An Employee's Guide to the 1095-C Form

ACA TRACK
Compliance | Modeling | Reporting

1095-C Form

The Affordable Care Act of 2010 requires most individuals to maintain and provide proof of health care coverage. To support this requirement, the law also requires employers to issue form 1095-B, 1095-C, or both (depending on their employment and coverage status) to all employees who were eligible for employer-based health coverage during the year.

Your 1095 form provides proof of insurance eligibility and coverage for each month of the year. If you were enrolled in a medical plan or eligible for coverage but did not elect a medical plan at any point during the year, you should receive a 1095 form.

☐ VOID ☐ CORRECTED — OMB No. 1545-2251 — **2017** — Form **1095-C** — **Employer Provided Health Insurance Offer and Coverage**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.	Employee Offer of Coverage				
ABC CENTRAL STATES REGION, LLC 123 MAIN STREET ANYWHERE, IA 50001 (877)255-3591	**Plan Start Mo.** (Enter 2-digit no.):	**14** Offer of Coverage (enter required code)	**15** Employee Required Contribution (see instructions)	**16** Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	
	All 12 Months	**1E**	$	**2C**	
	Jan		$ 115.00		
	Feb		$ 115.00		
Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c	Mar		$ 115.00		
	Apr		$ 115.00		
EMPLOYEE'S name, address, ZIP/postal code & country	May		$ 115.00		
BUGS BUNNY 123 MAIN CITY, MI 99999 US	Jun		$ 125.00		
	Jul		$ 125.00		
	Aug		$ 125.00		
	Sep		$ 125.00		
APPLICABLE LARGE EMPLOYER'S Identification number (EIN) **12-3456789** / EMPLOYEE'S Social Security number (SSN) **XXX-XX-6701**	Oct		$ 125.00		
	Nov		$ 125.00		
	Dec		$ 125.00		

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

Department of the Treasury -- IRS 38-2099803

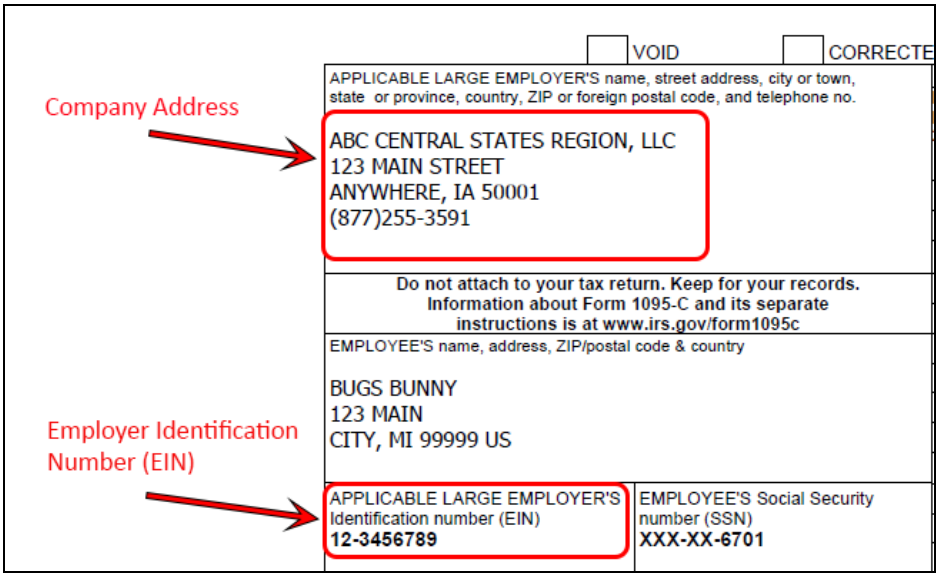
Covered Individuals If Employer provided self-insured coverage, check the box and enter information for each individual enrolled in coverage, including the employee. ☐

(a) Name of the covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 mos.	**(e)** Months of Coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
17			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

