




LIVE FROM NAHU!

ACA Employer Reporting - Form Completion How-Tos

Presented by Trey Tompkins, JD, MBA
President, Admin America, Inc.

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PAM MITROFF, MBA

Pamela Mitroff, MBA, NAHU Senior Director of Health Reform Compliance, has more than 30 years in the health care and workers' compensation insurance and cost control field. She joined NAHU's staff in 2011. Prior to joining NAHU's staff, Mitroff's consulting practice advised brokers, insurers and employers on health insurance and employer benefits and compliance issues. She has held positions with a major insurance company and a third-party administrator of benefit plans for self-funded companies. She was a lobbyist for the Illinois State Chamber of Commerce, lobbying on health insurance, employee benefits and workers' compensation issues. Mitroff is a licensed Illinois insurance producer. Prior to joining NAHU's staff, Mitroff had been an active NAHU member on federal, state and local levels.

WASHINGTON UPDATE

- Legislative calendar coming to a close
- Awaiting final details on budget, tax-extendors
- Coming up on the 2016 Elections
- Reconciliation Bill to repeal major ACA provisions
- Potential repeal of the Cadillac/excise tax
- Drug Prices
- Regulatory - Notice of Benefit and Payment Parameters

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 - Independent TPA based in Alpharetta, Georgia
 - Specializing in FSA, HRA, HSA and COBRA Administration
 - Also consults on PPACA, ERISA and HIPAA compliance
- 19 Years Employee Benefits Consulting Experience
- NAHU Region V Chapter Leadership & Development Rep.
 - Former Member of NAHU's National Legislative Council
 - Former President of NAHU's Atlanta and Georgia Chapters
- Member of the State Bar of Georgia
 - Graduate of Vanderbilt University, the University of Georgia School of Law and Georgia State University College of Business



ACA Employer Reporting: Form Completion How-Tos

Today's Webcast Will Cover:

- Choosing the Proper Forms For Employers (B or C Forms)
- Completing The Statements For Employees (Forms 1095)
- Delivering Statements To Employees
- Completing The Transmittal Forms (Forms 1094)
- Filing Transmittal Forms With The IRS
- Compliance Extensions

Choosing The Proper Forms

Plan Type / Employer Size	Non-ALE Members	ALE Members
Fully Insured	No Employer Reporting	Forms 1094-C and 1095-C
Self Insured	1094-B and 1095-B	1094-C and 1095-C
No Coverage	No Employer Reporting	1094-C and 1095-C

“ALE” = Applicable Large Employer

Completing Statements For Employees (Forms 1095)

- **Form 1095-B**

- “Health Coverage”
- For Non-ALE sponsored self-insured group plans
- Also used by ALEs to report coverage for non-Employees
- Also issued by insurance carriers and governments

- **Form 1095-C**

- “Employer-Provided Health Insurance Offer and Coverage”
- All ALEs

Completing Form 1095-B

- For reporting months of the calendar year during which individuals had Minimum Essential Coverage (MEC)
- Does not report unelected offers of coverage
- Related to the ACA's Individual Mandate

Form 1095-B (Page 1)

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

► Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.

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OMB No. 1545-2252

2015

Part I Responsible Individual

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (If SSN is not available)
4 Street address (including apartment no.)		5 City or town	6 State or province
			7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes): ► <input type="checkbox"/>		9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable	

Part II Employer Sponsored Coverage (see instructions)

10 Employer name		11 Employer identification number (EIN)	
12 Street address (including room or suite no.)		13 City or town	14 State or province
			15 Country and ZIP or foreign postal code

Part III Issuer or Other Coverage Provider (see instructions)

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)		20 City or town	21 State or province
			22 Country and ZIP or foreign postal code

Part IV Covered Individuals (Enter the information for each covered individual(s).)

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Forms 1095-B (Page 2)

Form 1095-B (2015)

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Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse (if you file a joint return), and individuals you claim as dependents had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who don't have minimum essential coverage and don't qualify for an exemption from this requirement may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage. For more information on the requirement to have minimum essential coverage and what is minimum essential coverage, see www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision.



TIP Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.

Part I. Responsible Individual, lines 1–9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank.



CAUTION If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

- A. Small Business Health Options Program (SHOP)
- B. Employer-sponsored coverage
- C. Government-sponsored program
- D. Individual market insurance
- E. Multiemployer plan
- F. Other designated minimum essential coverage



TIP If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will be reported on a Form 1095-A rather than a Form 1095-B.

