

# **Reporting Tool Kit**

Your Guide to 2023 Reporting

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# **2023 REPORTING TOOL KIT**



Table of Contents

Form 1095 Print Approval	
Form 1095-C At A Glance	
Form 1095-B At A Glance	
Manual Form 1095-C Creation	
Manual Form 1095-B Creation	
Non-Employee Reporting FAQs	13
Form 1094-C At A Glance	14
Form 1094 Filing	

# FORM 1095 PRINT APPROVAL

*Review and approve forms for printing with ease* 

<b>CREATE NE</b>	W REVIEW	1			Select Tax Year and Type
Submission Approval Submission	on Review Submitted Batches	s Pending Batches	Batch Hold	Manual Forms	Tax Year: 2023   Type: Print Approval
Print Approval Create / Select Approval	● 1095-C	1095-В	Approva	al Summary	Create An Appropriate Title
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Please select which forms to review 1095-B/C. Federal CA DC Please select which FEINs to review	NJ RI				Select All FEINS FEINS Sample Company (581519913) Ø Sample Company Sample Company 3 (581651002) Ø Sample Company
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### **REVIEW FORMS**

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One or more data item(s) have been marked as incorrect. Please review all items marked "Review Form" in the list above.

Changes can only be made via the Employee Details page. You will not be able to make changes in Print Approval. If a change has been made, it will not update the snapshot on the current print approval. A new review needs to be started and the employee specifically would need to be added to the new review.

### **REVIEW COMPLETED WITHOUT ERRORS**

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# **2023 FORM 1095-C AT A GLANCE**

#### 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.
- 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.)
- **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:

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.
- 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		Emp	loyer-Provid	ed Health	Insurance Of	fer and Cover	age					_ C	ORRECT	ED	OMB N	o. 1545-2	251		
_	Department of the Treasury Internal Revenue Service					ax return. Keep for you for instructions and the											2	023		
$\mathbf{A}$	Part I Employee						Applicable Large Em	ployer Member	(Employe	er)										
יי	1 Name of employee (first name, middle initial, la	st name)	2 Social se	ecurity number (SSN	)	7 Name of	employer					81	Employe	er identific	ation n	imber (l	EIN)			
$\sim$	User M.L	One	XXXXX55	55		••• Sample Co	mpany-1					10	000000	1						
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	required code) (6) 1E																			
	15 Employee Required Contribution (see instructions) 7 \$102.00																			
	16 Section 4980H Safe Harbor and Other Relief (enter code, 8 2C applicable)																			
$\sim$	17 ZIP Code																			
(3)	Part III Covered Individuals																			
$\mathbf{C}$	If Employer provided self-insured cover	age, check the box and ent	er the information for	r each individual enro	lled in coverage	including the employ	ee.													
	(a) Name of covered individual/s							(d) C	overed					(e) Months	of Covera	ge				
	Remove First name, middle initial, last name	ie .	(b) SSN or	other HN		(c) DOB (if SSN or oth	er TIN is not available)		months	Jan Fe	b Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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Line	e 14 Code Series 1
1A	Qualifying offer: Minimum essential coverage (MEC) providing minimum value (MV) offered to the full-time employee with the employee contribution for self-only coverage equal to or less than 9.83% of the mainland single federal poverty line and at least minimum essential coverage offered to the spouse and dependent(s). The employee must be offered for every day of the month for this code to be used.
1B	MEC providing MV offered to employee ONLY.
1C	MEC providing MV offered to the employee and at least MEC offered to the employee's dependent(s) but NOT to the spouse.
1D	MEC providing MV offered to the employee and at least MEC offered to the spouse but not to the dependent(s). If the offer of coverage to the spouse was conditional, use code 1J.
1E	MEC providing MV offered to the employee and at least MEC to the dependent(s) and spouse. If the offer of coverage to the spouse was conditional, use code 1K. The employee must be offered for every day of the month for this code to be used.
1F	MEC NOT providing MV offered to either: the employee; or to employee and spouse or dependent(s); or to employee, spouse, and dependents.
1G	Offer of coverage to employee who was not a full-time employee for any month of the calendar year or to an 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.
1H	No offer of coverage (employee not offered any health coverage or employee offered coverage that is not MEC).
11	Reserved.
1J	MEC providing MV offered to employee and at least MEC conditionally offered to spouse; MEC not offered to dependent(s).
1K	MEC providing MV offered to employee and at least MEC conditionally offered to dependents; and at least MEC conditionally offered to spouse.
1L	Individual coverage HRA only offered to the employee. Affordability is determined using the employee's primary residence ZIP code.
1M	Individual coverage HRA offered to the employee and dependent(s), but NOT to the spouse. Affordability is determined using the employee's primary residence ZIP code.
1N	Individual coverage HRA offered to the employee, spouse, and dependent(s). Affordability is determined using the employee's primary residence ZIP code.
10	Individual coverage HRA only offered to employees using the employee's primary employment site ZIP code affordability safe harbor.
1P	Individual coverage HRA offered to employee and dependent(s), but NOT to the spouse, using the employee's primary employment site ZIP code affordability safe harbor.
1Q	Individual coverage HRA offered to employee, spouse, and dependent(s), using the employee's primary employment site ZIP code affordability safe harbor.
1R	Individual coverage HRA that is NOT affordable offered to either: the employee; the employee and spouse or dependent(s); employee, spouse, and dependent(s).
15	Individual coverage HRA offered to an individual who was not a full-time employee.

