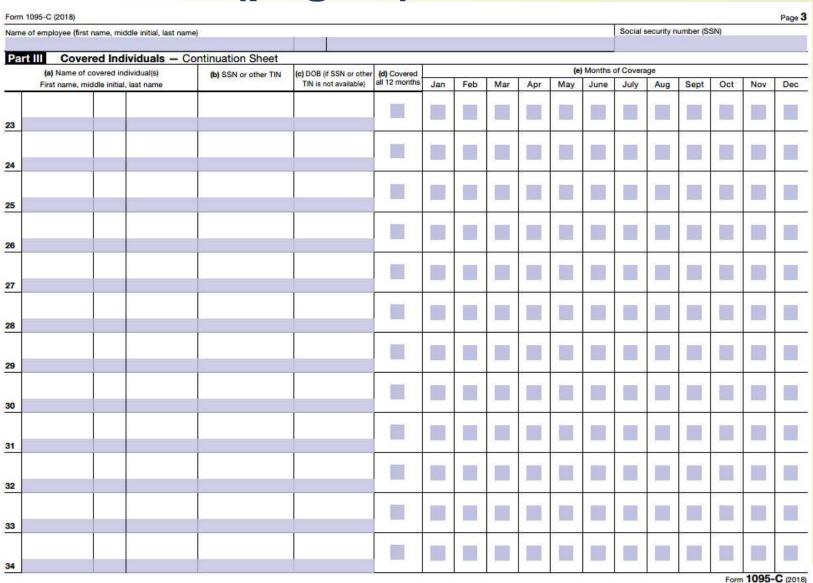
Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest-cost self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, 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)



2018 1094-C (page 1)

repartment of the Treasury		r-Provided Health I (e Information Retu 1094C for instructions and the	irns	CORRECTED OMB No. 1545-2251 2018
Part Applicable L	arge Employer Member (ALE Mem	ber)	%;	¥:
1 Name of ALE Member (Emp	oloyer)		2 Employer identification number (EIN)	
3 Street address (including ro	om or suite no.)			
City or town		5 State or province	6 Country and ZIP or foreign postal code	
Name of person to contact		*	8 Contact telephone number	
Name of Designated Govern	nment Entity (only if applicable)		10 Employer identification number (EIN)	
Street address (including ro	om or suite no.)			For Official Use Only
2 City or town		13 State or province	14 Country and ZIP or foreign postal code	
5 Name of person to contact			16 Contact telephone number	
	ns 1095-C submitted with this transmittal	* * * * * * * * * *		
8 Total number of Forn	ns 1095-C submitted with this transmittal ve transmittal for this ALE Member? If "Ye		THE WASHINGTON AND THE PROPERTY OF THE PROPERTY OF THE	
9 Is this the authoritation			THE WASHINGTON AND THE PROPERTY OF THE PROPERTY OF THE	
B Total number of Form 9 Is this the authoritation art II ALE Membe	ve transmittal for this ALE Member? If "Ye	es," check the box and contin	THE WASHINGTON AND THE PROPERTY OF THE PROPERTY OF THE	
8 Total number of Form 9 Is this the authoritation art II ALE Membe 0 Total number of Form	ve transmittal for this ALE Member? If "Ye	es," check the box and contin	THE WASHINGTON AND THE PROPERTY OF THE PROPERTY OF THE	Yes No
3 Total number of Form 3 Is this the authoritation 4 If ALE Member 5 Total number of Form	we transmittal for this ALE Member? If "Ye r Information ms 1095-C filed by and/or on behalf of ALI ember of an Aggregated ALE Group?	es," check the box and contin	THE WASHINGTON AND THE PROPERTY OF THE PROPERTY OF THE	Yes
8 Total number of Form 9 Is this the authoritation art II ALE Member 0 Total number of Form 1 Is ALE Member a me If "No," do not comp	we transmittal for this ALE Member? If "Ye r Information ms 1095-C filed by and/or on behalf of ALI ember of an Aggregated ALE Group?	es," check the box and contin	THE WASHINGTON AND THE PROPERTY OF THE PROPERTY OF THE	Yes N
8 Total number of Form 9 Is this the authoritation art II ALE Member 10 Total number of Form 11 Is ALE Member a me 15 "No," do not comp	we transmittal for this ALE Member? If "Yest Information ms 1095-C filed by and/or on behalf of ALI ember of an Aggregated ALE Group? lete Part IV. gibility (select all that apply):	E Member	ue. If "No," see instructions	. 98% Offer Method
8 Total number of Form 9 Is this the authoritative art II ALE Member 0 Total number of Form 1 Is ALE Member a me If "No," do not comp 2 Certifications of Elig A. Qualifying Offer	we transmittal for this ALE Member? If "Yest Information ms 1095-C filed by and/or on behalf of ALI ember of an Aggregated ALE Group? elete Part IV. gibility (select all that apply):	E Member	ue. If "No," see instructions	
8 Total number of Form 9 Is this the authoritative III ALE Member 0 Total number of Form 1 Is ALE Member a me If "No," do not comp 2 Certifications of Elig A. Qualifying Offer	we transmittal for this ALE Member? If "Yest Information ms 1095-C filed by and/or on behalf of ALI ember of an Aggregated ALE Group? plete Part IV. gibility (select all that apply): Method B. Reserved	E Member	ue. If "No," see instructions	. 98% Offer Method

2018 1094-C (page 2)

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

Form 1094-C (2018)

2018 1094-C (page 3)

Form 1094-C (2018)	Page 3
CHARLES ALEMAN AND AND AND AND AND AND AND AND AND A	10: 12:

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	
9		54	
0		55	
1		56	
2		57	
3		58	
4		59	
5		60	
6		61	
7		62	
8		63	
9		64	
60		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