Line 9. This line will be blank for 2015.

Part II. Employer-Sponsored Coverage, lines 10–15. This part will be completed by the insurance company if an insurance company provides your employer-sponsored health coverage. It provides information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. If your coverage isn't insured employer coverage, this part will be blank.

Part III. Issuer or Other Coverage Provider, lines 16–22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form.

Part IV. Covered Individuals, lines 23–28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if SSN or other TIN isn't 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 six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.

Forms 1095-B (Page 3*)

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Form 1095-C (2015)

Name of employee _____ Social security number (SSN) _____

Part III Covered Individuals — Continuation Sheet

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
23			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form 1095-C (2015)

* Only required if there are more than 6 covered individuals to be reported to the “Responsible Individual”

Slides and recording are available

www.nahu.org

Completing Form 1095-B

- Part I – Responsible Individual
 - Line 1 – Name of Responsible Individual
 - The statement recipient (the employee)
 - the person who, based on a relationship to the covered individuals, should receive the statement
 - Generally the taxpayer who would be liable for the individual mandate penalty if there was no coverage, if that person is known

Completing Form 1095-B (Continued)

- Line 2 – Social Security Number
 - May be truncated to last four digits for copies provided to employees
 - May not be truncated for returns filed with the IRS
- Line 3 – Date of birth
 - To be used only if the SSN is not available
- Line 4 – Street Address
 - Use the mailing address if a P.O. Box is used

Completing Form 1095-B (Continued)

- Line 8 – Origin of the Policy
 - A. SHOP
 - B. Employer-Sponsored Coverage**
 - C. Government-Sponsored Program
 - D. Individual Market Insurance
 - E. Multiemployer Plan
 - F. Other Designated MEC Plan
- Line 9 – SHOP Marketplace Identifier
 - To be left blank for 2015

Completing Form 1095-B (Continued)

- **Part II – Employer-Sponsored Coverage**

- Lines 10 – 15
- Left Blank By Self-Funded Plan Sponsors

- **Part III – Issuer or Other Coverage Provider**

- Lines 16 – 22
 - Self-Funded Plan Sponsor's Contact Info
- Line 17 – **EIN** – Do not truncate
- Line 18 – **Contact Telephone Number**
 - someone who can answer questions about the information reported on the form

Completing Form 1095-B (Continued)

- **Part IV – Covered Individuals**

- Column (a) – **Name**

- List name of each covered individual

- Column (b) – **SSN**

- May be truncated to last four digits on forms provided to covered individuals

- May not be truncated on forms provided to IRS

- Column (c) – **DOB**

- use only if SSN is not listed in column (b)

Completing Form 1095-B (Continued)

- **Part IV – Covered Individuals (Continued)**

- Column (d) – **Covered All 12 Months**

- Check box if individual was covered for at least one day for all 12 months of the year

- Column (e) – **Months of coverage**

- If box in Column (d) is not checked, check boxes for each month during which the individual was covered for at least one day

Reporting Complicated Self-Funded Plans

The responsible filing party for the following types of self-funded arrangements are:

1. for multiple employer plans, each participating employer (for its own employees)
2. for multiemployer plans (union plans), the board or committee that establishes the plan
3. for employee organization plans, the employee organization; and
4. for MEWAs, each participating employer

Reporting MEC Under Multiple Plans

- Typically reporting of coverage is only required for one plan, except:
 - If MEC coverage is provided by two unrelated employers, each is required to report
- HRA coverage is typically not reportable, except:
 - If the HRA is integrated with another employer's group health plan, the HRA coverage must be reported

Completing Form 1095-C

- For reporting months of the calendar year during which employees of **Applicable Large Employers (ALEs)**:
 - received an offer of coverage
 - whether the coverage was **Minimum Value**
 - whether the coverage was **Affordable**
 - whether the employee enrolled in the coverage
- Does not report all of the covered individuals unless the coverage is self-funded
- Primarily related to the ACA's Employer Mandate (and Individual Mandate for self-funded coverages)

Form 1095-C

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

Employer-Provided Health Insurance Offer and Coverage

► Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

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☐ CORRECTED

OMB No. 1545-2251

2015

Part I Employee

1 Name of employee			2 Social security number (SSN)			7 Name of employer			8 Employer identification number (EIN)		
3 Street address (including apartment no.)						9 Street address (including room or suite no.)			10 Contact telephone number		
4 City or town		5 State or province		6 Country and ZIP or foreign postal code		11 City or town		12 State or province		13 Country and ZIP or foreign postal code	

Applicable Large Employer Member (Employer)

Part II Employee Offer and 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 Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)													

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual. ☐

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN 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				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Form **1095-C** (2015)

Forms 1095-C (Page 2)

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Form 1095-C (2014)

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 1096-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 II if they request it for their records.