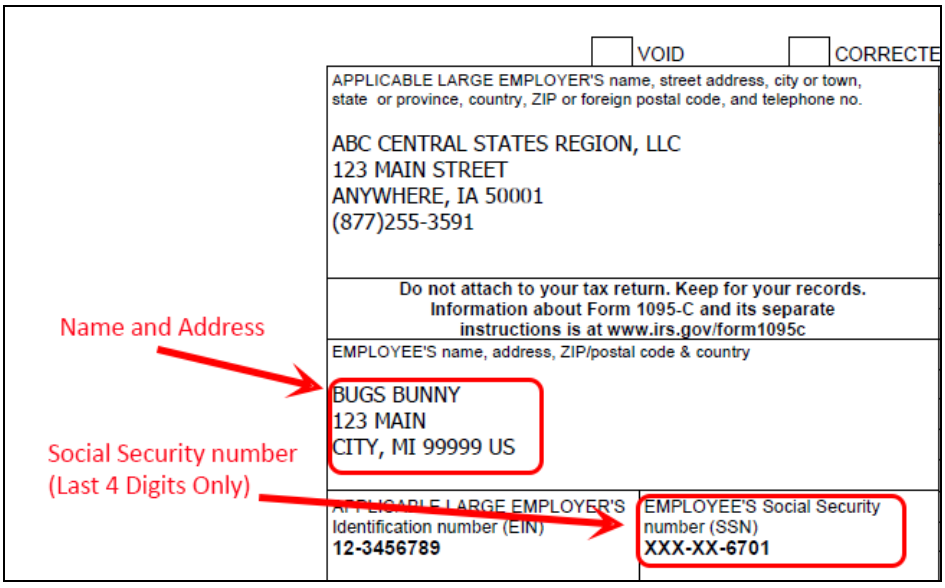
The 1095-C form is not required to file your income tax return. This form is being provided as proof of insurance and should be retained with your tax records.

Company and Employee Information

The left side of each 1095-C form contains identifying and contact information for you and your company. The company information includes the company name, address, phone number, and Employer Identification Number (EIN).



The Employee section includes your name, address, and Social Security number. For security purposes, only the last 4 digits of your SSN are printed on the form.



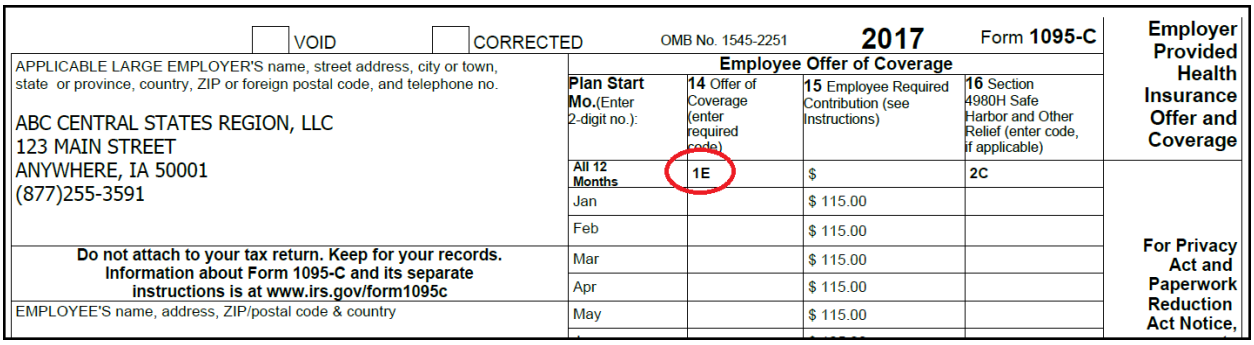
If you notice any errors on your 1095-C form, you should contact your Human Resources department.

Line 14 – Offer of Coverage

Line 14 on the 1095-C form provides details of the coverage you were offered throughout the year, including:

- Whether or not you were offered health insurance coverage.
- The type of coverage you were offered.
- The months in which you were offered coverage.

Line 14 does NOT indicate whether you accepted the offered coverage. That information is reported in Line 16.



☐ VOID ☐ CORRECTED | OMB No. 1545-2251 | **2017** | Form **1095-C** | **Employer Provided Health Insurance Offer and Coverage**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.