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

85																	60	0779
E	1095 xample 1-A	USS I	Emp	loyer-Pr	ovided	Health In	surance	Offer	and C	overag	е	<u> </u>	/OID		Ш	OMB No.	1545-22	51
	rtment of the T	reasury		>	Do not attac	th to your tax re	eturn. Keep fo	your rec	ords.			(CORRE	CTED	1	20	18	
_	Emp			, ac 10 mm	w.ms.gov//	mirosoc ioi ii	isa detions div			ble Large	Emplo	ver Me	ember	(Empl	over)			
11	ame of employ	ee (first name,	middle initial, last	name)	2 Soci	al security number	(SSN) 7	Name of e								identifica	tion num	ber (EIN)
	orge Wash	CONTRACTOR OF THE PARTY OF THE	A Washin			111-11-11	11 A	BC Mfg.	Compa	ny					2	0-1234	1567	
3 5	treet address ()	ncluding apart	ment no.)				9	Street add	iress (includ	ding room or s	uite no.)			10	Contact to	elephone	number	
	4 America	n Drive			19			00 Alpha							100,00	0-555	1000	
	ity or town		5 State or provin	ce		try and ZIP or foreign		1 City or tov			State or pr	ovince				d ZIP or fo	reign post	al code
	hmond	Javas Off	VA er of Covera		45676)		irand Ra		h (enter 2-	dialt aus	abort.		149	503			
re	City	All 12 Months		Feb	Mar	Apr	May	June	_	July	Aug	Ser	× 1	Oct	- 1	Nov	ľ	Dec
	ffer of	1	-		111111						7109	- 50,			-		-	
	rage (enter red code)	1E				ji												
15 E Requ	mployee ired																	
Cont	ribution (see actions)	s 10	08	\$	\$	s	s	S	\$	\$		\$	s		s		\$	
	ection 4980H	1.5			_		<u> </u>	<u> </u>	_			-	Ť					
Safe Othe	Harbor and Relief (enter if applicable)	2C	Ì	Ī			i i											
Safe Othe code	Harbor and Relief (enter If applicable) Cov If Em	ered Indiv	vided self-insu						ach indiv	ridual enro		verage,	100 PM 110 PM	-	employe	ee. 🗶		
Safe Othe code	Harbor and r Relief (enter if applicable) Telli Cov If Em (a) Name	ered Indiv	vided self-insu dividual(s)		e, check the	e box and ente	other (d) Covere	d		ridual enro	(€	-	100 PM 110 PM	-	Sept	ee. 🗴	Nov	Dec
Safe Othe code Pa	Harbor and r Relief (enter if applicable) rt III Cov If Em (a) Name First name	ered Indiv pployer prove of covered in- e, middle initial	vided self-insu dividual(s) , last name	(b) SSN o	or other TIN	(c) DOB (if SSN or	other (d) Covere	d		7	(€) Months	of Covera	ige				Dec
Safe Othe code Pa	Harbor and r Relief (enter if applicable) Telli Cov If Em (a) Name	ered Indiv pployer prove of covered in- e, middle initial	vided self-insu dividual(s)	(b) SSN o		(c) DOB (if SSN or	other ble) (d) Covere all 12 month	d		7	(€) Months	of Covera	ige				Dec
Safe Othe code Pa	Harbor and r Relief (enter if applicable) rt III Cov If Em (a) Name First name	ered India poloyer proves of covered in e, middle initial	vided self-insu dividual(s) , last name	(b) SSN c	or other TIN	(c) DOB (if SSN or	other ble) (d) Covere all 12 month	d		7	(€) Months	of Covera	ige				Dec
Safe Other code Pa	Harbor and Relief (enter if applicable) rt III Cov If Em (a) Name First name	ered India poloyer proves of covered in e, middle initial	vided self-insu dividual(s) , last name Washington	(b) SSN c	or other TIN	(c) DOB (if SSN or	other (d) Covere all 12 month	d		7	(€) Months	of Covera	ige				Dec
Safe Other code Pa	Harbor and Relief (enter if applicable) rt III Cov If Em (a) Name First name	ered India poloyer proves of covered in e, middle initial	vided self-insu dividual(s) , last name Washington	(b) SSN c	or other TIN	(c) DOB (if SSN or	other (d) Covere all 12 month	d		7	(€) Months	of Covera	ige				Dec
Pa 117	Harbor and Relief (enter if applicable) rt III Cov If Em (a) Name First name	ered India poloyer proves of covered in e, middle initial	vided self-insu dividual(s) , last name Washington	(b) SSN c	or other TIN	(c) DOB (if SSN or	other (d) Covere all 12 month	d		7	(€) Months	of Covera	ige				Dec
Safe Other Cooker Part 117	Harbor and Relief (enter if applicable) rt III Cov If Em (a) Name First name	ered India poloyer proves of covered in e, middle initial	vided self-insu dividual(s) , last name Washington	(b) SSN c	or other TIN	(c) DOB (if SSN or	other (d) Covere all 12 month	d		7	(€) Months	of Covera	ige				Dec
Safe Othe code Pa	Harbor and Relief (enter if applicable) rt III Cov If Em (a) Name First name	ered India poloyer proves of covered in e, middle initial	vided self-insu dividual(s) , last name Washington	(b) SSN c	or other TIN	(c) DOB (if SSN or	other (d) Covere all 12 month	d		7	(€) Months	of Covera	ige				Dec

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

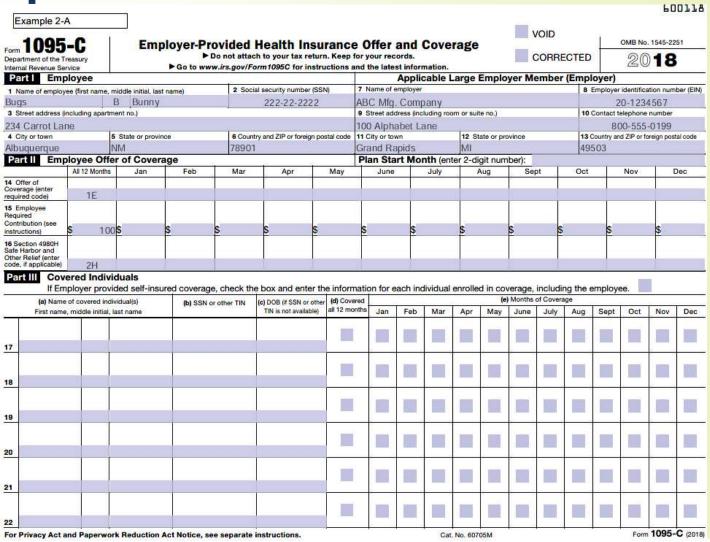
198			145																		ь	10118
E	Example 1-	В															/OID					
For	1095	-C		Emple	oyer-Prov								Cove	rage				2570902.0000	1	OMB No.		
	artment of the T			1	Go to www.i		7	your tax returi 195C for instru					mation.				CORR	ECTED	É	20	18	•
_	art I Em				77.7	40	0720,30						cable L	arge	Emplo	yer Me	embe	r (Emp	loyer)			
1	Name of employ	ee (first name	middle	initial, last na	ame)	2 Socia	l secu	rity number (SSI	N)	7 1	Name of e	mploye	r				-	8	Employer	r identifica	ition num	ber (EIN)
-	orge			Washingt	on		11	1-11-1111			C Mfg.								1	20-1234	4567	
3 !	Street address (including apart	ment no).)						9 5	Street add	ress (in	cluding roo	m or suit	e no.)			10	Contact t	telephone	number	
	34 America	n Drive	10			1					0 Alpha		ane	-						00-555-		
	City or town		5 State	e or province		-	y and	ZIP or foreign po	stal code		City or tow			MI St	ate or pro	vince.				nd ZIP or fo	reign pos	tal code
100000	chmond	ployee Off	A COLONY WHEN	Coverse	10	45676					and Ra	200111-0	nth (ent	2000	ait num	horl:		49	503			-
	LINE LINE	All 12 Month	_	Jan	Feb	Mar	7	Apr	May	7	June	LIVIO	July	-	Aug	Sei	nt	Oct	770	Nov	50	Dec
14	Offer of	All 12 Month	-	Dan	160	IVIDI	5/5	Apr	ividy	+	50116	-3	July	-	ing	00	P	OUL	-	1404	-	560
Cov	erage (enter iired code)	1E								Ú												
Req	Employee uired																				101	
	tribution (see ructions)	\$	S	100\$	100\$	10	0\$	100\$	10	0\$	- 1	00\$	11	0\$	110	\$	110		110\$	11	10\$	110
Safe	Section 4980H e Harbor and er Relief (enter e. if applicable)	2C																				
Pa		ered Indiv			d coverage,	check the	box	and enter th	e inform	nati	on for e	ach in	dividual	enrolle	d in cov	/erage,	includ	ing the	employ	ee. x		
		e of covered in e. middle initial			(b) SSN or o	ther TIN		OB (if SSN or other is not available)	(d) Cove all 12 mo		Jan	Feb	Mar	Apr	(e) May	Months	of Cover	age Aug	Sept	Oct	Nov	Dec
												_									-	
17	George	А	Wast	nington	111-11-	1111			×		9. J									3 8		
distri-	,								×		-											
18	Martha	Α	Wasl	nington	111-11-	1112				_	90					3, 3					9	
19									11	-							4	K			725	
20												1								1		
21										-												
22																						
For	Privacy Act	and Paperw	ork Re	duction Ac	t Notice, see	separate i	nstru	ictions.					Cat.	No. 607	05M			*1-	100	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
 - \rightarrow \$10 x 130 hrs = \$1,300; \$1,300 x .0956 = \$124.28
- Plan year: January 1 December 31

Example 2-A



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
 - \rightarrow \$19,500 x .0956 = \$1,864.20
 - Plan year: January 1 December 31