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 issuer 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.

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.

Part II. Employer Offer and 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. This information 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 contribution for self-only coverage equal to or less than \$1,108.65 (0.5% 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.

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 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. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).

Line 15. This line reports the employee share of the lowest-cost monthly premium for 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 codes 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a "0.00" for the amount.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. 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 (c) 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 (d) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional Forms 1095-C that continue Part III.

Forms 1095-C (Page 3*)

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Form 1095-C (2015)

Name of employee _____ Social security number (SSN) _____

Part III Covered Individuals — Continuation Sheet

(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
23			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Form 1095-C (2015)

* Only required if there are more than 6 covered individuals to be reported to the “Responsible Individual”

Completing Form 1095-C

- **Part I - Employee and Applicable Large Employer Member**
 - Line 2 – **Social Security Number**
 - same truncating rules as Form 1095-B
 - Lines 6 and 13 – **Country**
 - need not be specified for U.S. addresses
 - Line 8 – **Employer's EIN** (not SSN)
 - forms will not be processed without a EIN
 - Employers without EIN's should submit IRS Form SS-4 to acquire one immediately

Completing Form 1095-C

- **Part III – Covered Individuals**
 - Only for Employers with self-funded group health plan coverage
 - Completed exactly the same as described for Form 1095-B except:
 - If completing Part III, the box on the line under the “Part III” heading must be checked
 - There is no similar box on Form 1095-B

Completing Form 1095-C (Continued)

- **Part II – Employer Offer and Coverage**

- Plan Start Month
 - Optional for 2015
 - Two Digits Indicating Calendar Month
 - Month The Plan Year Began For Plan Employee Could Have Been Covered Under (If Eligible)
 - If more than one Plan Year began during the calendar year, indicate the earliest
 - If no health plan, enter “OO”

Completing Form 1095-C (Continued)

- **Part II – Employer Offer and Coverage**
 - Line 14 – Offer Of Coverage
 - Line 15 – Employee Share of Lowest Cost Monthly Premium for Self-Only Minimum Value Coverage
 - Applicable Section 4980H Safe Harbor

Completing Form 1095-C, Line 14

The Line 14 Codes:

- **1A** – Qualifying Offer: MEC, MV, FPL Affordable for Employee and at least MEC for Spouse and Dependents
- **1B** – MEC & MV for Employee Only*
- **1C** – MEC & MV for Employee and at least MEC for Dependents (but not Spouse)*
- **1D** – MEC & MV for Employee and at least MEC for Spouse (but not Dependents)*
- **1E** – MEC & MV for Employee and at least MEC for Spouse and Dependents*

* May or may not be Affordable under one of the safe harbors

Completing Form 1095-C, Line 14 (Continued)

- **1F** – MEC but not MV, offered to any group of family members
- **1G** – Offer of coverage to employee who was not full-time during the applicable period and enrolled in self-funded coverage (i.e., through COBRA)
- **1H** – No offer of coverage
- **1I** – Qualifying Offer Transition Relief 2015
 - No offer of coverage;
 - Offer was not a Qualifying Offer; or
 - Qualifying Offer was for less than 12 months

Completing Form 1095-C, Line 16

The Line 16 Codes

- **2A** – Employee not employed at all during the month
- **2B** – Employee not a full-time employee
 - Do not use if the employee enrolled in MEC
 - Also use if a full-time employee loses coverage mid-month due to mid-month termination of employment
 - Also use for the January 2015 Transition Relief
- **2C** – Employee enrolled in coverage offered for every day during the month
 - Use this code whenever it applies except:
 - When Code 2E would apply
 - When a terminated employee's coverage is through COBRA continuation (use 2A instead)

Completing Form 1095-C, Line 16 (Continued)

- **2D** – Limited Non-Assessment Period
 - For Waiting Periods
 - Also for Initial Measurement Periods
 - January – March during Employer’s 1st year as an ALE
 - First calendar month of employment
- **2E** – Multiemployer Limited Relief Rule (the “Union” code)
 - Use whenever applicable
 - Employer contributes on employees behalf to a multiemployer plan
 - Multiemployer plan must offer coverage that is MV and affordable to eligible employees
 - Must be pursuant to a collective bargaining agreement