Lin	e 16 Code Series 2
2A	The employee was not employed on any day of the month. This code should not be used in the month an employee terminates employment with the ALE Member.
2B	The employee is not a full-time employee for the month and did not enroll in MEC, if offered. Also enter code 2B if the employee is a full-time employee for the month and if their offer of coverage (or coverage if employee was enrolled) ended before the last day of the month because the employee terminated employment during the month.
2C	The employee enrolled in coverage that was offered. Code 2C should not be used if code 1G is used on Line 14 for all 12 months. Code 2C should not be used for any coverage that was not MEC.
2D	The employee is in a Section 4980H(b) limited non-assessment period (initial measurement period applies).
2E	Multi-employer interim rule relief.
2F	Section 4980H(b) Affordability Form W-2 Safe Harbor (must be used for all months of the calendar year for which the employee is offered health coverage).
2G	Section 4980H(b) Federal Poverty Level (FPL) Safe Harbor.
2H	Section 4980H(b) Rate of Pay Safe Harbor.
21	Reserved.
Note:	An affordability safe harbor code should not be entered on line 16 for any month that the ALE member did not offer um essential coverage to at least 95% of its full-time employees and their dependents.

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)

# **2023 FORM 1095-B AT A GLANCE**

A quick reference guide to Form 1095-B

Form 1095-B provides information about individuals who are covered by minimum essential coverage. This guide provides need-to-know details about how employers and/or insurance carriers should complete and transmit the form, should they choose to file Forms 1095-B.

#### Form 1095-B: The Basics

In general, small employers offering employer sponsored selfinsured group health plans who are not subject to the employer mandate (employer shared responsibility provisions) and health insurance issuers and carriers use Form 1095-B to report information about covered individuals. In most cases, Applicable Large Employer (ALE) Members who offer self-insured group health plans must report information about coverage on Part III of Form 1095-C. However, these ALE Members may furnish Form 1095-B to non-employees who enroll in self-insured health coverage and individual coverage HRAs.

#### How to complete Form 1095-B

There are four sections to Form 1095-B:

- 1 Part I Responsible Individual: Provides demographic information about the responsible individual.
- Part II Information About Certain Employer-Sponsored Coverage: Identifies information about the employer that provides coverage in certain cases.

- 3 Part III Issuer or Other Coverage Provider: Identifies information about employers reporting self-insured group health plan coverage.
- (4) **Part IV Covered Individuals:** Identifies individuals who had coverage for any month during the calendar year.

#### Additional Information About Form 1095-B:

(5) Line 8: Enter the Origin of Health Coverage. Refer to IRS instructions for additional detail. Insurance companies that enter codes A or B on Line 8 will complete Part II. Employers reporting self-insured group health plan coverage on Form 1095-B should enter code B on Line 8, skip Part II, and complete Part III. Employers reporting an employer-sponsored individual coverage HRA should enter code G on Line 8, skip Part II, and complete Part II. and complete Part III.

