

September 24, 2015

Employer Form 1094 & 1095 Reporting

Presented by Benefit Comply

Employer 1095 & 1094 Reporting

- Welcome! We will begin at 3 p.m. Eastern
- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.
- You will be able to submit questions during the webinar by using the “Questions” box located on your webinar control panel.
- Slides can be printed from the webinar control panel – expand the “Handouts” section and click the file to download.

Assurex Global Partners

- Catto & Catto
- Celedinas Insurance Group
- Cragin & Pike, Inc.
- The Crichton Group
- The Daniel & Henry Co.
- Engle-Hambright & Davies, Inc.
- Frenkel Benefits
- Gillis, Ellis & Baker, Inc.
- Haylor, Freyer & Coon, Inc.
- The Horton Group
- INSURICA
- Kapnick Insurance Group
- Kinney Pike Insurance
- Lanier Upshaw, Inc.
- Lipscomb & Pitts Insurance
- LMC Insurance & Risk Management
- Louisiana Cos./ Querbes & Nelson
- Lyons Companies
- The Mahoney Group
- MJ Insurance
- Parker, Smith & Feek, Inc.
- PayneWest Insurance
- R&R/The Knowledge Brokers
- RCM&D
- Roach Howard Smith & Barton
- The Rowley Agency
- Starkweather & Shepley Insurance Brokerage
- The Underwriters Group
- Woodruff-Sawyer & Co.
- Wortham Insurance & Risk Management

Background

Background

- Employer reporting of plan and coverage information will provide the IRS with the information necessary to administer and regulate:
 - Individual compliance with the requirement to have minimum essential coverage (“individual mandate”)
 - Individual eligibility for a premium tax credit/subsidy for coverage through a public marketplace
 - Employer compliance with the requirement to offer coverage to full-time employees and their dependent children under the employer shared responsibility rules (Section 4980H)

Background

- All “applicable large employers” (ALE = 50 or more FTEs)
 - Must report plan and offer of coverage information (§6056)
 - Employers with 50-99 FTEs satisfying the transition relief to delay 4980H compliance until 2016 must still report for 2015
- Employers offering self-funded plans (large and small)
 - Must report participant coverage information for any individual covered by the self-funded plan (§6055)
 - Final instructions and recent IRS notice make clear reporting is not required for a self-funded health reimbursement account (HRA) that is integrated with a health plan that is already subject to the reporting
- Electronic reporting
 - Employers who file 250 or more Form 1095s must file electronically

When Must Employers Report?

- First required in 2016 for the 2015 calendar year
 - Reporting is based on data from the previous calendar year regardless of the employer's plan year
- Annual timeframes for reporting (same as for W-2s)
 - Form 1094 and all Form 1095s must be filed with the IRS by Feb. 28 (Mar. 31, if filed electronically)
 - Form 1095s (employee statements) must be provided annually to employees by Jan. 31
- 2015 30-day extension to file with IRS
 - IRS 2015 instructions allow for an automatic 30-day extension to file with the IRS, but employee must still be provided Form 1095 (or alternative statement) by Jan. 31

Report on Who? And Form Details

- Who?
 - ALE reporting required on any employee who is full-time for at least 1 month during the year
 - Full-time as defined by Section 4980H using the monthly measurement method or the look-back measurement method
 - Self-funded plan must also report on anyone (even part-time or non-employees) covered by the plan
- What forms?
 - Form 1094 (B&C versions) Employer Summary & Transmittal Form
 - Used to report employer summary information to the IRS
 - Think of it as a cover sheet for the individual employee statements
 - Form 1095 (B&C versions) Employee Statement
 - Used to report employee-specific and covered individual information

Which Forms?

ALE Fully-Insured Plan

Form 1094-C (all parts)

Form 1095-C

- **Part I** - Employee & Employer Info
- **Part II** - Offer of Coverage (eligibility) Info

*Insurance carrier will provide coverage information on fully-insured plan via Form 1094/1095-B

ALE Self-Funded Plan

Form 1094-C (all parts)

Form 1095-C

- **Part I** - Employee & Employer Info
- **Part II** - Offer of Coverage (eligibility) Info
- **Part III** - Info on Covered Individuals