Example 2-B

None and the same																			ы	ידירוו
Example 2-	В														/OID					
_{om} 1095	-C	Em	ploy			Health Ins					Cove	rage			01/08/08/08/0			77177774	. 1545-22	7.70
epartment of the 1 itemal Revenue Se			►G			ch to your tax retu orm1095C for ins		-			mation.				CORR	ECTED	,	20	18	
Part I Em	oloyee	3								Appli	cable L	arge l	Emplo	yer Me	embe	r (Emp	loyer)	1		
1 Name of employ	yee (first name,	middle initial, la	st name)	2 Soci	al security number (S	SN)	7 N	vame of e	mployer						8	Employe	r identific	ation num	ber (EIN
Bugs		B Bunny	/	***		222-22-2222	2		C Mfg.									20-123		
3 Street address	including apart	ment no.)								15	cluding roo	m or suit	e no.)			10	Contact t	telephone	number	
34 Carrot La	ne							-	O Alpha		ane	-						00-555		
4 City or town		5 State or prov	rince		MANUFACTURED &	try and ZIP or foreign	postal code	100	City or tov			man and the first transfer	ate or pri	ovince		00%	Country ar	nd ZIP or f	oreign pos	tal code
Mbuquerque		NM			78901				and Ra			MI	-			49	503			
Part II Em		er of Cove	rage		200	1 2 1	-	Pla		rt Mo	nth (ent	_								
	All 12 Months	Jan	-	Feb	Mar	Apr	May	+	June		July	,	Aug	Se	pt	Oct	8	Nov		Dec
4 Offer of coverage (enter equired code)	1E	1	-0.0	-						- 17									-0.0	
5 Employee	12	T T						T		- 1		1		1	Î		T		1.7	
Required Contribution (see												Carl		i de						
structions)	\$ 108.3	3 \$	\$	\$		\$ \$		\$		\$		\$		\$		\$	S		\$	
	2F rered Indiv		sured o	coverage, c	heck the	e box and enter	the inform	natio	on for e	ach in	dividual	enrolle				400	employ	ee.		
	e of covered inc			(b) SSN or ot	her TIN	(c) DOB (if SSN or ot					recon			Months	10000	0.000	Personal State	1		1202
First nam	e, middle initial,	last name		19-11/20-10-12-12-12-12-12-12-12-12-12-12-12-12-12-		TIN is not available	all 12 mo	nths	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
											1				1	1				9
7										111		, manual,					, ament	,===		11
											Total State of the last of the	-			1					9
8								6					-			1	, See L			
															9				1	
9						·	1	2 3					_					_		
0						ľ		- 31					11.7							
1								Į												
2								<u>H</u>			1 1/2	10-11	-			1	10-11	#-3		
or Privacy Act	and Paperwo	ork Reduction	Act N	otice, see s	eparate	instructions.	778	30	. 3	*	Cat	No. 607	05M		dir.	65	AC 18	Forn	1095-	C (201

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-	1000														V	/OID		8			
1095	j-C	Er	nplo				ealth In					Cove	rage					. 2		. 1545-22	22-1
partment of the ' ernal Revenue S			٠				to your tax re 11095C for in	The second second	() () () () ()	he lates	t inform						ECTED		20	18	3
art I Em	ployee				38.				4			cable L	arge I	Emplo	yer Me	ember					
Name of emplo	yee (first name	munchasining (Alabahahas)		me)	2 5	Social se	ecurity number	(SSN)	100,000	ame of en							8	Employer	identifica	ation num	ber (E
igs		B Bun	19			2	222-22-222	2	1000000	C Mfg.	100								0-123		
Street address		tment no.)							100000	treet addr		The same of the same of	m or suit	e no.)			10	Contact to	1000000000		
4 Carrot La	ine	i	SAME OF STREET		12.5	CONTA TRANSP	- V March		of the state of the state of	Alpha		ane	Tree or		0000000				00-555	the second second	
City or town		5 State or pr	ovince		500000	EDITOR SERVICES	and ZIP or foreig	n postal code	100000000000000000000000000000000000000	ity or tow			THE RESIDENCE OF THE PARTY OF T	ate or pro	vince		3700	Country an	d ZIP or fo	oreign pos	tal cod
buquerque art II Em	ployee Of	NM			789	101			DOM: DOM: N	ind Rap		atla /ani	MI	alk manage	b and a		49	503			
Em	All 12 Month		erage	Feb	Ma	2	Apr	May	Pia	June	TIMOI	July		git num	Der):		Oct	-1	Nov		Dec
Offer of	All 12 MUNU	S Jan	- 10	ren	IVIA		Aþi	Ividy	9	June	- 0	July	36 36	uy	Sel	,,	OCI	-9-	NOV	0 3	Dec
verage (enter uired code)	1E																				
Employee quired ntribution (see																					
ructions)	\$ 10	00\$	\$		\$	\$	\$	S	\$		\$		\$		\$	S	ė.	\$		\$	
ection 4980H			\$ \$																		
e Harbor and er Relief (enter le, if applicable)	- F2	2H		2H	21-	1	2H	2H		2H		2H	1	2C	20		2C		2C		2C
e Harbor and er Relief (enter le, if applicable) ert III Cov If Er	vered Indi	viduals vided self-i	nsured	d coverag	ge, check	the b	2H oox and ente	r the inforn	-		ach ind			in cov		includi	ng the	employe			2C
If Er	vered Indi	viduals vided self-i idividual(s)	nsured	d coverag		the b	ox and ente	r the inform	ered		ech ind			in cov	verage,	includi	ng the	employe			2C De
e Harbor and er Relief (enter le, if applicable) art III Cov If Er (a) Nam First nam	vered Indi inployer pro se of covered in se, middle initia	viduals vided self-i dividual(s) I, last name	nsurec	(b) SSN	ge, check I or other TIN	the bo	ox and ente	r the inform	ered	n for ea		lividual	enrolled	d in cov	verage,	includi	ng the		ee. x		
e Harbor and er Relief (enter le, if applicable) ert III Cov If Er (a) Nam First nam	vered Indianployer pro	viduals vided self-i idividual(s)	nsurec	(b) SSN	ge, check	the bo	ox and ente	r the inform	ered	n for ea		lividual	enrolled	d in cov	verage,	includi	ng the eage	Sept	Oct	Nov	De
a Harbor and er Relief (enter e, if applicable) ert III Cov If Er (a) Nam First nam	vered Indi inployer pro se of covered in se, middle initia	viduals vided self-i dividual(s) I, last name	nsureo	(b) SSN	ge, check I or other TIN	the bo	ox and ente	r the inform	ered	n for ea		lividual	enrolled	d in cov	verage,	includi	ng the e	Sept	Oct	Nov	De
e Harbor and erer Relief (enter e, if applicable) art III Cov If Er (a) Nam First nam Bugs	wered India imployer pro se of covered in se, middle initia	viduals vided self-i idividual(s) I, last name Bunny	nsureo	(b) SSN	ge, check i or other Tif 22-2222	the bo	ox and ente	r the inform	ered	n for ea		lividual	enrolled	d in cov	verage,	includi	ng the eage	Sept	Oct	Nov	De
art III Cov If Errst nam First nam	wered India imployer pro se of covered in se, middle initia	viduals vided self-i idividual(s) I, last name Bunny	nsurec	(b) SSN	ge, check i or other Tif 22-2222	the bo	ox and ente	r the inform	ered	n for ea		lividual	enrolled	d in cov	verage,	includi	ng the eage	Sept	Oct	Nov	De
Harbor and er Relief (enter en Relief (en Relie	wered India imployer pro se of covered in se, middle initia	viduals vided self-i idividual(s) I, last name Bunny	nsurec	(b) SSN	ge, check i or other Tif 22-2222	the bo	ox and ente	r the inform	ered	n for ea		lividual	enrolled	d in cov	verage,	includi	ng the eage	Sept	Oct	Nov	De
art III Cov If Errst nam First nam	wered India imployer pro se of covered in se, middle initia	viduals vided self-i idividual(s) I, last name Bunny	nsurec	(b) SSN	ge, check i or other Tif 22-2222	the bo	ox and ente	r the inform	ered	n for ea		lividual	enrolled	d in cov	verage,	includi	ng the eage	Sept	Oct	Nov	De
e Harbor and ser Relief (enter le, if applicable) art III Cov If Er (a) Nam First nam Bugs	wered India imployer pro se of covered in se, middle initia	viduals vided self-i idividual(s) I, last name Bunny	nsurec	(b) SSN	ge, check i or other Tif 22-2222	the bo	ox and ente	r the inform	ered	n for ea		lividual	enrolled	d in cov	verage,	includi	ng the eage	Sept	Oct	Nov	De
e Harbor and erer Relief (enter e, if applicable) art III Cov If Er (a) Nam First nam Bugs	wered India imployer pro se of covered in se, middle initia	viduals vided self-i idividual(s) I, last name Bunny	nsurec	(b) SSN	ge, check i or other Tif 22-2222	the bo	ox and ente	r the inform	ered	n for ea		lividual	enrolled	d in cov	verage,	includi	ng the eage	Sept	Oct	Nov	De

