

# IRS Reporting - 2016

## 1095C / 1094C

October 2015



# IRS Reporting - 2016

## **Will Compton**

VP of Marketing

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**WARNING!!**

**Hang in there.....**



**This stuff is really important!**

## What is going on here?

The Affordable Care Act (ACA) imposes new reporting responsibilities on employers starting with the 2015 calendar year.

The reporting is similar to the current Form W-2 in that an information return **1095-C** will be prepared for each applicable employee, and these returns will be filed with the IRS using a single transmittal form **1094-C**.

## What is the IRS looking for?

The IRS will use the information to determine whether **employees** are subject to the new penalty for not having health coverage or....are eligible for premium tax credits on insurance purchased through the health insurance marketplace.

The information will also allow the IRS to determine if an **employer** is liable for a shared responsibility penalty.



## How to determine if this applies to you or not?

Applicable large employers are those that had, on average, at least 50 full-time employees (including full-time equivalent employees) during the preceding calendar year.

Full-time employees are those who work, on average, at least 30 hours per week or 130 hours a month

Employers need to look at 2014 hours in order to determine 2015 Full Time Status (*any consecutive 6 months*)

Seasonal, Part Time, Variable Hour, Temporary...  
Look Back Measurement Periods

**OKAY LETS GET GOING**



# 1095-C

Part I  
Lines 1 – 13  
Basic Employer & Employee  
Information

Part II  
Lines 14 – 16  
Offer, Coverage & Cost  
Information

Part III  
Lines 17 – 22  
Covered Individuals  
Information

Form **1095-C** **Employer-Provided Health Insurance Offer and Coverage**  VOID  CORRECTED OMB No. 1545-0045  
**2014**  
 Department of the Treasury Internal Revenue Service 600115  
 Information about Form 1095-C and its separate instructions is at [www.irs.gov/ff1095c](http://www.irs.gov/ff1095c).

Part I Employee						Applicable Large Employer Member (Employer)					
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"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form 1095-C (2014)



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](http://www.irs.gov/form1095c)

VOID

600116

OMB No. 1545-2251

CORRECTED

**2015**

#### Part I Employee

#### Applicable Large Employer Member (Employer)

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.)	
4 City or town	5 State or province	6 Country and ZIP or foreign postal code	11 City or town

**EMPLOYEE INFO**

1. Must be provided to any employee who worked full time for you **in any month throughout the year.**
2. Must be provided to any employee who worked full time for you in any month throughout the year, **even if they waived coverage.**

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

### Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

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**2015**

#### Part I Employee

#### Applicable Large Employer Member (Employer)

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.)			
4 City	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

**EMPLOYER INFO**



## 9 Possible Codes for Line 14 (1A – 1I)

- 1. 1A.** Qualifying Offer: Minimum essential coverage providing minimum value offered to full-time employee with employee contribution for self-only coverage equal to or less than 9.5% mainland single federal poverty line and at least minimum essential coverage offered to spouse and dependent(s).
- 2. 1B.** Minimum essential coverage providing minimum value offered to employee only.
- 3. 1C.** Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) (not spouse).
- 4. 1D.** Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to spouse (not dependent(s)).
- 5. 1E.** Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse.
- 6. 1F.** Minimum essential coverage NOT providing minimum value offered to employee, or employee and spouse or dependent(s), or employee, spouse and dependents.
- 7. 1G.** Offer of coverage to employee who was not a full-time employee for any month of the calendar year and who enrolled in self-insured coverage for one or more months of the calendar year. (COBRA)
- 8. 1H.** No offer of coverage (employee not offered any health coverage or employee offered coverage that is not minimum essential coverage).
- 9. 1I.** Qualifying Offer Transition Relief 2015: Employee (and spouse or dependents) received no offer of coverage, received an offer that is not a qualifying offer, or received a qualifying offer for less than 12 months.

## 1A – Qualifying Offer

Minimum essential coverage providing minimum value offered to full-time employee with employee contribution for self-only coverage equal to or less than 9.5% mainland single federal poverty line (FPL) and at least minimum essential coverage offered to spouse and dependent(s).

In order to meet the mainland FPL affordability test the employee's monthly cost of coverage for the employer's lowest cost MV/MEC plan can be no more than \$93.17 per month in 2015.

## 1E – MV/MEC Offer of Coverage

Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse.

For most employers that offer coverage – this will be the most common code used.

## 1H – No Offer of Coverage

No offer of coverage

(employee not offered any health coverage or employee offered coverage that is not minimum essential coverage).

This code may be used often – especially during a new FT EE's waiting period and first year of employment if on a measurement period.