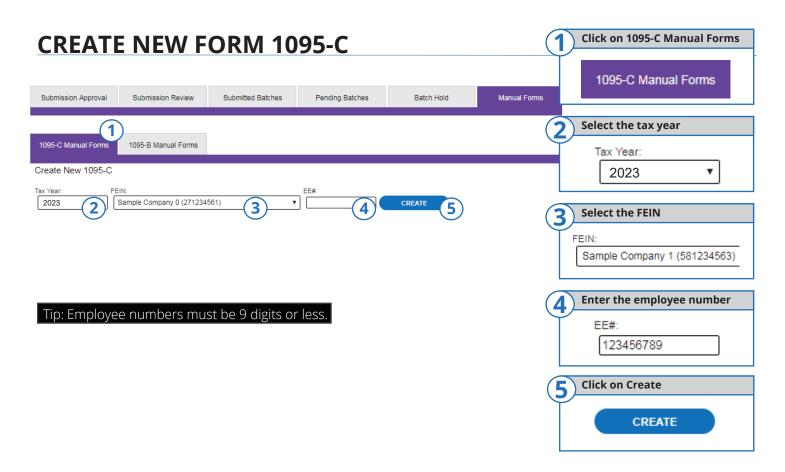
Note: This information is not intended to be legal advice and should not be relied upon in lieu of consultation with appropriate legal advisors.

Source: U.S. Department of the Treasury, Internal Revenue Service. (https://www.irs.gov/pub/irs-pdf/f1095b.pdf)

Form 1095-B		He	alth Cov	erage					(	CORF	RECTED	OMB N	o. 1545-22	52			
Department of the Treasury Internal Re Service				r tax return. Keep fo B for instructions ar	r your records. Id the latest information.									20	23		
Part I R ble Individual																	
1 Name of onsible individual-First name, middle initial, last name	h			2 Social security no	umber (SSN) or other TIN							or other 11	N is not av	/ailable)			
First Name Middle Initial 4 Street address (including apartment no.)	Last Name 5 City or town			6 State or province						B (mm/dd	d ZIP or fo	volan noo	tal oodo				
Street Address	City or Town			State or Province						untry		neigii pos		ZIP or Pos	tal Cada		
8 Enter letter identifying Origin of the Health Coverage (see instructions for codes):		(5	В	9 Reserved													
Part II I 2 Jon About Certain Employer-Sponsored Coverage (see instructions)																	
10 Employ me									11 E	Employer	identificat	ion numbe	er (EIN)				
12 Street address (including room or suite no.)	13 City or town			14 State or provinc	e				15 (	Country a	nd ZIP or	foreign po	stal code				
									Cou	untry			2	ZIP or Pos	tal Code		
Part III ( 3) Other Coverage Provider (see instructions)																	
16 Name				17 Employer identi	fication number (EIN)				18 (	Contact te	elephone r	umber					
Demo Corporation				55-555555						-234-567							
19 Street address (including room or suite no.)	20 City or town			21 State or provinc	e						nd ZIP or	foreign po					
1 Main Street	Sample City			GA					US				1	12345			
Part IV (4) Individuals (Enter the information for each covered individual.) (a) Name of covered individual(s)				SN or other TIN is						(-)	) Months (		-				
Eirst name, middle initial, last name		(b) SSN or other TIN		available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
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### **CREATE FORM 1095-C MANUALLY**

*Create and edit Forms 1095-C manually* 



### **COMPLETE NEW FORM 1095-C**

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me of employee (first name,	m b last name	)	2 Soc	cial security number (SS	SN)	7 Name of e				-( (		i ui c i		
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y or town	5 State or	province	6 Co	untry and ZIP or foreign	n postal code	11 City or to		12 State or	province				-	
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		eck the box and enter the in	information for each in	dividual enrolled in cove	erage, including the e	employee.	)				requ	ired code)		
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epartment of the Treasury Iternal Revenue Service						ot attach to your tax ret .gov/Form1095C for in							20	023
rt I Employee								Applicable Large E	mployer Member (	Employer)			1	
lame of employee (first name,	middle initial, last na	ne)		2 Social s	ecurity number (SS	N)	7 Name of	employer			8 Er	mployer identification	n number (EIN)	
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rt II Employee Offer of Cov				03				on January 1: Age	00			(enter 2-digit numbe	er):01	
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Employee Required ntribution (see instructions)		\$102	2.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00
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18 User	M.I. One		XXXXX55				h/day/year) if SSI					14 Offer of C	Coverage (ente	er
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### **EDIT MANUALLY CREATED FORM 1095-C**