Completing Form 1095-C, Line 16 (Continued)

- **2F** – W2 Safe Harbor Affordability
 - Calculated at the end of the year
 - Based on employee's Form W2, Box 1 annual wage
 - Can be pro-rated for partial year employees
- **2G** – FPL Safe Harbor Affordability
 - the same for everyone regardless of actual income
 - known prior to the beginning of the calendar year
- **2H** – Rate of Pay Safe Harbor Affordability
 - Based on hourly wage or monthly salary
 - For hourly employees, assumes 130 hours per month
- **2I** – Non-Calendar Year Transition Relief Applies
 - For the months prior to the 2015 Plan Year
 - Requires non-calendar year plan in place as of 12/27/12

Delivering Statements To Employees

- Must be “delivered” on or before Monday, 02/01/16
- Can be provided on paper by mail or hand delivery, or
 - Delivery considered complete at time of mailing
- Can be provided electronically
 - Electronic delivery requires affirmative consent
 - The consent must be obtained or confirmed electronically
 - Electronic delivery can be via e-mail or by informing recipient how to access via the internet

Completing The Transmittal Forms (Forms 1094)

•Form 1094-B

- “Transmittal of Health Coverage Information Returns”
- For Non-ALE Self-Insured Plans
- Also issued by insurance carriers

•Form 1094-C

- “Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns”
- All ALE Members
- Separate forms must be submitted for each EIN with one or more full-time employees

Form 1094-B

Form **1094-B**

Department of the Treasury
Internal Revenue Service

Transmittal of Health Coverage Information Returns

► Information about Form 1094-B and its separate instructions is at www.irs.gov/form1094b.

1115

OMB No. 1545-2252

2015

1 Filer's name		2 Employer identification number (EIN)	
3 Name of person to contact		4 Contact telephone number	
5 Street address (including room or suite no.)		6 City or town	
7 State or province		8 Country and ZIP or foreign postal code	
9 Total number of Forms 1095-B submitted with this transmittal ►			

For Official Use Only
□ □ □ □ □ □ □ □

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. 61570P

Form **1094-B** (2015)

Completing Form 1094-B

- Essentially a “fax cover page” for the employer’s 1095-B Forms
- How many 1095-B Forms are being submitted?
- “Name of Person To Contact” and Phone
 - Someone who can answer questions about the information reported in the 1095-B Forms
 - Can affect good-faith compliance protection

Form 1094-C (Page 1)

Form 1094-C <small>Department of the Treasury Internal Revenue Service</small>	Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns <small>► Information about Form 1094-C and its separate instructions is at www.irs.gov/form1094c</small>	<input type="checkbox"/> CORRECTED	120116 OMB No. 1545-2251 2015
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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If "No," do not complete Part IV.			
22 Certifications of Eligibility (select all that apply):			
<input type="checkbox"/> A. Qualifying Offer Method <input type="checkbox"/> B. Qualifying Offer Method Transition Relief <input type="checkbox"/> C. Section 4980H Transition Relief <input type="checkbox"/> 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 (2015)

Form 1094-C (Page 2)

120216

Page 2

Form 1094-C (2015)

Part III ALE Member Information—Monthly

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

Form 1094-C (Page 3)

120315

Page 3

Form 1094-C (2015)

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 (2015)

Completing Form 1094-C

- **Part I - Applicable Large Employer Member**
 - Line 2 – **Employer's EIN** (not SSN)
 - forms will not be processed without a EIN
 - Employers without EIN's should submit IRS Form SS-4 to acquire one immediately
 - Lines 3-6 – **Employer's Address**
 - should match address on 1095-C Forms
 - Lines 7-8 – **Name of Person To Contact**
 - same concerns as Form 1094-B

Completing Form 1094-C (Continued)

- **Part I - Applicable Large Employer Member**
 - Lines 9-16 - **Designated Government Entity**
 - Only applicable for public sector employers
 - If the employer is not a government, skip these
 - Line 18 – **Total Number of 1095-C Forms With This Transmittal**
 - Note relationship to Line 20
 - Line 19 – **Is This The Authoritative Transmittal For This ALE Member?**
 - If yes, check the box and continue
 - If no, sign the bottom of Page 1 and submit

Completing Form 1094-C (Continued)