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

																				ь	ومتالا
Examp	le 3-A	(i)														OID.					
om 10	95.	-C	Emp	loyer-			Health					Cove	rage						OMB No		120111
Department on Internal Rever				► Go to			h to your ta m1095C fo					mation.				CORRE	CTED		20	18	<u>V</u>
Part I	Empl	loyee			10 -					C10	Applic	cable l	arge I	Emplo	yer Me	ember	(Empl	oyer)			
1 Name of e	employe	e (first name,	middle initial, last	name)		2 Socia	al security num	ber (SSN	N) 7	Name of	employer		-		-		8 1	Employer	identifica	ition num	ber (EIN
George	11.00		A Washin	gton			111-11-	1111		BC Mfg								. 2	0-123	1567	
3 Street add	dress (in	cluding apart	ment no.)						9	Street ad	dress (inc	luding roo	m or suit	e no.)			10 (Contact t	elephone	number	
1234 Ame								-		00 Alph		ane							00-555		
4 City or tov			5 State or provin	ce			ry and ZIP or fo	reign pos		City or to			THE RESERVE OF THE PARTY OF THE	ate or pro	vince		1/955	947500	d ZIP or fo	reign pos	tal code
Richmono			VA		14	45678				rand Ra		-41- /	MI		h - A -		149:	503			
Part II	Empi	All 12 Months	er of Covera	ge Feb	18	Mar	Ann	- 1	May	lan Sta	_			git num lug	Der):		Oct	- 1	Mau	1 ,	Dec
14 Offer of	- 4	All 12 Monute	Jan	reb		war	Apr		way	June	4	July	,	lug	26	,,	OCI	- 8	Nov	4 -	Dec
Coverage (ent equired code		1K											10								
5 Employee Required																					
Contribution (nstructions)		10	0\$	\$	\$		\$	\$		\$	\$		\$		\$	s		\$		\$	
	HOSE																				
safe Harbor a Other Relief (e	and enter	20			10		-						10		7			1/2			
Safe Harbor a Other Relief (e ode, if applic	enter cable)	2C ered Indiv	riduals rided self-insu	red cove	erage, che	eck the	e box and e	nter the	e informat	tion for e	each inc	dividual	enrolled	d in cov	/erage,	includi	ng the e	employe	ee. X		
Safe Harbor a Other Relief (e ode, if applic Part III	Cove If Emp	ered Indiv ployer prov of covered ind	vided self-insu dividual(s)	- T	erage, che		(c) DOB (if SSN	or other	(d) Covered				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155		
Safe Harbor a Other Relief (e code, if applic Part III	Cove If Emp	ered Indiv	vided self-insu dividual(s)	- T			8	or other		i	each inc	dividual Mar	enrolled			tal con-	. 10	employe	ee. X	Nov	Dec
Safe Harbor a Other Relief (e code, if applic Part III	Cove If Emp	ered Indiv ployer prov of covered ind	vided self-insu dividual(s)	- T			(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
safe Harbor a other Relief (e ode, if applic Part III	Cove If Emp Name out	ered Indiv ployer prov of covered ind middle initial.	rided self-insu Ilvidual(s) last name	(b) S	SN or other	TIN	(c) DOB (if SSN	or other	(d) Covered				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
Safe Harbor a Other Relief (e code, if applic Part III	Cove If Emp Name out	ered Indiv ployer prov of covered ind middle initial.	vided self-insu dividual(s)	(b) S		TIN	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
safe Harbor a other Relief (e ode, if applic Part III	Cove If Emp Name out	ered Indiv ployer prov of covered ind middle initial.	rided self-insu Ilvidual(s) last name	(b) S	SN or other	TIN	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
iafe Harbor a ther Relief (c ode, if applic Part III (a) Firs 7 Georg	Cove If Emp) Name of at name,	ered Individual Provider Provi	rided self-insu Ilvidual(s) last name	(b) S	SN or other	TIN 11	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
Safe Harbor a Other Relief (e ode, if applic Part III (a) Firs 7 Georg	Cove If Emp) Name of at name,	ered Individual Provider Provi	vided self-insu dividual(s) last name Washington	(b) S	SN or other	TIN 11	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
safe Harbor is safe Harbor is other Relief (e ode, if applied First III (a) First 7 Georg 8 Marth:	Cove If Emp) Name of at name,	ered Individual Provider Provi	vided self-insu dividual(s) last name Washington	(b) S	SN or other	TIN 11	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
safe Harbor is safe Harbor is other Relief (e ode, if applied First III (a) First 7 Georg 8 Marth:	Cove If Emp) Name of at name,	ered Individual Provider Provi	vided self-insu dividual(s) last name Washington	(b) S	SN or other	TIN 11	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
safe Harbor is safe Harbor is other Relief (e ode, if applied First III (a) First 7 Georg 8 Marth:	Cove If Emp) Name of at name,	ered Individual Provider Provi	vided self-insu dividual(s) last name Washington	(b) S	SN or other	TIN 11	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
safe Harbor e stafe Harbor e stafe Harbor e stafe feeded, if applie Part III (a) Firs 7 Georg 8 Marth:	Cove If Emp) Name of at name,	ered Individual Provider Provi	vided self-insu dividual(s) last name Washington	(b) S	SN or other	TIN 11	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
safe Harbor e sharbor e sh	Cove If Emp) Name of at name,	ered Individual Provider Provi	vided self-insu dividual(s) last name Washington	(b) S	SN or other	TIN 11	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
safe Harbor e sharbor e sh	Cove If Emp) Name of at name,	ered Individual Provider Provi	vided self-insu dividual(s) last name Washington	(b) S	SN or other	TIN 11	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
safe Harbor e Marthor e Martha (a) First III (a) First III (a) First Martha (a) Martha (Cove If Emp) Name of at name,	ered Individual Provider Provi	vided self-insu dividual(s) last name Washington	(b) S	SN or other	TIN 11	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
(a) Firs	Cove If Emp) Name of at name,	ered Individual Provider Provi	vided self-insu dividual(s) last name Washington	(b) S	SN or other	TIN 11	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec
Safe Harbor a Dither Relief (e bode, if applic Part III (a) Firs 17 Georg 18 Marth:	Cove If Emp) Name of at name,	ered Individual Provider Provi	vided self-insu dividual(s) last name Washington	(b) S	SN or other	TIN 11	(c) DOB (if SSN	or other	(d) Covered all 12 month				- 25 - 1	(e)	Months	of Covers	ige	-	JG. 155	Nov	Dec