ABC CENTRAL STATES REGION, LLC
123 MAIN STREET
ANYWHERE, IA 50001
(877)255-3591

Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

EMPLOYEE'S name, address, ZIP/postal code & country

Employee Offer of Coverage

Plan Start Mo. (Enter 2-digit no.):	**14** Offer of Coverage (enter required code)	**15** Employee Required Contribution (see Instructions)	**16** Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
All 12 Months	**1E**	$	**2C**
Jan		$ 115.00	
Feb		$ 115.00	
Mar		$ 115.00	
Apr		$ 115.00	
May		$ 115.00	

For Privacy Act and Paperwork Reduction Act Notice,

In the above example, the employee had the same coverage available for the entire year, so the response is listed only once, at the top of the column. If the available coverage changed during the year, a separate response would be entered for each month.

Line 14 Codes

A Line 14 response is reported for each month of the year, and may contain one of the following codes:

1A – Qualifying offer

You were made an offer for health insurance in the given month, which was considered a Qualifying Offer. A Qualifying Offer means the health insurance plan provided minimum essential coverage and minimum value coverage for the employee, and the lowest-cost self-only plan cost less than the IRS-mandated percentage of the federal poverty line.

A Qualifying Offer must also include an offer of minimum essential coverage to your spouse and dependents.

**NOTE. This does not indicate what coverage you enrolled in, but what coverage was offered to you.*

1B – Employee Only Offered

You were made an offer for minimum essential coverage and minimum value coverage, at an affordable rate. Health insurance coverage was not offered for your spouse or dependents.

**NOTE. This does not indicate what coverage you enrolled in, but what coverage was offered to you.*

1C – No Spouse Coverage Offered

You were made an offer for minimum essential coverage and minimum value coverage, at an affordable rate. Minimum Essential Coverage was also offered for your dependents, but not for your spouse.

**NOTE. This does not indicate what coverage you enrolled in, but what coverage was offered to you.*

1D – No Dependent Coverage Offered

You were made an offer for minimum essential coverage and minimum value coverage, at an affordable rate. Minimum Essential Coverage was also offered for your spouse, but not for dependents.

**NOTE. This does not indicate what coverage you enrolled in, but what coverage was offered to you.*

1E – Spouse or Dependent Coverage Offered

You were made an offer for minimum essential coverage and minimum value coverage, at an affordable rate. Minimum Essential Coverage was also offered for your spouse and dependents.

1F – Plan Does Not Cover 60% of Estimated Claims

You were offered Minimum Essential Coverage, but that offer did not provide Minimum Value to you, your spouse, and/or dependents.

1G – Insured Non-Full-time Employee

You were offered insurance coverage through a self-funded plan, but were not a full-time employee for any month of the calendar year. This code is commonly used for retirees.

1H – No Offer of Coverage

You were not offered health insurance coverage, or the offer did not include Minimum Essential Coverage.

1J – Conditional Spouse Coverage - Spouse Coverage Offered, No Dependents Coverage Offered

Your company offered conditional spousal coverage. This code is used when Minimum Essential Coverage was conditionally offered for a spouse, but Minimum Essential Coverage was not offered to your dependents.

1K – Conditional Spouse Coverage - Dependents Coverage Offered, No Spouse Coverage Offered

Your company offered conditional spousal coverage. This code is used when Minimum Essential Coverage was conditionally offered for a spouse and Minimum Essential Coverage was offered for dependents.

ACA TRACK
Compliance | Modeling | Reporting

Line 15 – Employee Required Contribution

Line 15 reports your required contribution for each month. *The Employee Required Contribution listed here does not represent the cost of the specific medical plan you enrolled in, but the monthly cost for the lowest-cost, self-only coverage available under the plan*.

☐ VOID ☐ CORRECTED | OMB No. 1545-2251 | **2017** | Form **1095-C** | **Employer Provided Health Insurance Offer and Coverage**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.

ABC CENTRAL STATES REGION, LLC
123 MAIN STREET
ANYWHERE, IA 50001
(877)255-3591

Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

EMPLOYEE'S name, address, ZIP/postal code & country

BUGS BUNNY
123 MAIN
CITY, MI 99999 US

APPLICABLE LARGE EMPLOYER'S Identification number (EIN)
12-3456789

EMPLOYEE'S Social Security number (SSN)
XXX-XX-6701

Employee Offer of Coverage

Plan Start Mo. (Enter 2-digit no.):	**14** Offer of Coverage (enter required code)	**15** Employee Required Contribution (see Instructions)	**16** Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
All 12 Months	**1E**	$	**2C**
Jan		$ 115.00	
Feb		$ 115.00	
Mar		$ 115.00	
Apr		$ 115.00	
May		$ 115.00	
Jun		$ 125.00	
Jul		$ 125.00	
Aug		$ 125.00	
Sep		$ 125.00	
Oct		$ 125.00	
Nov		$ 125.00	
Dec		$ 125.00	