Form 1095-C				Employer-Provided Health Insurance Offer and Coverage										OMB No. 1545-2251	
Department of the Treasury Internal Revenue Service					► Do no	t attach to you	ir tax return. Keep iC for instructions a	for your r	records.	-				202	23
Part I Employee					Go to WWW.Ifs.	yov/ro/m1095	o for instructions (		atest information. Applicable Large En	nplover Member (F	mplover)			1	
Name of employee (first name, i	middle initial,	ast name)		2 Social s	ecurity number (SSN	I)	7 Na	ame of em		upro y or monitoler (r			8 Employer identification r	number (EIN)	
Jser M.I.		One		XXXXX55				nple Com					10000001		
Street address (including apartn	nent no.)								ess (including room	or suite no.)			10 Contact telephone num	iber	
23 Main Street City or town	5 State	or province		6 Country	and ZIP or foreign p	ostal code		ain Street		12 State or	province		111-234-5678 13 Country and ZIP or fore	aign postal code	
xample	MO	or province		US		2345		nple City	~~	GA	province		US 12345	eigii postal code	
art II Employee Offer of Cove	erage								n January 1: Age				onth (enter 2-digit number)	):01	
4 Offer of Coverage (enter	All 12 Mo	nths	Jan	Feb	Mar	Apr	May	1	June	July	Aug	Sept	Oct	Nov	Dec
quired code)			1E	1E	1E	1E	1E		1E	1E	1E	1E	1E	1E	1E
5 Employee Required contribution (see instructions)			\$102.00	\$102.00	\$102.00	\$102.00	\$102.0	00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00
6 Section 4980H Safe Harbor nd Other Relief (enter code, if pplicable)			2C	2C	2C	2C	2C		2C	2C	2C	2C	2C	<sup>20</sup>	20
7 ZIP Code															
art III Covered Individuals															
If Employer provided sel			e box and ent	er the information fo	r each individual enn	olled in covera	ge, including the e	employee.							
(a) Name of o First name min	overed individual ddle initial, last na	s) me		(b) SSN or	other TIN		(c) DOB (if SS	SN or other 1	TIN is not available)	(d) Cov all 12 m		eb Mar Ap	(e) Months of Cover r May June July		Oct Nov
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r changes have been saved a	nd are pendi	ng approval.										3 cli	ck on Appro APPROVE		
orm 1095-C				Emp	oloyer-Provid					erage			CORRECTED	OMB No. 1545-2	251
Department of the Treasury Internal Revenue Service							ur tax return. Keep 5C for instructions							20	023
Part I Employee									Applicable Large E	mployer Member (	Employer)			-	
Name of employee (first name,	middle initial,				security number (SS	N)		lame of er					8 Employer identification 100000001	number (EIN)	
Iser M.I. Street address (including apartr	ment no )	One	•	XXXXX5	555			mple Com	npany-1 ress (including room	or suite no.)			100000001 10 Contact telephone nu	mher	
23 Main Street	nom no.)							freet addr fain Street		or suite no.)			10 Contact telephone nul 111-234-5678		
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4 Offer of Coverage (enter	All 12 M	ntns	Jan	Feb		Apr	May		June	July	Aug	Sept	Oct	Nov	Dec
equired code)			1E	1E	1E	1E	1E		1E	1E	1E	1E	1E	1E	1E
5 Employee Required			\$102.00	\$102.00	\$102.00	\$102.00									
ontribution (see instructions)			3102.00	0102.00	3102.00	\$102.00	\$102.	.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.00	\$102.

17 ZIP Code
Part III Covered Individuals

and Other Relief (enter code, if

applicable)

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) First name, middle initial, last name (d) Covered all 12 months (b) SSN or other TIN (c) DOB (if SSN or other TIN is not available) (e) Months of Coverage Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec 18 User M.L One XXXXX5555  $\checkmark$ ----DB (Month/day/year) if SSN unkn 19 User Two XXXXX7777 < M.L 20 First Na OB (Month/day/year) if SSN unknowr М.І Last Nan 21 First Name M.L Last Name OOB (Month/day/year) if SSN unknow 22 First Name M.I. Last Name DOB (Month/day/year) if SSN unknown Form 1095-C is approved 9 23 First Name Last Name OB (Month/day/year) if SSN unkno M.I. 9)