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

n 1095-(partment of the Treas rmal Revenue Service Part II Employ																			
artment of the Treas mal Revenue Service	C	Empl			Health Ir					Cove	rage			/OID			OMB No		Sier_
art Employ	sury				to your tax in the second of t		200			nation.				ORRE	ECTED	Đ.	20	18	3
	yee			333				Α	pplic	cable L	arge E	mplo	yer Me	ember	(Emp	loyer)			
Name of employee (f	first name, m	iddle initial, last n	ame)	2 Soci	al security number	er (SSN)	7 Nan	ne of em	ployer						8	Employer	identifica	ation num	ber (
orge	1	Washing	ton		111-11-11	11	ABC	Mfg. 0	Comp	any						2	0-123	4567	
treet address (inclu	ding apartme	nt no.)		- 22			9 Stre	et addre	ss (incl	luding roo	m or suite	no.)			10	Contact t	elephone	number	
4 American D	Drive						100 A	Mphab	et La	ine						8	00-555	-0199	
City or town	5	State or province	Ė.	6 Count	try and ZIP or fore	gn postal code	11 City	or town			12 Sta	te or pro	vince		13	Country an	d ZIP or fo	reign pos	tal co
hmond	V	A		45678	3		Gran	d Rap	ids		MI				49	503			
ert II Employ	yee Offer	of Coverag	je		32	80	Plan	Start	Mor	nth (ent	er 2-dig	git num	ber):						
A	II 12 Months	Jan	Feb	Mar	Apr	May	3 0	June	13	July	A	ug	Seg	ot	Oct	3	Nov		Dec
Offer of erage (enter	41				- I		8		-					- 1		- 5		- E	
ired code) Employee	1.J								T									Ť	
uired tribution (see	100	•		6	¢	c	9		4		¢		¢:	6		6		4	
ection 4980H	100	2 4			Ψ	-	-		Ψ.		Ψ.		۳		9	-		Ψ	
Harbor and																			
er Relief (enter le, if applicable)	2C																		
If Emplo		luals led self-insure	ed coverage.	check the	e box and ent	er the inform	nation	for eac	ch ind	lividual i	enrolled	f in cov	erage.	includi	na the e	employe	ee. X	1	
(a) Name of o	covered indiv	idual(s)	(b) SSN or		(c) DOB (if SSN o	r other (d) Cove	ered					(e)	Months	of Cover	age			Trees.com	1 25
First name, mi	iddle initial, fa	st name	200	-	TIN is not avail	able) all 12 mo	nins	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	D
						×													
George	A V	/ashington	111-11	-1111		100	1	-						-					-
Coorge	13.	asimigron							- 3							i i	8		
1						×													
	A V	/ashington	111-11	-1112		70						-	-						1
Martha		The state of the s	- Alata da la				-	- 1					7		_	t —			\vdash
Martha										!	l l								
Martha																			
Martha																			
Martha																			
Martha																			
Martha																			
Martha																			
Martha																			
Martha																			
Martha																			
Martha																			

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

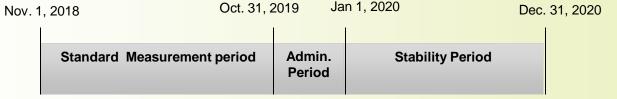
New Employee Initial Determination



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 <u>full-time</u> 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																		
1095	- MEDIT - 100	 En	nplo	yer-Pı	rovided	Health Ins	urance	Offer	and	Cove	rage		V	/OID		L	OMB No.	. 1545-22	251
epartment of the ternal Revenue S	Treasury	- Facility				ch to your tax re	10 miles 55	EE A. 100 U.S.		mation.	east e ea			CORRE	CTED	10	20	18	3
Part I Em	0.73.00.00.00.00.00.00.00.00.00.00.00.00.00		-						11111111111111111	cable L	arge	Emplo	ver Me	ember	(Empl	loyer)			
Name of emplo	oyee (first name	, middle initial,	last nan	ne)	2 Soc	al security number	SSN)	7 Name of	mployer		-				8	Employer	dentifica	ition num	ber (El
hn		C Doe		-Va		333-33-333	3	ABC Mfg	Com	oanv						2	20-1234	4567	
Street address	(including apart	tment no.)			-			9 Street add			om or suit	e no.)			10		elephone		1
6 Unknow	n Drive							100 Alph	abet La	ane						80	00-555	0199	
City or town		5 State or pro	vince		6 Cour	try and ZIP or foreign		11 City or to			12 St	ate or pro	vince		13		nd ZIP or to		tal cod
ywhere		MI			46789	9		Grand Ra	pids		MI				49	503			
7	ployee Of		erage	•		ar.		Plan Sta	47300000	nth (ent	2000	ait num	ber):		- 1				
- E. 111	All 12 Month			Feb	Mar	Apr	May	June		July	-	ug	Ser	ot	Oct		Nov	1 7	Dec
Offer of			- 45		4	-			-		-					-		-	
verage (enter uired code)	i.	1H	- 17	1H	1H	1H	1H	1H	100	1E	1	1E	18		1E		1E	Y 3	1E
Employee								1					-					1	
quired						_													
ntribution (see ructions)	s	S	\$		\$	\$	ŝ	s	\$	10	00\$	100	\$	1005		100\$	10	00\$	1
ection 4980H		7	- 20		2				1.50		2					118		- 22	
					1														
e Harbor and			_								-					_		-	
e Harbor and er Relief (enter de, if applicable)	2A		2A	2A	2D	2D	2D		2C	1	2C	20		2C		2C	1 3	2C
e Harbor and ler Relief (enter de, if applicable	vered Indi	viduals	sured			2D e box and ente	the inform	ation for e	ach inc	voca v stanova		d in cov	erage,	includi	ng the	employe	192	221	2C
e Harbor and er Relief (enter de, if applicable ert III Co If E (a) Nan	vered Indi	viduals vided self-ir dividual(s)	nsured	coverag			the inform	ation for e	ach inc	voca v stanova	enrolle	d in cov	erage,	includio of Covers	ng the e	1	192	221	
e Harbor and ner Relief (enter de, if applicable art III Co If E (a) Nan	vered Indiv	viduals vided self-ir dividual(s)	nsured	coverag	je, check th	e box and ente	the inform	ation for e	255.75	dividual		d in cov	erage, Months	includi	ng the	employe	ee. 🗶		2C
e Harbor and er Relief (enter de, if applicable ert III Co If E (a) Nan	vered Indiv	viduals vided self-ir dividual(s)	sured	coverag	je, check th	e box and ente	the inform	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De
e Harbor and er Relief (enter le, if applicable art III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	sured	(b) SSN	ge, check th or other TIN	e box and ente	the inform	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers	ng the e	1	ee. 🗶		De
fe Harbor and her Relief (enter de, if applicable art III Co	vered Indiv	viduals vided self-ir dividual(s)	sured	(b) SSN	je, check th	e box and ente	the inform	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	
e Harbor and er Relief (enter le, if applicable ert III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	nsured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De
e Harbor and er Relief (enter le, if applicable art III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	asured	(b) SSN	ge, check th or other TIN	e box and ente	the inform	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De
e Harbor and er Relief (enter le, if applicable art III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	nsured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De
e Harbor and er Relief (enter le, if applicable art III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	sured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De
a Harbor and er Relief (enter e, if applicable art III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	sured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	D
e Harbor and er Relief (enter le, if applicable ert III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	esured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	D
Harbor and er Relief (enter e, if applicable IT III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	esured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De
Harbor and er Relief (enter e, if applicable IT III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	sured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	D
e Harbor and er Relief (enter le, if applicable art III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	sured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De
e Harbor and her Relief (enter te, if applicable art III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	sured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De
e Harbor and her Relief (enter te, if applicable art III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	sured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De
e Harbor and her Relief (enter te, if applicable art III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	asured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De
e Harbor and er Relief (enter le, if applicable art III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	asured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De
e Harbor and er Relief (enter le, if applicable art III Co If E (a) Nan First nan	pvered India mployer pro- ne of covered in ne, middle initial	viduals vided self-in dividual(s) , last name	asured	(b) SSN	ge, check th or other TIN	e box and ente	the inform (d) Cover all 12 mon	ation for e	255.75	dividual	enrolle	d in cov	erage, Months	includio of Covers July	ng the e ge Aug	Sept	ee. X	Nov	De