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

Department of the Treasury -- IRS 38-2099803

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

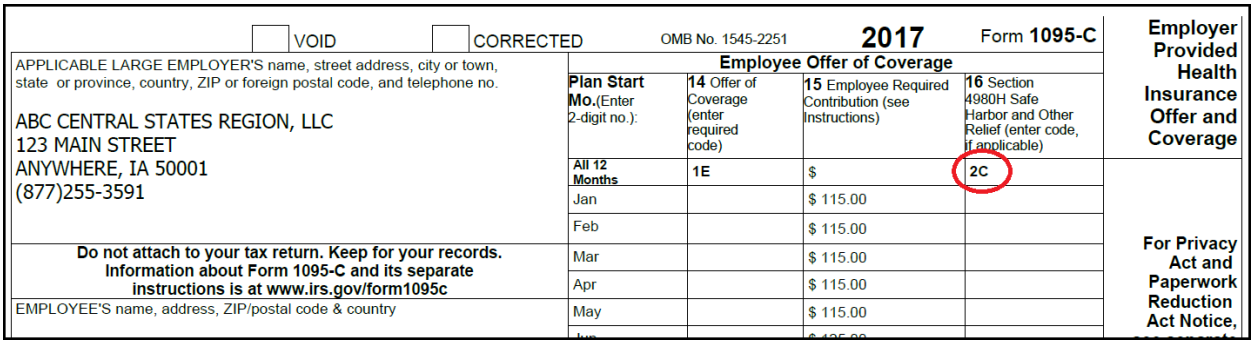
This section should only contain information if line 14 has a response code of 1B, 1C, 1D, 1E, 1J, or 1K. If line 14 has one of those responses for "All 12 Months," there should be a line 15 entry for all 12 months as well. If line 14 has any months without one of these responses, line 15 should be blank for the corresponding months.

Line 16 - Eligibility

Line 16 lists your eligibility for health insurance coverage and your coverage status for each month of the year.

Line 16 addresses the following:

- Whether you were employed, and whether that employment was full-time.
- Whether you were enrolled in health insurance coverage.
- Whether your employer was eligible for any form of relief because of contributions to a union health plan or because you were in a limited non-assessment period. The most common limited non-assessment period is a new hire waiting period.
- Whether the offered coverage was affordable, and which IRS safe harbor was used to determine affordability.



☐ VOID ☐ CORRECTED | OMB No. 1545-2251 | **2017** | Form **1095-C** | **Employer Provided Health Insurance Offer and Coverage**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.

ABC CENTRAL STATES REGION, LLC
123 MAIN STREET
ANYWHERE, IA 50001
(877)255-3591

Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

EMPLOYEE'S name, address, ZIP/postal code & country

Employee Offer of Coverage

Plan Start Mo.(Enter 2-digit no.):	**14** Offer of Coverage (enter required code)	**15** Employee Required Contribution (see Instructions)	**16** Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
All 12 Months	**1E**	$	**2C**
Jan		$ 115.00	
Feb		$ 115.00	
Mar		$ 115.00	
Apr		$ 115.00	
May		$ 115.00	

For Privacy Act and Paperwork Reduction Act Notice,

In the above example, the employee had the same eligibility for the entire year, so the response is listed only once, at the top of the column. If your eligibility changed during the year, your form should include a separate response for each month.

Line 16 Codes

A Line 16 response is reported for each month of the year, and may contain one of the following codes:

2A – Not Employed

You were not employed during the reported month.

*NOTE. This information only pertains to the reporting employer. If you were employed somewhere else during this month, you should receive a separate 1095 form from that employer.

2B – Employed but Not Full Time for the Entire Month

You were employed during the month but not on a full-time basis; therefore, you were not eligible for health insurance benefits through the employer for the entire month or you were offered benefits but opted not to enroll.