## Question #16: Applicable Section 4980H Safe Harbor (enter code if applicable)

You may enter one of 9 possible codes for each month of the year – only if applicable. Leave blank if no safe harbor code applies.

You may enter 1 code in the “All 12 Months” box if the code is the same for all 12 months of the year.

<b>Part II</b> Employee Offer and Coverage	Start Month (Enter 2-digit number):												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14</b> Offer of Coverage (enter required code)													
<b>15</b> Employee Share of Lowest Cost Monthly Premium for Self-Only Minimum Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
<b>16</b> Applicable Section 4980H Safe Harbor (enter code, if applicable)													

SAFE HARBOR CODE



## 9 Possible Codes for Line 16 (2A – 2I)

- 1. 2A. Employee not employed during the month.**
2. 2B. Employee not a full-time employee.
- 3. 2C. Employee enrolled in coverage offered.**
- 4. 2D. Employee in initial waiting period, measurement period, etc.**
- 5. 2E. Multiemployer interim rule relief – Union employees**
6. 2F. Section 4980H affordability Form W-2 safe harbor. (if used, must use for all months coverage offered)
7. 2G. Section 4980H affordability federal poverty line safe harbor (may use for any month eligible, but waived)
8. 2H. Section 4980H affordability rate of pay safe harbor. (may use for any month eligible, but waived) Note calculated off of 130 hours per month.
9. 2I. Non-calendar year transition relief applies to this employee.

**Lets look at some  
examples**

- John has worked at XYZ Company for 2 yrs.
- His plan is affordable based on his salary.
- He covers himself and his dependents are offered the chance to enroll for the entire calendar year.

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

**Employer-Provided Health Insurance Offer and Coverage**

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VOID  
 CORRECTED

OMB No. 1545-2251  
**2014**

Part I Employee			Applicable Large Employer Member (Employer)		
1 Name of employee	2 Social security number (SSN)	7 Name of employer	8 Employer identification number (EIN)		
John Q. Smith	000-12-3456	XYZ Company	00-1111111		
3 Street address (including apartment no.)		9 Street address (including room or suite no.)		10 Contact telephone number	
123 Main St.		456 Broadway		617-123-4567	
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
Boston	MA	02120	Boston	MA	02110

Part II Employee Offer and Coverage	All 12 Months	Year				
		Jan	Feb	Mar	Apr	May
14 Offer of Coverage (enter required code)	1E					
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$ 125.00	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2C					

	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage					
15 Employee Share of Lowest Cost Monthly Premium	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor					

1E – Employee was offered coverage for the entire year

EE Cost for Self Only Coverage  
 Lowest cost plan

2C – EE enrolled in plan for entire year

- Full Time Employee Hired March 1<sup>st</sup> 2015
- Employee enrolled, dependents offered the chance to enroll
- Waiting Period – 1st month after 30 days
- Plan costs \$100 a month

**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
<b>14 Offer of Coverage</b> (enter required code)		1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E
<b>15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage</b>	\$	\$	\$	\$	\$	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100
<b>16 Applicable Section 4980H Safe Harbor</b> (enter code, if applicable)		2A	2A	2D	2D	2C	2C	2C	2C	2C	2C	2C	2C

1H – Not employed yet / no offer of coverage

1E – MV/MEC Offer of Coverage

Cost of plan

2A – Not employed yet

2D – Waiting period

2C – Employee enrolled in coverage offered

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600115  
OMB No. 1545-2251  
**2014**

**Health Insurance Offer and Coverage**

Form 1099

1 Social Security Number

2 Social Security Number

3 Street address (including apartment no.)  
999 9th Street

4 City or town  
Blissville

5 State  
FL

6 Country and postal code  
22222

7 Street address (including room or suite)  
123 Turtle Street

8 City or town  
Blissville

9 State  
FL

10 Employer Member (Employer)

11 Employer identification number (EIN)

**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	1A	1A	1A	1A	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)	2C	2C	2C	2C	2C	2C	2C	2G	2G	2G	2G	2G	2G

1A – Employee was offered coverage for the entire year

2C – Employee enrolled in coverage offered

2G – employee waived coverage

**Full Time Employee / Waived Coverage at Open Enrollment**

- Plan Anniversary 7/1
- Employee and dependents eligible to enroll.
- FPL Safe Harbor -\$50 per month

# Retiree / COBRA Covered All 12 months of Year

## Assumptions

### Plan anniversary 1/1

VOID 600115  
 CORRECTED OMB No. 1545-2251

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/1095c](http://www.irs.gov/1095c).