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																ьц	נידח
1095		 Em	ployer	-Provided	Health Insu	rance (Offer	and	Cove	rage		N.	/OID		\perp	OMB No	. 1545-22	51
epartment of the	Treasury	300000	▶ Go to		ach to your tax retur Form 1095C for instr		The second second		mation.	NOT THE			CORRE	CTED		20	18	
arti Em		77.	(5.1957)						cable L	arge	Emplo	yer Me	ember	(Emp	loyer)	56111-54	100000	
Name of emplo	yee (first name,	middle initial, la	ast name)	2 So	cial security number (SS	N) 7 1	Name of	employer		- 1				8	Employer	dentifica	ation num	ber (
hn		C Doe			333-33-3333	AB	C Mfg	. Comp	oany						2	20-123	4567	
Street address	(including apart	ment no.)		88		9 :	Street ad	dress (inc	luding roo	m or suit	te no.)			10	Contact t	elephone	number	
5 Unknown	Drive					10	0 Alph	abet La	ane						80	00-555	-0199	
City or town		5 State or pro	vince	6 Cou	intry and ZIP or foreign po	ostal code 11	City or to	wn		12 St	ate or pro	vince		13	Country an	nd ZIP or fo	reign pos	tal co
ywhere		MI		4678	39	Gr	and Ra	pids		MI				49	503			
art II Em	ployee Off	er of Cove	erage			PI	an Sta	rt Mo	nth (ent	er 2-di	git num	ber):						
10	All 12 Months	s Jan	Fet) Mar	Apr	May	June	0 17	July	1	Aug	Sep	ot	Oct		Nov		Dec
Offer of verage (enter		94	12	*	9	88		- 12		18	· ·		9		- 50		2	
verage (enter uired code)		1H	1H	I 1H	1H	1E	1E		1E	- 2	1E	16		1E		1E		1E
Employee quired	- PC:	8	2.0	36	3			23		36					86		88	
ntribution (see	\$	s	\$	\$	s s	100\$		100\$	10	0\$	100	\$	100\$	15	100\$	10	00\$	- 23
Section 4980H e Harbor and er Relief (enter									15200		A-CLE I							LPSOVOIII
de, if applicable)		2D	20	2D	2D	2C	2C		2C	1	2C	20	3	2C		2C		2C
	vered Indiv mployer prov		sured cov	erage, check t	he box and enter th	ne informati	on for e	ach inc	dividual	enrolle	d in cov	verage,	includir	ng the	employ	ee. ×		
7.7	ne of covered in		(b)	SSN or other TIN	(c) DOB (if SSN or othe	(d) Covered all 12 months		17.722.4	no serec	D1 20 50 10		Months		A	I construction	923000	1 30 000	
First nam	ne, middle initial	, last name			TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	De
10.000		2									×	×	×	×	×	×	×	*
John	С	Doe	3.	33-33-3333					90	0 0				K.	10 S			
						-												į,
		3			8													
																The state of		
																		-
																		l
		5																
																		L
	07/2				* 0 00				25 5.5	No. 10	-				Ų,	Form	1005	

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

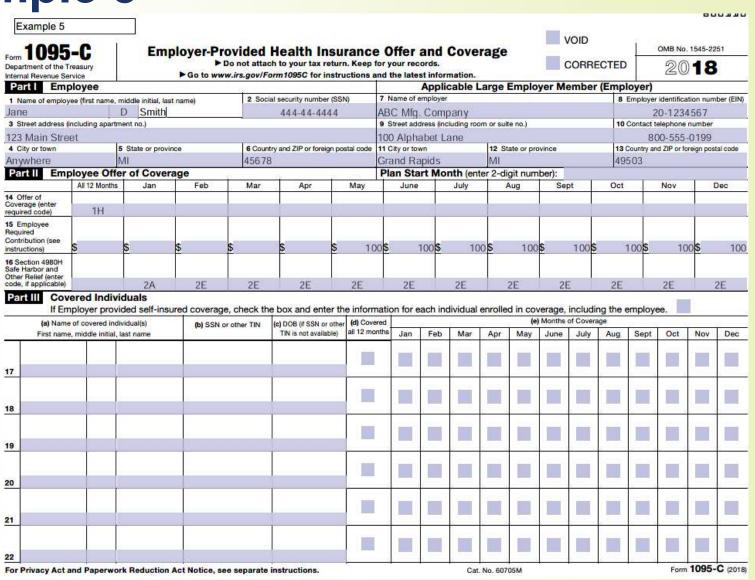
Example 4	D	- 9																		ы	
		En	ıplo	yer-P	rovide	d H	lealth In	surance	e 0	ffer a	and (Cove	rage			OID			OMB No	. 1545-2:	251
partment of the	Treasury		•				to your tax re		100			nation.				ORRE	CTED	K T	20	18	3
art I Em			757.8	(T107)						1919-1919-19		cable L	arge I	mplo	yer Me	ember	(Empl	loyer)			
Name of emplo	vee (first name,	middle initial, I	ast nan	ne)	2	Social	security number	(SSN)	7 N	lame of er	mployer			•			8	Employer	identifica	ation nun	nber (
hn		C Doe					333-33-333	33	AB	C Mfg.	Comp	anv						2	0-123	4567	
Street address	including apart	ment no.)			68				9 S	treet add	ress (inc	luding roo	m or suit	e no.)			10	Contact t	elephone	number	
Unknown	Lane								100) Alpha	bet La	ane						80	00-555	-0199	
City or town		5 State or pro	vince		60	country	and ZIP or foreig	n postal code	11 C	ity or tow	n		12 St	ate or pro	vince		13	Country an	d ZIP or fo	oreign pos	tal c
ywhere		MI			45	678			Gra	and Ra	pids		IM				49	503			
rt II Em	ployee Off	er of Cove	erage	9	90				Pla	an Star	rt Mor	nth (ent	er 2-di	git num	ber):		- 0				
	All 12 Months	Jan		Feb	M	ır	Apr	May		June		July	1	ug	Sep	t	Oct		Nov		Dec
Offer of erage (enter uired code)	1H		36						- 4		- 18					- 2		8		16	
Employee uired tribution (see		*	38								- 18									-16	
uctions)	s	\$	\$		\$		\$	s	\$		\$		\$		\$	s		\$		\$	
Harbor and er Relief (enter		92.0		246	123	110		25275									2017		SIGN.		-
Harbor and er Relief (enter e, if applicable)	oved ladio	2A		2A	2)	2B	2B									2B		2B		2B
Harbor and er Relief (enter e, if applicable)		iduals	sured		onen. Warren	DANG-SAE	2B box and ente	er the inform	-	on for ea	ach inc	lividual	enrolle	7000		00000000	ng the e	employe			2B
e Harbor and er Relief (enter e, if applicable) ITE III Cov If Er (a) Nam	nployer prove e of covered inc	riduals rided self-in tividual(s)	sured	l covera	onen. Warren	the l		er the inform	red	on for ea	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			(e)	Months	of Covers	ng the e		ee.		28
e Harbor and er Relief (enter e, if applicable) ITE III Cov If Er (a) Nam	nployer prov	riduals rided self-in tividual(s)	sured	l covera	ge, chec	the l	box and ente	er the inform	red		ach inc	dividual Mar	enrolled Apr	7000		00000000	ng the e	Sept		Nov	
Harbor and er Relief (enter e, if applicable) Int III Cov If Er (a) Nam	nployer prove e of covered inc	riduals rided self-in tividual(s)	sured	l covera	ge, chec	the l	box and ente	er the inform	red		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			(e)	Months	of Covers	ng the e		ee.		
e Harbor and er Relief (enter e, if applicable) ITE III Cov If Er (a) Nam	nployer prove e of covered inc	riduals rided self-in tividual(s)	sured	l covera	ge, chec	the l	box and ente	er the inform	red		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			(e)	Months	of Covers	ng the e		ee.		
e Harbor and er Relief (enter e, if applicable) ITE III Cov If Er (a) Nam	nployer prove e of covered inc	riduals rided self-in tividual(s)	sured	l covera	ge, chec	the l	box and ente	er the inform	red		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			(e)	Months	of Covers	ng the e		ee.		
e Harbor and er Relief (enter e, if applicable) ert III Cov If Er (a) Nam	nployer prove e of covered inc	riduals rided self-in tividual(s)	sured	l covera	ge, chec	the l	box and ente	er the inform	red		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			(e)	Months	of Covers	ng the e		ee.		
e Harbor and er Relief (enter e, if applicable) ert III Cov If Er (a) Nam	nployer prove e of covered inc	riduals rided self-in tividual(s)	sured	l covera	ge, chec	the l	box and ente	er the inform	red		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			(e)	Months	of Covers	ng the e		ee.		
e Harbor and er Relief (enter e, if applicable) ITE III Cov If Er (a) Nam	nployer prove e of covered inc	riduals rided self-in tividual(s)	sured	l covera	ge, chec	the l	box and ente	er the inform	red		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			(e)	Months	of Covers	ng the e		ee.		
Harbor and FRelief (enter e, if applicable) ITI Cov If Er (a) Nam	nployer prove e of covered inc	riduals rided self-in tividual(s)	sured	l covera	ge, chec	the l	box and ente	er the inform	red		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			(e)	Months	of Covers	ng the e		ee.		
e Harbor and er Relief (enter e, if applicable) ITE III Cov If Er (a) Nam	nployer prove e of covered inc	riduals rided self-in tividual(s)	sured	l covera	ge, chec	the l	box and ente	er the inform	red		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			(e)	Months	of Covers	ng the e		ee.		
e Harbor and er Relief (enter e, if applicable) ITE III Cov If Er (a) Nam	nployer prove e of covered inc	riduals rided self-in tividual(s)	sured	l covera	ge, chec	the l	box and ente	er the inform	red		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			(e)	Months	of Covers	ng the e		ee.		
(a) Nam	nployer prove e of covered inc	riduals rided self-in tividual(s)	sured	l covera	ge, chec	the l	box and ente	er the inform	red		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			(e)	Months	of Covers	ng the e		ee.		