2C - Enrolled

You were employed during the reported month and covered under a health insurance plan offered as a result of that employment.

2D – Waiting Period

You were in a measurement or waiting period, prior to becoming eligible for health insurance coverage. This is sometimes referred to as a limited non-assessment period.

2E – Union Sponsored Plan

You were covered under a multi-employer plan, such as a Union Sponsored Plan, for which the employer paid a fee based on a collective bargaining agreement.

2F – Waived Coverage

You waived coverage for the reported month, and the employer used the Form W-2 Safe Harbor to determine affordability.

2G – Waived Coverage

You waived coverage for the reported month, and the employer used the Federal Poverty Line Safe Harbor to determine affordability.

2H – Waived Coverage

You waived coverage for the reported month, and the employer used the Rate of Pay Safe Harbor to determine affordability.

ACA TRACK
Compliance | Modeling | Reporting

Covered Individuals

If your employer offered a self-insured health plan, you and any covered dependents will be listed in the "Covered Individuals" section of the 1095-C.

☐ VOID ☐ CORRECTED — OMB No. 1545-2251 — **2017** — Form **1095-C**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.

ABC SOUTH REGION, LLC
123 BAKER STREET
MEMPHIS, TN 37501
(877)255-3591

Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

EMPLOYEE'S name, address, ZIP/postal code & country

GOOFY GOPHERS
123 MAIN
CITY, MI 99999 US

APPLICABLE LARGE EMPLOYER'S Identification number (EIN) **12-3456780**

EMPLOYEE'S Social Security number (SSN) **XXX-XX-6709**

Employee Offer of Coverage

Plan Start Mo. (Enter 2-digit no.)	14 Offer of Coverage (enter required code)	15 Employee Required Contribution (see Instructions)	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
All 12 Months		$	
Jan	1H	$	2A
Feb	1H	$	2A
Mar	1H	$	2A
Apr	1H	$	2D
May	1E	$ 10.00	2C
Jun	1E	$ 10.00	2C
Jul	1E	$ 10.00	2C
Aug	1E	$ 10.00	2C
Sep	1E	$ 10.00	2C
Oct	1E	$ 111.01	2C
Nov	1E	$ 111.01	2C
Dec	1E	$ 111.01	2C

Employer Provided Health Insurance Offer and Coverage

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

Department of the Treasury -- IRS 38-2099803

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

	(a) Name of the covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered all 12 mos.	(e) Months of Coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
17	Goofy Gophers	XXX-XX-6709		☐	☐	☐	☐	☐	☒	☒	☒	☒	☒	☒	☒	☒
18	Ryan Gophers	XXX-XX-1002		☐	☐	☐	☐	☐	☒	☒	☒	☒	☒	☒	☒	☒
19	Shane Gophers	XXX-XX-1003		☐	☐	☐	☐	☐	☒	☒	☒	☒	☒	☒	☒	☒

If the individuals were covered all year, there will be an X in the "Covered all 12 mos." box. Otherwise, each month they were covered will be marked separately.

Note: This section only pertains to self-insured health plans. If your employer offered a fully-insured plan, your dependents will not be listed on your 1095-C form. They will receive separate documentation directly from the health insurance provider.

Sample 1095-C Documents

The following examples assume your company's health benefits meet minimum value, are not part of a qualifying offer outlined in 1A above, and are offered unconditionally to both spouses and dependent children.

Each employee situation is different, and your 1095-C form may not match any of the examples below. If you believe there is an error on your form, contact your Human Resources department.

Full-time, Insured All Year

If your status and coverage remained the same throughout the year, columns 14, 15, and 16 will remain unchanged. In this case, you should only find one entry for each in the "All 12 Months" line, rather than an entry for each individual month.

☐ VOID ☐ CORRECTED — OMB No. 1545-2251 — **2017** — Form **1095-C** — **Employer Provided Health Insurance Offer and Coverage**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.