*Form 1094/1095-B may be used instead for non-employees covered under the plan

Small Employer Fully-Insured Plan

No reporting required by the employer

*Insurance carrier will provide coverage information via Form 1094/1095-B

Small Employer Self-Funded Plan

Form 1094-B and 1095-B
Info on Covered Individuals

Reporting Responsibilities

- ALEs in an “Aggregated Group” (controlled group)
 - Each must file separately with their own Form 1094 and Form 1095s for respective full-time employees
- Multiple employers participating in a self-funded plan (MEWA or controlled group)
 - Each must file separately with their own Form 1094 and Form 1095s for respective covered individuals
- Multi-employer plans (Union or Taft-Hartley)
 - ALE employer still files Form 1094-C & Form 1095-C (Parts I & II)
 - Trust administrator will provide coverage statement (i.e. Form 1095-B & Form 1094-B) for self-funded plans; insurer will provide this for insured multiemployer plans

Form 1094-C

Form **1094-C**Department of the Treasury
Internal Revenue Service**Transmittal of Employer-Provided Health Insurance Offer and
Coverage Information Returns**► Information about Form 1094-C and its separate instructions is at www.irs.gov/form1094c☐ 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? ☐ Yes ☐ No

If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):☐ **A.** Qualifying Offer Method ☐ **B.** Qualifying Offer Method Transition Relief ☐ **C.** Section 4980H Transition Relief ☐ **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

Line 22 Certifications of Eligibility

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

Box A - Qualifying Offer Method

- “Qualifying Offer” definition
 - A minimum value plan offered at an employee cost for employee-only coverage not exceeding \$93.18/month for 2015 (9.5 percent of the mainland single federal poverty line [FPL]), and at least minimum essential coverage offer to spouses and dependents
 - Offer was for all months during the year in which the employee was a full-time employee and the employer was subject to shared responsibility rules

Note: Employers are not required to make a qualifying offer – it simply changes the reporting process

Box A - Qualifying Offer Method

- “Qualifying Offer” benefits to the employer
 - No need to complete cost of plan on line 15 of Form 1095-C
 - Use Code 1A for those offered coverage with a qualifying offer
 - Employer may provide a simplified statement to any employee who received a qualifying offer all year instead of copy of Form 1095
 - Important Note - Employer still has to provide a Form 1095 to the IRS
 - Self-funded employers cannot use the simplified statement for anyone who has elected coverage
 - Advantage for employers is that the employee statement must be delivered by Jan. 31, but Form 1095 does not need to be sent to the IRS until Feb. 28 or March 31 if filing electronically
 - Employer can also request a 30-day extension to file Form 1095 with the IRS, but employee statement must still be delivered by Jan. 31

Box B –Qualifying Offer Method Transition Relief

- Qualifying offer made for one or more months of 2015 to at least 95% of full-time employees
- Benefits to employer
 - May use simplified statement for all employees, including those not receiving the offer all 12 months, instead of copy Form 1095
 - Employer still has to provide Form 1095 to the IRS
 - Self-funded employers cannot use the simplified statement for anyone who has elected coverage on the plan
 - Advantage for employers is that the employee statement must be delivered by Jan. 31, but Form 1095 does not need to be sent to the IRS until Feb. 28 or March 31 if filing electronically
 - Employer can also request a 30-day extension to file Form 1095 with the IRS, but employee statement must still be delivered by Jan. 31

Box B - Qualifying Offer Method Transition Relief

- Simplified Statement

- Self-funded plans cannot use simplified statement for anyone who has elected coverage
- Contents of simplified statement
 - Employer name, address, and EIN
 - Contact name and telephone number for providing information about the offer of coverage and information on Form 1095-C
 - A statement for individuals receiving a qualifying offer all 12 months, indicating that the employee (and spouse/dependents, if any) has received a qualifying offer and is not eligible for a premium tax credit
 - For employers that use the 2015 transition relief, include a statement that explains possible eligibility for premium subsidy for employees who did not receive a qualifying offer all 12 months
 - A statement directing the employee to Pub. 974 (“Premium Tax Credit [PTC]”) for more information on eligibility for the premium tax credit

Box C – 4980H Transition Relief

- Check this box if the employer is eligible for section 4980H Transition Relief under either:
 - 2015 Section 4980H Transition Relief for ALEs with 50-99 Full-Time Equivalent (FTE) Employees
 - 2015 Transition Relief for Calculation of Assessable Payments Under Section 4980H(a) for ALEs with 100 or More FTEs
 - 2015 4980H(a) payment applies only after first 80 full time employees (will be after first 30 beginning in 2016)
 - Employer would only use this if they fail to offer coverage to 70% of their full-time employees in 2015