- **Part II - ALE Member Information**

- Line 20 – Total number of Forms 1095-C filed by and/or on behalf of ALE Member
 - Will typically be the same number as Line 18
 - Will differ from Line 18 if multiple Forms 1094-C are filed for the same EIN
- Line 21 – Is ALE Member a member of an Aggregated ALE Group? (Yes or No)
 - Was the employer part of a controlled group at any time during 2015?
 - If no, skip Part IV (the third page of this form)

Completing Form 1094-C (Continued)

- **Part II - ALE Member Information**
 - Line 22 – **Certifications of Eligibility**
 - Form says “select all that apply”
 - The four possible certifications
 1. Qualifying Offer Method
 2. Qualifying Offer Method Transition Relief
 3. Section 4980H Transition Relief
 4. 98% Offer Method

Form 1094-C, Line 22 - Certifications of Eligibility

What is a “Qualifying Offer”?

1. An offer of Minimum Essential Coverage (MEC)
2. Providing Minimum Value (MV)
3. To one or more full-time employees
4. For all calendar months during the year for which the Employee was a full-time employee for whom the Employer Mandate penalty could apply
5. At an employee cost of less than 9.5% of the Single Federal Poverty Line
6. Also offering MEC to spouses and dependents

Form 1094-C, Line 22 - Certifications of Eligibility

Certifications of Eligibility **(Select All That Apply – maybe)**

- A. Qualifying Offer Method
- B. Qualifying Offer Method Transition Relief
- C. Section 4980H Transition Relief
- D. 98% Offer Method

Form 1094-C, Line 22 - Certifications of Eligibility

A. Qualifying Offer Method

<u>Criteria</u>	<u>Benefit(s)</u>
------------------------	--------------------------

- | | |
|---|--|
| 1. The Employer made a Qualifying Offer; | 1. Allows fully-insured employers to issue a generic form to Full-Time Employees who received a Qualifying Offer for 12 months |
| 2. To one or more full-time employees; | 2. Still must submit Form 1095-C to the IRS by March 31 |
| 3. For all months during the year to which the Employer Mandate applied | 3. Do not complete Form 1095-C, Line 15 for any month that a Qualifying Offer was made |
| 4. Not mandatory to use if applicable | |

Form 1094-C, Line 22 - Certifications of Eligibility

B. Qualifying Offer Method Transition Relief

Criteria

1. The Employer made a Qualifying Offer;
2. To 95% of its Full-Time Employees (not counting Employees in a Limited Non-Assessment Period);
3. For one or more months during 2015
4. Not mandatory to use if applicable

Benefit(s)

1. Allowed to issue a generic form to Full-Time Employees who received a Qualifying Offer for all 12 months (only if fully-insured) in January
2. Still must submit Form 1095-C to the IRS by March 31
3. Do not complete Form 1095-C, Line 15 for any month that a Qualifying Offer was made

Form 1094-C, Line 22 - Certifications of Eligibility

C. Section 4980H Transition Relief Relief Based On Full-Time Employee Count

Criteria

1. **50-99 FTEs** during 2014
2. No workforce reductions between 02/09/14 and 12/31/14 to qualify for this relief
3. No material reductions of health coverage between 02/09/14 and last day of 2015 Plan Year

Benefit(s)

1. No employer mandate penalty during 2015 Plan Year for Members of Aggregated ALE Groups of 50-99 FT Employees
2. 80 FT Employee Exemption from employer mandate penalty in 2015 (instead of 3 FT Employees) for Members of Aggregated ALE Groups of 100 or more FT Employees

Form 1094-C, Line 22 - Certifications of Eligibility

D. 98% Offer Method

Criteria

The employer offered coverage

- to 98% of employees receiving Form 1095-C
- which was MV and affordable
- for each month of the year the individuals were employees and not in a LNAP
- with MEC to dependents

Benefit(s)

- The Employer is not required to complete the Full-Time Employee Count in Part III (b)

Completing Form 1094-C (Continued)

- **Part III - ALE Member Information - Monthly**
 - Column (a) – **MEC Offer Indicator**
 - Will typically be the same number as Line 18
 - Will differ from Line 18 if multiple Forms 1094-C are filed for the same EIN
 - Column (b) – **Is ALE Member a member of an Aggregated ALE Group?** (Yes or No)
 - Was the employer part of a controlled group at any time during 2015?
 - If no, skip Part IV (the third page of this form)

Completing Form 1094-C (Continued)