ABC CENTRAL STATES REGION, LLC
111 FIRST COMPANY LANE
BUILDING 2
FIRST, NY 12345
(877)255-3591

Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

EMPLOYEE'S name, address, ZIP/postal code & country

BUGS BUNNY
123 MAIN
CITY, MI 99999 US

APPLICABLE LARGE EMPLOYER'S Identification number (EIN)
11-1111111

EMPLOYEE'S Social Security number (SSN)
XXX-XX-6701

Employee Offer of Coverage

Plan Start Mo. (Enter 2-digit no.):	14 Offer of Coverage (enter required code)	15 Employee Required Contribution (see instructions)	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
All 12 Months	1E	$ 125.00	2C
Jan		$	
Feb		$	
Mar		$	
Apr		$	
May		$	
Jun		$	
Jul		$	
Aug		$	
Sep		$	
Oct		$	
Nov		$	
Dec		$	

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

Department of the Treasury -- IRS 38-2099803

In the above example, the employee was offered insurance for themselves, dependents, and their spouse (2E); the offer was accepted (2C); and their monthly required contribution remained unchanged throughout the year.

It is also possible that some of the categories will remain the same all year, while others will change. If your plan's renewal date is mid-year, lines 14 and 16 may remain unchanged, but the Employee Required Contribution will change:

☐ VOID ☐ CORRECTED — OMB No. 1545-2251 — **2017** — Form **1095-C** — **Employer Provided Health Insurance Offer and Coverage**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.

ABC CENTRAL STATES REGION, LLC
123 MAIN STREET
ANYWHERE, IA 50001
(877)255-3591

Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

EMPLOYEE'S name, address, ZIP/postal code & country

BUGS BUNNY
123 MAIN
CITY, MI 99999 US

APPLICABLE LARGE EMPLOYER'S Identification number (EIN)
12-3456789

EMPLOYEE'S Social Security number (SSN)
XXX-XX-6701

Employee Offer of Coverage

Plan Start Mo. (Enter 2-digit no.):	14 Offer of Coverage (enter required code)	15 Employee Required Contribution (see Instructions)	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
All 12 Months	1E	$	2C
Jan		$ 115.00	
Feb		$ 115.00	
Mar		$ 115.00	
Apr		$ 115.00	
May		$ 115.00	
Jun		$ 125.00	
Jul		$ 125.00	
Aug		$ 125.00	
Sep		$ 125.00	
Oct		$ 125.00	
Nov		$ 125.00	
Dec		$ 125.00	

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

Department of the Treasury -- IRS 38-2099803

Mid-year Hire (waiting Period)

If you were hired mid-year, you may have been required to go through a waiting period before becoming eligible for health benefits. In this case, your 1095-C form will show:

1. During the period of time you were not employed, the value in line 14 will be 1H (no offer of coverage), line 15 will be blank, and line 16 will be 2A (not employed).
2. Once you were hired, line 16 will indicate you were in a waiting period (2D).
3. Once you become eligible for insurance, line 14 will indicate that an offer was given, line 15 will reflect the price of the lowest-cost single-only coverage option, and line 16 will specify whether you accepted the insurance.

☐ VOID ☐ CORRECTED — OMB No. 1545-2251 — **2017** — Form **1095-C** — **Employer Provided Health Insurance Offer and Coverage**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.		Employee Offer of Coverage			
ABC CENTRAL STATES REGION, LLC 123 MAIN STREET ANYWHERE, IA 50001 (877)255-3591		**Plan Start Mo.** (Enter 2-digit no.):	**14** Offer of Coverage (enter required code)	**15** Employee Required Contribution (see Instructions)	**16** Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
		All 12 Months		$	
		Jan	**1H**	$	**2A**
		Feb	**1H**	$	**2A**
Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c		Mar	**1H**	$	**2D**
		Apr	**1H**	$	**2D**
EMPLOYEE'S name, address, ZIP/postal code & country		May	**1H**	$	**2D**
ELMER FUDD 123 MAIN CITY, MI 99999 US		Jun	**1E**	$ 125.00	**2C**
		Jul	**1E**	$ 125.00	**2C**
		Aug	**1E**	$ 125.00	**2C**
		Sep	**1E**	$ 125.00	**2C**
APPLICABLE LARGE EMPLOYER'S Identification number (EIN) **12-3456789**	EMPLOYEE'S Social Security number (SSN) **XXX-XX-6703**	Oct	**1E**	$ 125.00	**2C**
		Nov	**1E**	$ 125.00	**2C**
		Dec	**1E**	$ 125.00	**2C**

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

Department of the Treasury -- IRS 38-2099803

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

ACA TRACK
Compliance | Modeling | Reporting

Full-time to Part-time

If you experienced a reduction in hours that moved you from full-time to part-time, you may have become ineligible for your employer's health insurance coverage and been offered COBRA coverage instead.

