2020 FORM 1095-C AT A GLANCE

Health efx
Leading through change.

A quick reference guide to Form 1095-C

Form 1095-C identifies whether an employee was offered coverage and whether the employee was enrolled in coverage at any time during the tax year. This guide provides need-to-know details about how employers should complete and transmit Form 1095-C.

Form 1095-C: The Basics

Applicable Large Employer (ALE) Members are either: a person or entity that is an Applicable Large Employer, or each person or entity within an Aggregated ALE Group. ALE Members must file Form 1095-C for every full-time employee eligible for medical coverage. Forms 1095-C must be transmitted to the IRS with Form 1094-C. Together, these forms are used to determine whether an employer is subject to penalty under the employer shared responsibility provisions under Section 4980H.

How to complete Form 1095-C

Form 1095-C has three parts:

1. **Part I – Employee & ALE Information:** Provides specific information about the employee and the ALE.
2. **Part II – Offer of Coverage:** Identifies whether the employee was full-time for any month of the calendar year AND whether a plan was offered during any month of the calendar year. (See Additional Information for more details.)
3. **Part III – Covered Individuals:** Identifies individuals who had coverage for any month during the calendar year.

Employers must fill out the appropriate form sections based on the type of plans that are offered:

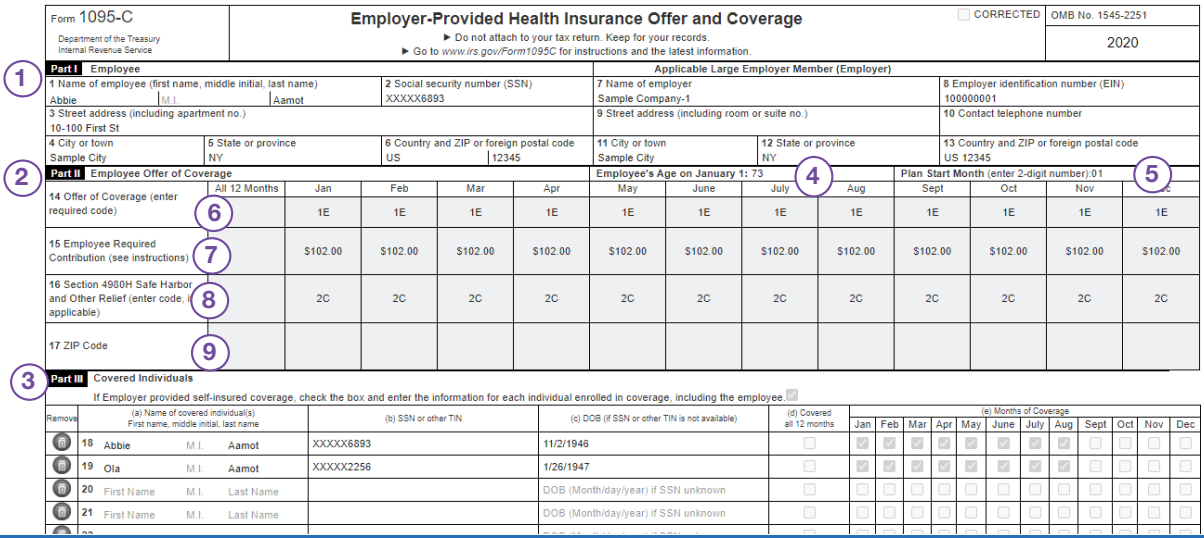
- Fully insured plans: complete only Parts I and II.
- Self-insured plans: complete Parts I, II, and III.
- Individual Coverage Health Reimbursement Arrangement (ICHRA) plans: complete Parts I, II, and III.

Additional Information About Form 1095-C:

4. **Employee's Age on January 1st:** Shows the employee's age on January 1st if they were offered an individual coverage Health Reimbursement Arrangement (HRA). The age in this field may not match the age used for the silver premium if the plan year does not start in January.
5. **Plan Start Month:** Identifies the first month of the plan year of the plan offered to the employee.
6. **Line 14 (Code Series 1):** Identifies the type of coverage offered to an employee. Line 14 cannot be left blank.
7. **Line 15:** Identifies the employee's share of the lowest-cost self-only minimum essential coverage plan that provides minimum value that's offered to the employee (this may not be the amount the employee pays for coverage). If an ICHRA plan is offered, the following formula determines the employee contribution: (age and location based on lowest cost silver plan monthly premium) – (monthly employer ICHRA contribution amount) = (employee contribution used to determine affordability of coverage under the ACA). Line 15 should only be used if code 1B, 1C, 1D, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, or 1Q is entered on Line 14 or in the 'All 12 Months' checkbox.
8. **Line 16 (Code Series 2):** Identifies applicable Section 4980H affordability safe harbor or other relief for ALE Members. Line 16 may be left blank if no code applies.
9. **Line 17:** Identifies the ZIP code used to calculate the employee contribution for an individual coverage HRA offer on Line 15. The ZIP code is either for the employee's primary residence or for their primary employment site. ZIP code is only included when an ICHRA plan is offered.

Note: This information is not intended to be legal advice and should not be relied upon in lieu of consultation with appropriate legal advisors.

Source: U.S. Department of the Treasury, Internal Revenue Service. (https://www.irs.gov/pub/irs-pdf/f1095c.pdf)



Form 1095-C — Department of the Treasury, Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095C* for instructions and the latest information.

CORRECTED | OMB No. 1545-2251 | 2020

Part I Employee

1 Name of employee (first name, middle initial, last name)	2 Social security number (SSN)
Abbie M.I. Aamot	XXXXX6893
3 Street address (including apartment no.)	
10-100 First St	
4 City or town	5 State or province
Sample City	NY
6 Country and ZIP or foreign postal code	
US 12345	

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Sample Company-1	100000001
9 Street address (including room or suite no.)	10 Contact telephone number
11 City or town	12 State or province
Sample City	NY
13 Country and ZIP or foreign postal code	
US 12345	

Part II Employee Offer of Coverage — Employee's Age on January 1: 73 — Plan Start Month (enter 2-digit number): 01

	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	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)		$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00	$102.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
17 ZIP Code													

Part III Covered Individuals

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

Remove	(a) Name of covered individual(s) First name, middle initial, last name	(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	June	July	Aug	Sept	Oct	Nov	Dec
	18 Abbie M.I. Aamot	XXXXX6893	11/2/1946													
	19 Ola M.I. Aamot	XXXXX2256	1/26/1947													
	20 First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown													
	21 First Name M.I. Last Name		DOB (Month/day/year) if SSN unknown													