• Part III – ALE Member Information – Monthly

- Column (a) – MEC Officer Indicator
 - Generally based on whether coverage was offered to 95% of full-time employees and their dependents
 - Don't count full-time employees in a waiting period or LNA for purposes of calculating the percentage
 - For months in a 2015 Plan Year, there is Transition Relief allowing ALEs with a 70% coverage offering can check "Yes" for those month
 - If MEC coverage is offered to all but five or less full-time employees, the employer is also deemed to have offered coverage
 - ALEs who did not historically offer coverage to dependents can check "Yes" if they continue to offer coverage to their Employees and take steps in 2015 to extend coverage to dependents in 2015
 - For non-calendar year plans that did not alter their plan years after 12/27/2012, full-time employees who were not eligible under the Plan's terms until the first day of the Plan Year beginning in 2015 can be treated as having been offered coverage for all of 2015

Completing Form 1094-C (Continued)

• Part III – ALE Member Information – Monthly

- Column (b) – **Full-Time Employee Count for ALE Member**
 - Employees working 130 or more hours during a month
 - Do not count employees in a LNAP
 - Should be skipped if 98% Offer Method was certified
- Column (c) – **Total Employee Count for ALE Member**
 - Based on a monthly snapshot
 - Includes all employees as of a given day of each month
 - the first day
 - the last day
 - first day of the first pay period
 - last day of the first pay period
- Column (d) – **Aggregated Group Indicator**
 - Control Group Status for any day that period

Completing Form 1094-C (Continued)

• Part III – ALE Member Information – Monthly

- Column (e) – **Section 4980H Transition Relief Indicator**
 - Employers that certify eligibility for “C. Section 4980H Transition Relief” on Line 22 must indicate a code in column (e) for at least one month or the entire year.
 - “A” - 50-99 Transition Relief (ALEs with fewer than 100 full-time employees)
 - “B” - 100 or more Transition Relief (ALEs with 100 or more full-time employees)

Completing Form 1094-C (Continued)

• Part IV – Other ALE Members of Aggregated ALE Group

- Required Information
 - Name
 - EIN
- List up to the largest 30 other members by Full-Time Employee

Filing Transmittal Forms With the IRS

- Transmittal Forms and their the corresponding 1095 Forms must be submitted to the IRS by March 31
 - If submitted in paper format, they must be submitted by the end of February
 - If required to file more than 250 forms, electronic filing is mandatory
 - Electronic filing is accomplished via the IRS's new ACA Information Return (AIR) System
 - Extensions of Time To File Are Available

Electronically Transmitting Forms To IRS

Steps Required To Utilize the ACA Information Return (AIR) System

1. Register with the IRS's e-services website including submission of personal information about the person registering on behalf of the entity. More info can be accessed online [here](#).
2. Obtain an **AIR Transmitter Control Code (TCC)**, a unique identifier authorizing each Submitting Entity to submit the reporting forms
3. Pass a series of technical/system tests to ensure that Reporting Forms will be properly submitted when due.

The first two steps can be completed now while the third step will be available for completion later in 2015.

Obtaining a Transmitter Control Code

Detailed Instructions For Obtaining a Transmitter Control Code (TCC) for the ACA Information Return (AIR) System can be obtained online at:

https://www.irs.gov/PUP/for_taxpros/software_developers/information_returns/aca_app_tutorial_online.pdf

Compliance Extensions

- Automatic 30 day extensions to file with the IRS are available by filing Form 8809 with the IRS prior to the March 31 (or February 29) deadline
 - An additional 30 days is available with a for-cause explanation
- Extensions of time to provide disclosure forms to employees can be obtained via a letter request sent the IRS prior to the January 31 deadline
 - Extensions are for-cause and are not automatic
 - There is no form for requesting the extension

Trey's Top 10 Employer Reporting Questions

1. Which employees are reported on?
2. How do we report COBRA participants?
3. How do we report union employees?
4. How do we report unaffordable coverage?
5. Which affordability safe harbor should we use and in which situations?

Trey's Top 10 Employer Reporting Questions (Continued)

6. How do we define full-time employees for reporting purposes?
7. How do we report employees during their waiting period / measurement period?
8. How do we report seasonal employees?
9. What is a Aggregated ALE group and what ownership percentages cause two employers to be under common control?
10. How do we report the various transitional relief situations?

QUESTIONS?

- You can submit written questions in the questions pane.
- Any questions that we do not answer we will review and post responses to on the webcasts page of the Compliance Corner.

Other Questions?

Today's Topic

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Other Compliance Questions

NAHU Compliance Corner

Current NAHU Members can submit their benefits compliance questions to NAHU's Legislative Council's team of Compliance Corner experts online [here](#).





Thank You for Attending!