COBRA Elected

If you accepted the offer of COBRA coverage, Lines 14 and 16 won't change (because you were still insured), but your Employee Required Contribution will reflect the typically higher COBRA rate.

☐ VOID ☐ CORRECTED — OMB No. 1545-2251 — **2017** — Form **1095-C** — **Employer Provided Health Insurance Offer and Coverage**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.		Employee Offer of Coverage			
		Plan Start Mo.(Enter 2-digit no.):	**14** Offer of Coverage (enter required code)	**15** Employee Required Contribution (see Instructions)	**16** Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
ABC CENTRAL STATES REGION, LLC 123 MAIN STREET ANYWHERE, IA 50001 (877)255-3591		**All 12 Months**	**1E**	$	**2C**
		Jan		$ 115.00	
		Feb		$ 115.00	
Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c		Mar		$ 115.00	
		Apr		$ 115.00	
EMPLOYEE'S name, address, ZIP/postal code & country		May		$ 685.00	
PORKY PIG 123 MAIN CITY, MI 99999 US		Jun		$ 685.00	
		Jul		$ 685.00	
		Aug		$ 685.00	
		Sep		$ 685.00	
APPLICABLE LARGE EMPLOYER'S Identification number (EIN) **12-3456789**	EMPLOYEE'S Social Security number (SSN) **XXX-XX-6715**	Oct		$ 685.00	
		Nov		$ 685.00	
		Dec		$ 685.00	

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

Department of the Treasury -- IRS 38-2099803

In the example above, the employee transitioned to COBRA coverage in May.

COBRA Waived

If you waived COBRA coverage, line 16 will be updated to show you were no longer eligible for employer-based insurance coverage (2B), while line 15 will reflect the price of the COBRA coverage you were offered.

☐ VOID ☐ CORRECTED — OMB No. 1545-2251 — **2017** — Form **1095-C** — **Employer Provided Health Insurance Offer and Coverage**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.

ABC CENTRAL STATES REGION, LLC
111 FIRST COMPANY LANE
BUILDING 2
FIRST, NY 12345
(877)255-3591

Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

EMPLOYEE'S name, address, ZIP/postal code & country

ROAD RUNNER
123 MAIN
CITY, MI 99999 US

APPLICABLE LARGE EMPLOYER'S Identification number (EIN)
11-1111111

EMPLOYEE'S Social Security number (SSN)
XXX-XX-6712

Employee Offer of Coverage

Plan Start Mo. (Enter 2-digit no.):	14 Offer of Coverage (enter required code)	15 Employee Required Contribution (see Instructions)	16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
All 12 Months	1E	$	
Jan		$ 125.00	2C
Feb		$ 125.00	2C
Mar		$ 125.00	2C
Apr		$ 125.00	2C
May		$ 685.00	2B
Jun		$ 685.00	2B
Jul		$ 685.00	2B
Aug		$ 685.00	2B
Sep		$ 685.00	2B
Oct		$ 685.00	2B
Nov		$ 685.00	2B
Dec		$ 685.00	2B

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

Department of the Treasury -- IRS 38-2099803

Note that line 14 does not change, because an offer of coverage was still made, even if you chose not to enroll.

Part-time to Full-time

If you transitioned from part-time to full-time, you may have become eligible for employer-based health coverage. In this case:

1. For the months you were part-time, line 14 will show 1H (no offer given) and line 16 will be 2B (employed but not full-time). Because you were not offered insurance during these months, line 15 will be blank.
2. If you were required to go through a waiting period before becoming eligible for insurance, lines 14 and 15 will remain unchanged during this time, but line 16 will be changed to 2D, indicating that you were in a waiting period.
3. Once you became eligible for insurance, line 14 will note your full-time status, line 15 will list your required contribution, and line 16 will indicate whether you accepted or waived coverage.