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 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																ידידו
1095	i-C	Em			Health In				verage	•		/OID			OMB No	. 1545-22	251
partment of the Ternal Revenue Se					ch to your tax re orm1095C for in		7 1 Table 1		on.			CORRE	CTED		20	18	}
Part I Em	ployee	10						Applicab	le Large	Emplo	yer Me	ember	(Emp	loyer)			
Name of emplo	yee (first name,	middle initial, la	st name)	2 Soc	ial security number	(SSN)	7 Name of e	mployer	1.6	11110	-		8	Employer	identifica	ation num	ber (Ell
erald		R Ford			555-55-555	5	ABC Mfg.	Compan	у					2	0-123	4567	
Street address	(including apart	ment no.)					9 Street add	ress (includir	g room or su	ite no.)			10	Contact t	elephone	number	
956 Universi	ity Drive						100 Alpha	bet Lane						80	00-555	-0199	
City or town		5 State or prov	ince	1100000000	ntry and ZIP or foreign	n postal code	11 City or tov	m	0.000000	tate or pr	ovince		100004	Country an	d ZIP or to	oreign post	tal code
nn Arbor		MI		4810	3		Grand Ra		MI				49	503			
Part II Em	ployee Off	er of Cove	rage	777 **********************************	W. 0000		Plan Sta	rt Month	(enter 2-c	ligit num	nber):						
-7	All 12 Months	Jan	Feb	Mar	Apr	May	June	Ju	у	Aug	Sep	ot	Oct	1	Nov		Dec
4 Offer of overage (enter equired code)		1E	1E	1E	1E	1E	1E	11		1E	11	1	1H		1H		1H
5 Employee equired																.5	
ontribution (see structions)	s	S	\$	\$	\$	s 10	008 1	00\$	100\$	100	\$	S		S		\$	
Section 4980H afe Harbor and ther Relief (enter																	
de Manuellandela)	100	00	00	200	0.0	200	0.0			200		0 10	7.6		0.0	(5)	0.8
A STATE OF THE STA		2C	2C	2C	2C	2C	2C	20		2B	2/	4	2A		2A		2A
Part III Cov	vered Indiv	viduals			2C ne box and ente	r the inform	nation for e	recte more above	ene provincian	ed in co	verage,	includir	ng the e	employe			2A
Part III Cov If En	vered Indiv nployer prove e of covered inc	viduals vided self-ins dividual(s)	sured coverag		e box and ente	r the inform	nation for e	ach individ	lual enrolle	ed in co	verage,) Months	includir of Covers	ng the e	100	е. х		
Part III Cov If En	vered Indiv	viduals vided self-ins dividual(s)	sured coverag	ge, check th	ne box and ente	r the inform	nation for e	ach individ	ene provincian	ed in co	verage,	includir	ng the e	employe			
If En (a) Nam First nam	vered Indiv nployer proviet of covered incide, middle initial	riduals vided self-ins dividual(s) , last name	(b) SSN	ge, check th	e box and ente	r the inform	nation for e	ach individ	lual enrolle	ed in co	verage,) Months	includir of Covers	ng the e	100	е. х		2A Dec
Part III Cov If En (a) Nam First nam	vered Indiv nployer prove e of covered inc	viduals vided self-ins dividual(s)	(b) SSN	ge, check th	e box and ente	r the inform	nation for e	Feb N	ar Apr	ed in co	verage,) Months June	includir of Covers July	ng the e	100	е. х		
Cart III Cov If En (a) Nam First nam	vered Indiv nployer proviet of covered incide, middle initial	riduals vided self-ins dividual(s) , last name	(b) SSN	ge, check th	e box and ente	r the inform	nation for e	Feb N	ual enrolle ar Apr	ed in co (e May	verage,) Months June	includir of Covers July	ng the e	100	е. х		
Cart III Cov If En (a) Nam First nam	vered Indiv nployer provi- e of covered ince, middle initial	viduals vided self-ins dividual(s) , last name	(b) SSN	ge, check the or other TIN	e box and ente	r the inform	nation for e	Feb N	ar Apr	ed in co	verage,) Months June	includir of Covers July	ng the e	100	е. х		
Cov. If Er. (a) Nam. First nam. Gerald Betty	vered Indiv nployer provi- e of covered ince, middle initial	viduals vided self-ins dividual(s) , last name	(b) SSN	ge, check the or other TIN	e box and ente	other (d) Cove all 12 mo	nation for e	Feb N	ar Apr	ed in co	verage,) Months June	includir of Covers July	ng the e	100	е. х		
Cov. If Er. (a) Nam. First nam. Gerald Betty	vered Indiv nployer provi- e of covered ince, middle initial	viduals vided self-ins dividual(s) , last name	(b) SSN	ge, check the or other TIN	e box and ente	other (d) Cove all 12 mo	nation for e	Feb N	ar Apr	ed in co	verage,) Months June	includir of Covers July	ng the e	100	е. х		
Covered III Covere	vered Indiv nployer provi- e of covered ince, middle initial	viduals vided self-ins dividual(s) , last name	(b) SSN	ge, check the or other TIN	e box and ente	other (d) Cove all 12 mo	nation for e	Feb N	ar Apr	ed in co	verage,) Months June	includir of Covers July	ng the e	100	е. х		
If En (a) Nam First nam 7 Gerald 8 Betty	vered Indiv nployer provi- e of covered ince, middle initial	viduals vided self-ins dividual(s) , last name	(b) SSN	ge, check the or other TIN	e box and ente	other (d) Cove all 12 mo	nation for e	Feb N	ar Apr	ed in co	verage,) Months June	includir of Covers July	ng the e	100	е. х		
Cov. If En. (a) Nam First nam Gerald Betty	vered Indiv nployer provi- e of covered ince, middle initial	viduals vided self-ins dividual(s) , last name	(b) SSN	ge, check the or other TIN	e box and ente	other (d) Cove all 12 mo	nation for e	Feb N	ar Apr	ed in co	verage,) Months June	includir of Covers July	ng the e	100	е. х		