Box D - 98% Offer Method

- For all months of the calendar year, employer offered affordable, minimum value coverage to at least 98% of its full-time employees and offered at least minimum essential coverage to the employees' dependents
 - Affordability can be based on any of the affordability safe harbors
 - Benefits to employer:
 - Employer does not have to provide number of full-time employees by month in column (b) of Form 1094-C
 - As long as the employer files a Form 1095-C for each full-time employee, the employer is not required to identify which employees are full-time or part-time
 - Must provide a Form 1095-C for any employees taken into consideration in establishing the 98%

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"/>	

Page 2 Information Required

- Column (a) – offered coverage to 95% (70% in 2015) of full-time employees and dependent children?
 - Employee in a limited non-assessment period (i.e. waiting period or initial measurement period) is not counted
 - Employee for whom employer is contributing to a multi-employer plan is treated as offered coverage
 - For 2015 only:
 - If employer offered to 70% or more of its full-time employees, the employer may check “Yes”
 - For non-calendar year plans, if employer is in compliance as of the start of the 2015 plan year, employer may check “Yes” for the months prior to the beginning of the 2015 plan year

Page 2 Information Required

- Column (b) – number of full-time employees
 - Not necessary to complete if using the 98% Offer Method
 - Do not count employees in a limited non-assessment period (i.e. waiting period or initial measurement period)
- Column (c) – total number of employees
 - Use either (a) first or last day of the month; (b) 12th day of each month; or (c) first or last day of the first payroll period for the month
- Column (d) – is employer part of a controlled group?
- Column (e) – transition relief codes
 - Code A for employer with 50-99 FTEs
 - Code B for employer with 100 or more FTEs that fails to offer coverage to 70% of full-time employees (waiver for the first 80 full-time employees when calculating penalty 4980H(a))
 - Check box “C” on line 22, page 1, to indicate that either Code A or Code B is being claimed

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 1095-C

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ 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	

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"/>

Fully-Insured Plan - Employer does not fill out Part III

Part II - Information Required

- Line 14 Code Series 1 (Offer of Coverage Codes)
 - Offer of coverage valid only if available for the entire month

Code	Description
1A	MV offered at less than 9.5% of mainland FPL (\$93.18/mo.), at least MEC offered to spouse & dependents (“qualifying offer”)
1B	MV Offer to EE only
1C	MV Offer to EE + Dependent (not spouse)
1D	MV Offer to EE + Spouse
1E	MV offered to EE, at least MEC offered to spouse & dependents
1F	MEC that is not MV offered to employee
1G	Part-time EE or non-employee covered under self-funded plan
1H	No offer of coverage to full-time employee
1I	No offer to employee, but employer using 2015 qualifying offer transition relief

Audio Trouble? Dial 1-719-867-1571 Access Code 265313

Part II - Information Required

- Line 15
 - Complete line 15 only if Code 1B, 1C, 1D or 1E was used on Line 14
 - Provide monthly employee contribution required to participate as an employee-only (single coverage) in the lowest cost minimum value plan offered
 - To calculate the monthly amount, divide the total employee share of the premium for the plan year by the number of months in the plan year
 - For example, for a calendar plan year, use the total annual employee contribution divided by 12
 - Be sure to consider any applicable wellness incentives or opt-out (waiver) incentives when determining the employee contribution

Part II - Information Required

- Line 16 Code Series 2

Code	Description
2A	Not employed any day that month
2B	Part-time or termination month when not covered all month
2C	Enrolled in coverage (use over any other code if applicable, except 2E)
2D	EE in non-assessment period (e.g. waiting period or initial measurement period)
2E	Multi-employer plan interim relief (use over any other code if applicable)
2F	W-2 affordability safe harbor
2G	FPL affordability safe-harbor
2H	Rate of pay affordability safe harbor
2I	Non-calendar year plan transition relief

Audio Trouble? Dial 1-719-867-1571 Access Code 265313

Part III - Information Required

- Employers fill out Part III for self-funded plans only
 - Report on each individual (employee, spouse, dependents) covered by the self-funded plan
 - Name
 - SSN (can use date of birth only if unable to obtain SSN or TIN)
 - Months during the year the individual was covered
 - Individual is considered covered for the month if covered for any day during the month
 - If individual is covered by two self-funded plans in a month (i.e. major medical plan and an HRA), employer only required to report coverage once