☐ VOID ☐ CORRECTED — OMB No. 1545-2251 — **2017** — Form **1095-C**

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.	Employee Offer of Coverage				**Employer Provided Health Insurance Offer and Coverage**
ABC CENTRAL STATES REGION, LLC 111 FIRST COMPANY LANE BUILDING 2 FIRST, NY 12345 (877)255-3591	**Plan Start Mo.** (Enter 2-digit no.):	**14** Offer of Coverage (enter required code)	**15** Employee Required Contribution (see instructions)	**16** Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	
	All 12 Months		$		
	Jan	1H	$	2B	
	Feb	1H	$	2B	
Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c	Mar	1H	$	2B	**For Privacy Act and Paperwork Reduction Act Notice, see separate instructons.**
	Apr	1H	$	2B	
EMPLOYEE'S name, address, ZIP/postal code & country LOLA BUNNY 123 MAIN CITY, MI 99999 US	May	1H	$	2D	
	Jun	1E	$ 125.00	2C	
	Jul	1E	$ 125.00	2C	
	Aug	1E	$ 125.00	2C	
	Sep	1E	$ 125.00	2C	
APPLICABLE LARGE EMPLOYER'S Identification number (EIN) **11-1111111** / EMPLOYEE'S Social Security number (SSN) **XXX-XX-6713**	Oct	1E	$ 125.00	2C	
	Nov	1E	$ 125.00	2C	**Department of the Treasury -- IRS 38-2099803**
	Dec	1E	$ 125.00	2C	

In the above example, this employee worked part-time from January to March, was in a waiting period in May, and then was full-time and insured from June through December.

ACA TRACK
Compliance | Modeling | Reporting

Termed Employee

If you left the company at some point in the year (voluntarily or involuntarily), your 1095-C form will show your insurance status up to the month you left, and then change to a 1H/2A (No Offer of Coverage/Not-Employed) status for the remainder of the year.

☐ VOID ☐ CORRECTED	OMB No. 1545-2251	**2017**	Form **1095-C**	**Employer Provided Health Insurance Offer and Coverage**
APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. ABC CENTRAL STATES REGION, LLC 123 MAIN STREET ANYWHERE, IA 50001 (877)255-3591	**Employee Offer of Coverage**			
	Plan Start Mo.(Enter 2-digit no.):	**14** Offer of Coverage (enter required code)	**15** Employee Required Contribution (see Instructions)	**16** Section 4980H Safe Harbor and Other Relief (enter code, if applicable)
	All 12 Months		$	
	Jan	**1E**	$ 115.00	**2C**
	Feb	**1E**	$ 115.00	**2C**
Do not attach to your tax return. Keep for your records. Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c	Mar	**1E**	$ 115.00	**2C**
	Apr	**1E**	$ 115.00	**2C**
EMPLOYEE'S name, address, ZIP/postal code & country FOGHORN LEGHORN 123 MAIN CITY, MI 99999 US	May	**1H**	$	**2A**
	Jun	**1H**	$	**2A**
	Jul	**1H**	$	**2A**
	Aug	**1H**	$	**2A**
	Sep	**1H**	$	**2A**
APPLICABLE LARGE EMPLOYER'S Identification number (EIN) **12-3456789**	Oct	**1H**	$	**2A**
EMPLOYEE'S Social Security number (SSN) **XXX-XX-6708**	Nov	**1H**	$	**2A**
	Dec	**1H**	$	**2A**

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

Department of the Treasury -- IRS 38-2099803

In this example, the full-time employee was insured from January through April, at which time they ended employment with the company.

**NOTE. This information only pertains to the reporting employer. If you were employed somewhere else during the remainder of the year, it will not be reflected on this form. You should receive a separate 1095 form from your new employer.*

Self-Insured Plan

If you accepted COBRA coverage after your employment ended, it will not be reflected in your "Offer of Coverage" section. However, if your employer offered a self-insured health plan, the "Covered Individuals" section will indicate which months you and your dependents were covered, both under your employer's health plan and COBRA:

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

(a) Name of the covered individual(s)	**(b)** SSN or other TIN	**(c)** DOB (If SSN or other TIN is not available)	**(d)** Covered all 12 mos.	**(e)** Months of Coverage											
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
17 Hippety Hopper	XXX-XX-6716		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

If your employer offered a fully-insured plan, you will receive a separate form from your health insurance provider documenting your COBRA coverage.