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

8																				ы	פיריוונ
	mple 6-	1 1922 77	C C	Empl	over-Pro	vided	Hea	alth Insu	rance (Offer	and	Cove	rage		\	/OID		f -	OMB No.	1545-2	251
Departm	ent of the T	reasury			► D	o not atta	ch to y	your tax retur	n. Keep for	your red	ords.					CORRE	CTED		20	18	3
	Em	A-100-1-1-1			40 10 11 11	r.ii d.govii	O mile	occ ici mou	otiono una	the rate			arge	Employ	er Me	ember	(Emp	lover)	011111111		
		yee (first name,	middle	initial, last n	ame)	2 Soc	ial secu	urity number (SS	N) 7	Name of									r identificat	tion nun	nber (EIN
Gerale	DESCRIPTIONS	SECONOMIC TO SEC	0000000000	Ford	70107		55	5-55-5555	AE	C Mfa	. Comi	oanv						-1-0	20-1234	567	
3 Stree	et address (including apart	ment n	0.)			172000		9	Street ad	dress (inc	luding roo	om or suit	te no.)			10	Contact	telephone i	number	è
1955	Universi	ty Drive							10	0 Alph	abet L	ane						8	00-555-	0199	
4 City	or town		5 Stat	e or province	•	6 Cour	ntry and	ZIP or foreign po	stal code 11	City or to	wn		12 St	ate or pro	vince		13	Country as	nd ZIP or for	eign pos	stal code
Ann A		7.0	MI			4810	3	1944		and Ra			MI				49	503			
Part	Em	ployee Off	_				-	10	P				_	git numl		i i		-		,	
		All 12 Months		Jan	Feb	Mar		Apr	May	June		July	,	Aug	Se	ot	Oct		Nov] 17	Dec
14 Offer Coverage required	e (enter	1E																			
15 Empl Required Contribut Instruction	tion (see	s	s	100\$	100	\$ 1	00\$	100\$	100\$		100\$	10	00\$	100	\$	100\$		500 \$	60	0\$	600
6 Section Safe Har Other Re	on 4980H bor and elief (enter applicable)			2C	2C	2C		2C	2C	2C	Ī	2C		2C	20						
Part I	100000000000000000000000000000000000000	ered Indiv			ed coverage	, check th	ne box	and enter th	e informati	ion for e	each inc	dividual	enrolle				-	employ	ee. x	ĺ_	
	7000 mm	e of covered inc e, middle initial		2.6/11	(b) SSN or	other TIN		OB (if SSN or other is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of Covers July	Aug	Sept	Oct	Nov	Dec
			_							×	×	×	×	×	×	×	×	×			
17 Ge	erald	R	Ford		555-55	1-5555	T														
18 Be	tty	A	Ford		555-55	-5556				×	×	×	×	×	×	×	×	×			
10 10	chael	G	Ford		555-55	×6667				×	×	×	×	×	×	×	×	×			
19 Mi	CHaei		rotu		333-33	1-3337				×	×	×	×	×	×	×	×	×		-	
20 Ja	ck	G	Ford		555-55	-5558							Real					Real		1 1	
21 Ste	even	M	Ford		555-55	:5559				×	×	×	×	×	×	×	×	×			
. Call	ar v tari i	IVI	· oru		333-33	7333				×	×	×	×	×	×	×	×	×			
22 Su	san	E	Ford		555-55	-5550				(CASSIS)	IOSOUIL	independ.	154550	pistore	(A)	1000sm	TOBON.	massa	, married		1
For Dri	vacy Act	and Panerwo	rk Ro	duction A	t Notice, se	senarate	instr	ections.	27		100	Cat	No. 607	05M			.00	10 3	Form	1095	-C (201

1094-C Example

Example 7 (page 1)

Example 7 - page 1]	-		15011
and the second of the second	Transmittal of Employer	Provided Health In	surance Offer and	CORRECTED OMB No. 1545-2251
_{om} 1094-C				
Department of the Treasury		e Information Return 1094C for instructions and the		2018
nternal Revenue Service			latest information.	
1 Name of ALE Member (Emple	arge Employer Member (ALE Memb	erj	2 Employer identification number (EIN)	
ABC Mfg. Company	yes		20-1234567	
3 Street address (including roo	m or suite no.)		20-1234307	
00 Alphabet Lane				
4 City or town		5 State or province	6 Country and ZIP or foreign postal code	
Grand Rapids		MI	49503	
7 Name of person to contact			8 Contact telephone number	
Jay Smith			800-555-0199	
9 Name of Designated Governi	nent Entity (only if applicable)		10 Employer identification number (EIN)	
11 Street address (including roo	m or suite no.)			For Official Use Only
12 City or town		13 State or province	14 Country and ZIP or foreign postal code	
				ппппп
15 Name of person to contact		5 3 .79	16 Contact telephone number	
17 Reserved		Example 7 - page	1	
18 Total number of Form	s 1095-C submitted with this transmittal			▶ 150
19 Is this the authoritative	e transmittal for this ALE Member? If "Yes	" check the box and continu	ue. If "No," see instructions	25 26 26 26 26 26 26 26 26 26 26 26 26 26
Part II ALE Member			PH 1072, THE HILLSON PER	
20 Total number of Form	s 1095-C filed by and/or on behalf of ALE	Member		150
				100
21 Is ALE Member a mer	nber of an Aggregated ALE Group?		F 20 20 20 20 20 20 20 20 20 20 20 20 20	Yes N
If "No," do not comple	ete Part IV.			
22 Certifications of Elig	ibility (select all that apply):			
A. Qualifying Offer	Method B. Reserved	C. Re	served	. 98% Offer Method
Inder penalties of perjury, I d	eclare that I have examined this return and acc	ompanying documents, and to t	he best of my knowledge and belief, they a	re true, correct, and complete.
· ·		Chief Financial Of	ficer	
Signature		Title	* 1	Date
or Privacy Act and Paperw	ork Reduction Act Notice, see separate inst	ructions	Cat No 61571A	Earn 1094-C (20)

Example 7 (page 2)

om 1094-C (2018) Part III ALE Member	Information - N	onthly	700	35	io 241	
	(a) Minimum Ess Offer In	ential Coverage	(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	Employee count to the liveribe	TO THE MEMBER	aroup molector	
23 All 12 Months	×				×	
4 Jan			147	165		
5 Feb			147	165		
6 Mar						
27 Apr			146	164		
			149	167		
28 May			149	167	**************************************	
g June			148	170		
o July						
			142	164		
1 Aug			142	164		
2 Sept			142	168		
3 Oct			143	169		
ALC:			145	109		
Nov Nov			143	169	A-1	
35 Dec						
UNIX SECTION L		J.	143	169	· · · · · · · · · · · · · · · · · · ·	

Form 1094-C (2018)

Example 7 (page 3)

Example 7 - page 3

Form 1094-C (2018)

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	
87 L&M Company	11-1111112	52	
3		53	
9		54	
0		55	
1		56	
2		57	
3		58	
4		59	
5		60	
6		61	
7		62	
8		63	
9		64	
0		65	

Form 1094-C (2018)

Questions & Answers

Thank you!

Norbert F. Kugele Warner Norcross + Judd LLP nkugele@wnj.com 616.752.2186

Stephanie H. Grant
Warner Norcross + Judd LLP
sgrant@wnj.com
248.784.5068

17783046.1