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID

600116
OMB No. 1545-2251

☐ CORRECTED

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	

Part II Employee Offer and Coverage

	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"/>

Form 1094-B and Form 1095-B

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

Health Coverage► Information about Form 1095-B and its separate instructions is at www.irs.gov/form1095b.☐ VOID☐ CORRECTED**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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<input type="checkbox"/>

Examples

Covered All Year

- Employee and spouse covered on minimum value self-funded plan all year, child added in July
- \$100 per month to participate in single minimum value coverage

Part II Employee Offer and Coverage													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1E												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$ 100	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2C												

Part III Covered Individuals																
If Employer provided self-insured coverage, check the box and enter the information for each covered individual. <input type="checkbox"/>																
(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 Employee Name	123-45-6789		<input checked="" 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 Spouse Name	987-65-4321		<input checked="" 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 Child Name		7/1/2015	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

Audio Trouble? Dial 1-719-867-1571 Access Code 265313

Qualifying Offer Covered All Year

- Offer of minimum value coverage to employee (cost of single coverage less than \$93.18/month) and coverage offered to spouse and dependents
- Employee is covered under the fully-insured plan all year

Part II Employee Offer and Coverage													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1A												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2C												

Audio Trouble? Dial 1-719-867-1571 Access Code 265313

New Hire

- New employee hired Feb. 15, made a “qualifying offer” May 1 after waiting period of 1st of the month following 60 days – employee waives coverage

Part II Employee Offer and Coverage													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2A	2D	2D	2D								

Audio Trouble? Dial 1-719-867-1571 Access Code 265313

Terminated Employee

- Fully-insured minimum value plan offered, employee accepted
- \$110 per month for minimum value single coverage
- Employee terminated Aug. 15 and plan offers coverage only through date of termination
- Final 2015 reporting instructions changed COBRA Instructions – COBRA would be reported in this manner whether the individual elected COBRA or not
 - When reporting an offer of COBRA coverage to an active employee (e.g. due to reduction in hours), it would be reported just like an offer of coverage to any other active employee

Part II Employee Offer and Coverage													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1H	1H	1H	1H	1H
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$ 110	\$ 110	\$ 110	\$ 110	\$ 110	\$ 110	\$ 110	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2B	2A	2A	2A	2A

Audio Trouble? Dial 1-719-867-1571 Access Code 265313

COBRA to Non-Employee

- Using a Form 1095-C – COBRA coverage under a self-funded plan of individual not full-time for any month during the year
- Could also choose to use Form 1095-B instead of Form 1095-C

Part II Employee Offer and Coverage

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)	1G												
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	Employee Name	123-45-6789		<input checked="" 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	Spouse Name	987-65-4321		<input checked="" 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"/>

Audio Trouble? Dial 1-719-867-1571 Access Code 265313

IRS Resources

- IRS Forms Sites: Links to forms and instructions
 - 1094-C: <http://www.irs.gov/uac/About-Form-1094-C>
 - 1095-C: <http://www.irs.gov/uac/About-Form-1095-C>
 - 1094-B: <http://www.irs.gov/uac/About-Form-1094-B>
 - 1095-B: <http://www.irs.gov/uac/About-Form-1095-B>
- IRS Reporting Information and FAQ Websites
 - <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Employer-Shared-Responsibility-Provisions-Under-the-Affordable-Care-Act>
 - <http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-about-Information-Reporting-by-Employers-on-Form-1094-C-and-Form-1095-C>

Assurex Global Partners

- Catto & Catto
- Celedinas Insurance Group
- Cragin & Pike, Inc.
- The Crichton Group
- The Daniel & Henry Co.
- Engle-Hambright & Davies, Inc.
- Frenkel Benefits
- Gillis, Ellis & Baker, Inc.
- Haylor, Freyer & Coon, Inc.
- The Horton Group
- INSURICA
- Kapnick Insurance Group
- Kinney Pike Insurance
- Lanier Upshaw, Inc.
- Lipscomb & Pitts Insurance
- LMC Insurance & Risk Management
- Louisiana Cos./ Querbes & Nelson
- Lyons Companies
- The Mahoney Group
- MJ Insurance
- Parker, Smith & Feek, Inc.
- PayneWest Insurance
- R&R/The Knowledge Brokers
- RCM&D
- Roach Howard Smith & Barton
- The Rowley Agency
- Starkweather & Shepley Insurance Brokerage
- The Underwriters Group
- Woodruff-Sawyer & Co.
- Wortham Insurance & Risk Management

Thank you.

September 24, 2015

Employer Form 1094 & 1095 Reporting

Presented by Benefit Comply