IDAHO DEPARTMENT OF
HEALTH & WELFARE
PO BOX 83720
BOISE, ID 83720-0026

Owen F Rowe
545 S 2ND E APT 308
REXBURG, ID 83440 - 2433

Dear Owen,

The Idaho Department of Health and Welfare is required to provide you with important information relating to **M**inimum **E**ssential **C**overage (MEC) that was provided to members of your household for 2021. We are sending you this completed Form 1095-B (Health Coverage Form) because it includes this information. A copy of this information will also be given to the IRS.

Please keep this form for your records as you will need the enclosed information to correctly fill out your federal income tax return. This form serves as your proof of MEC for members of your household in the form of Medicaid and/or CHIP coverage provided by the Idaho Department of Health and Welfare for 2021.

If you think the information on your Form 1095-B is incorrect, please contact the Idaho Department of Health and Welfare. If the "CORRECTED" box on the top of your Form 1095-B is checked, this means we made a change to the information we originally provided. Be sure you use this corrected form when you file your federal income tax return.

Please contact a tax professional or the **I**nternal **R**evenue **S**ervice (https://www.irs.gov) if you have questions regarding how and when to use Form 1095-B.

Sincerely,

Idaho Department of Health and Welfare
P.O. Box 83720
Boise, ID 83720-0026

Phone: 1-877-456-1233
Fax: 1-866-434-8278
E-mail: **MyBenefits@dhw.idaho.gov**

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

► *Do not attach to your tax return. Keep for your records.*
► *Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.*

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

2021

Part I Responsible Individual

1 Name of responsible individual		2 Social security number (SSN or other TIN)	3 Date of birth (If SSN or other TIN is not available)
Owen F Rowe		**646-52-4870**	
4 Street address (including apartment no.)	**5** City or town	**6** State or province	**7** Country and ZIP or foreign postal code
545 S 2ND E APT 308	**REXBURG**	**ID**	**83440**
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . . . ► **C**		**9** Reserved	

Part II Information about Certain 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
Department of Health and Welfare		**82-6000995**	**(877) 456-1233**
19 Street address (including room or suite no.)	**20** City or town	**21** State or province	**22** Country and ZIP or foreign postal code
PO Box 83720	**Boise**	**ID**	**83720-0036**

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

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23 **Owen F Rowe**	**646-52-4870**		☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☒	☒	☒
24			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see https://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-about-Health-Care-Information-Forms-for-Individuals.*

Line 9. Reserved.

Part II. Information about Certain Employer-Sponsored Coverage, lines 10–15. If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

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.