Part I Employee		Applicable Large Employer Member (Employer)											
1 Name of employee		2 Social security number (SSN)			7 Name of employer				8 Employer identification number (EIN)				
Jenna Johnson		no dashes			Loggerhead County Tax Collector				with dash				
3 Street address (including apartment no., including room or suite no.)		4 City or town			5 State			12 State or province			10 Contact telephone number		
999 9th Street		Blissville			FL			FL			(305)444-4444		
13 Country and ZIP or foreign postal code													
22222													
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												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2B	2A											

1H – No offer of coverage

2B – Month of termination

2A – Months no longer employed

**Notes:**

Employer would use 2B on line 16 for the month of termination and 2A for the remaining months an employee no longer works for the company

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](http://www.irs.gov)

VOID

600115

OMB No. 1545-2251

2014

<b>Part I Employer Information</b>		<b>Applicable Employer</b>	
1 Name of employer Homer Simps	2 Social security number (SSN) 019-00-0000	7 Name of employer Springfield Nucle	8 Employer identification number (EIN) 04-1234567
3 Street address 742 Evergree	6 Country and ZIP or foreign postal code 99999	9 Street address (Includ 1234 Sunset Blvd	10 Contact telephone number 999-999-9999
4 City or town Springfield	OR	11 City or town Springfield	13 Country and ZIP or foreign postal code 99999

1H. No offer of coverage

1H- MV/MEC Offer of Coverage

14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
		1H	1H	1H	1H	1H	1H	1E	1E	1E	1E	1E	1E
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	2A	2A	2A	2A	2A	2E	2E	2E	2E	2E	2E

2A. Employee not employed during the month.

2E. Multiemployer interim rule relief.

## Union employee covered by a multiemployer plan

Homer belongs to the Local 123 (union). He started to work at Springfield Nuclear on 7/1/2015. Homer is eligible for – and participates in – Local 123’s multiemployer health plan. Springfield Nuclear is required to contribute towards the cost of Homer’s coverage under a collective bargaining agreement.

# Part III – Self Insured Employers Only Covered Individuals (Dependents)

<b>Part III Covered Individuals</b>																
If Employer provided self-insured coverage, check the box and enter the information for each covered individual. <input checked="" 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	Mary J. Smith	001-23-4567		<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"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
18	Bill J. Smith	002-34-5678		<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"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
19	Suzy Q. Smith	003-45-6789		<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"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

- 1095-C Part III is for employers with self insured coverage only!
- Need to add info for any covered dependents.
- Name, SSN & Months Covered.
- *(If SSN is not available a DOB may be used after at least 1 initial + 2 documented attempts to get the SSN.)*



**WOW.....**



**Hang in there.....**

**Part I** Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer) XYZ Company		2 Employer identification number (EIN) 01-9999999
3 Street address (including room or suite no.) 123 Main St.		
4 City or town Boston	5 State or province MA	6 Country and ZIP or foreign postal code 02129
7 Name of person to contact Ms. Mary H.R. Executive		8 Contact telephone number 617-123-4567
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 . . . . . **350**

**Part II** ALE Member Information

19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions . . . . .

20 Total number of Forms 1095-C filed by and/or on behalf of ALE Member . . . . . **350**

21 Is ALE Member a member of an Aggregated ALE Group? . . . . .  Yes  No

Yes, these can be the same number

**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: **Senior Vice President, Human Resources** Date: \_\_\_\_\_

1094C

Part I  
Basic Employer  
Information

Part II  
Understanding  
Controlled Group  
Status

Total Number of  
1095C filed

Certifications  
of Eligibility



## Answering Question #22 – 1094C

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

### \* **Box A – Qualifying Offer Method**

A Qualifying Offer (QO) is:

1. An offer of Minimum Essential Coverage (MEC) and Minimum Value (the employee-only plan), and MEC to spouse AND dependents AND
2. Employee share of premiums (for employee-only coverage) is affordable based on the Federal Poverty Level (FPL) safe harbor

you are saying “my plan is affordable for anyone that is legally considered to be full-time in the entire country; AND their spouse AND dependents are offered coverage. *Note you could leave question 15 on the 1095C blank.*

### **Box B – Qualifying Offer Method Transition Relief**

If you made a QO to at least 95% of your full-time employees, for AT LEAST one month in 2015, you may check this box. It is meant as a grace period for plans that were not in effect, or were not compliant before their plan year started in 2015.

The benefit of checking this box is that for any legally full-time employee that did not receive a QO for all 12 months, you may provide them with a generic statement that says they MAY qualify for subsidies or tax credits for Exchange-based insurance plans. This is not any sort of admission of guilt, this is just a company saying they are working towards compliance and an affordable insurance plan.

## Answering Question #22 – 1094C

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

### **Box C – Section 4980H Transition Relief**

If you have 50-99 Full-Time Equivalencies (FTEs), and you are able to check Box C, you are protected from any penalties for the 2015 calendar year.

If you have 100+ FTEs you will (for 2015 only) qualify for Minus 80 relief from the penalty (\$2000 per non-covered employee for not offering insurance plan). For 2015, if you qualify and can check Box C, you will be allowed to subtract the first 80 FTEs from that penalty number.

### **\* Box D – 98% Offer Method**

If you, as an employer, can certify that affordable, MV coverage was offered for ALL 12 months to AT LEAST 98% of employees for whom you are filing a 1095-C (using any of the safe harbors), you can check Box D. The benefit of this box is simple,

***If you can check it and do; you do not have to fill out column b in Part III on this form (FT Employee Count for each month).***

## PART III – 1094C

### Column A – Minimum Essential Coverage Offer Indicator

These columns help to determine whether an employer is liable any penalty. You check **"yes"** if you offered coverage to at least 95% of full-time employees AND dependents.

### Column B – Full-Time Employee Count

**If you checked Box D (98% method on question #22) you do not do this column.** For everyone else: this is where your monthly numbers from the look back time frame will come into play.

Form 1094-C (2014)

### Part III ALE Member Information – Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member
		Yes	No	
23	All 12 Months	<input checked="" type="checkbox"/>	<input type="checkbox"/>	
24	Jan	<input type="checkbox"/>	<input type="checkbox"/>	325
25	Feb	<input type="checkbox"/>	<input type="checkbox"/>	325
26	Mar	<input type="checkbox"/>	<input type="checkbox"/>	332
27	Apr	<input type="checkbox"/>	<input type="checkbox"/>	330
28	May	<input type="checkbox"/>	<input type="checkbox"/>	331
29	June	<input type="checkbox"/>	<input type="checkbox"/>	331
30	July	<input type="checkbox"/>	<input type="checkbox"/>	330
31	Aug	<input type="checkbox"/>	<input type="checkbox"/>	332
32	Sept	<input type="checkbox"/>	<input type="checkbox"/>	331
33	Oct	<input type="checkbox"/>	<input type="checkbox"/>	332
34	Nov	<input type="checkbox"/>	<input type="checkbox"/>	331
35	Dec	<input type="checkbox"/>	<input type="checkbox"/>	332

# PART III – 1094C

## Column C – Total Employee Count

You must count ALL employees every month. You may use one of the following days (but must use the same day every month).

1. First Day of Month
2. Last Day of Month
3. First day of the first payroll period that starts in a month
4. Last day of the first payroll period that starts in a month

## Column D – Aggregated Group Indicator

If you are a member of an aggregated group (subsidiary, affiliates filing under same tax ID, Leased Hospital) you are a member and you will check this box for the months you were considered such.

## Column E – 4980 Transition Relief Indicator

1. If you qualified and checked Box C on Question 22, you will specify what protection you are eligible for.
2. If you qualify for the 50-99 FTE relief (and checked the proper box) you will put "A"
3. If you qualify for the Minus 80 relief (and checked the proper box) you will put "B"
4. If neither applies, and you didn't check the box, you can leave this column blank.

(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
	<input type="checkbox"/>	
351	<input type="checkbox"/>	B
352	<input type="checkbox"/>	B
349	<input type="checkbox"/>	B
352	<input type="checkbox"/>	B
350	<input type="checkbox"/>	B
350	<input type="checkbox"/>	B
350	<input type="checkbox"/>	
353	<input type="checkbox"/>	
351	<input type="checkbox"/>	
351	<input type="checkbox"/>	
351	<input type="checkbox"/>	
351	<input type="checkbox"/>	

**We made it.....**



## In closing.....

### NOTES:

- What Payroll Vendor if any are you using?
- Electronic filing is required if the employer files at least 250 returns.
- Employers must file these returns annually by Feb. 28 (March 31 if filed electronically).
- A copy of the Form 1095, must be given to the employee by Jan. 31 and can be provided electronically with the employee's consent.
- Employers will be subject to penalties of up to \$500 per return for failing to timely file the returns or furnish statements to employees.
- This is good faith or best effort year.

### Tips!

- Deliver with the W-2
- Let your Employees know they're coming!
- Call our team!!



**Thank you....**

**Contact us:  
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