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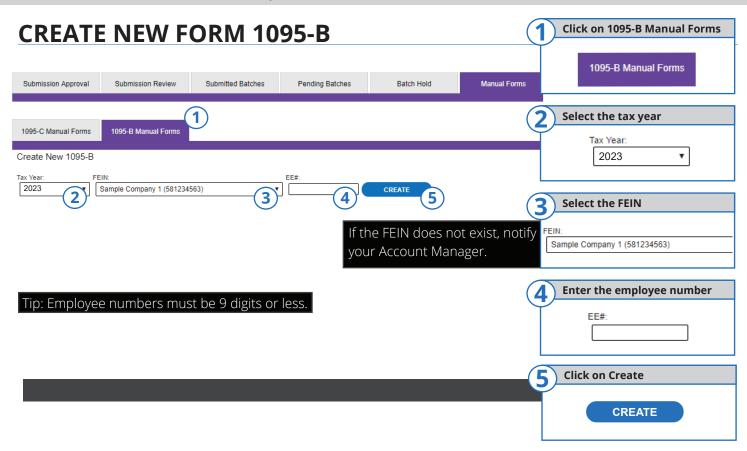
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### **CREATE FORM 1095-B MANUALLY**

*Create and edit Forms 1095-B manually* 



### **COMPLETE NEW FORM 1095-B**

at leaves     C 00 know <i>is govFom10988</i> for instauctions and the latest information.     2023       Responsible individual-F     Social security number (SN) or other TNI     D all or bind (ICSN) or other TNI is not available)       Responsible individual-F     Social security number (SN) or other TNI     D all or bind (ICSN) or other TNI is not available)       Address     Social security number (SN) or other TNI     D all or bind (ICSN) or other TNI is not available)       Address     C 0/r or Town     S State or province     C ountry and ZIP or foreign postal code       Information About Certain Employer-Sponsored Coverage (see instructions for codes)     Issue or province     11 Employer identification number (EIN)       Information About Certain Employer-Sponsored Coverage (see instructions)     13 City or forum     14 State or province     11 Employer foreign postal code       Country and ZIP or foreign postal code     Country     ZIP or Postal Code     20 or Postal Code       Information About Certain Employer-Sponsored Coverage (see instructions)     13 City or forum     14 State or province     15 Country and ZIP or foreign postal code       Country     Information for each covered individual(s)       Single CUP     Information for each covered individual(s)     Information for each covered individual(s)     Information for each covered individual(s)     Information	Name in the low of the purchase and the later later.     Query       Streamed to indicate and the later later and the low of the later lat	orm 1095-B			н	lealth Cov	rage					CORRECTED	OMB No. 1545-2252
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Cat. No. 60704B

This form was edited by Test User on 10/28/2023 1:13:30 PM Changes were approved by Test User on 10/28/2023 1:13:30 PM

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

Changes have been saved and approved.

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This form was edited by Test User on 10/28/2023

Changes were approved by Test Useron 10/28/20

# **NON-EMPLOYEE REPORTING FAQS**

Answers to your non-employee reporting questions

The IRS offers specific guidance regarding reporting for individuals who are inactive due to termination, retirement, or other reason and are enrolled in employer-sponsored self-insured health plans. This document provides answers to frequently asked questions about non-employee reporting for individuals offered and enrolled in employer-sponsored self-insured health plans.

### Who is a non-employee?

For this purpose, any individual who is not actively employed but is offered coverage through an employer-sponsored health plan or an individual coverage HRA is considered a non-employee (e.g. former employees who terminated employment during a previous year, non-employee directors, COBRA beneficiaries, retirees, board members, etc.).

### When do employers have to report coverage for non-employees and COBRA participants?

If a non-employee is offered and enrolls in employer-sponsored self-insured coverage, the coverage sponsor (former employer) may report this information on either Form 1095-C or 1095-B to satisfy reporting requirements under 26 U.S. Code § 6055. Additionally, if an active employee loses health coverage due to a reduction in hours, an offer of COBRA coverage is always reported, regardless of whether the plan offered is self-insured or fully insured.

### What form should I use to report non-employee coverage?

The IRS has stated either Form 1095-C or 1095-B can be used for non-employee reporting. In most cases, Health e(fx) uses Form 1095-B to report non-employee coverage. However, if an individual transitions from employee to non-employee status during the current reporting year, Health e(fx) will report coverage on Form 1095-C.

### How do I report coverage for an employee who terminates employment?

If an employee is not active for any day of the calendar year, Health e(fx) will report enrollment in an employer-sponsored selfinsured plan on Part IV of Form 1095-B.

If the employee is terminated during the calendar year, the COBRA qualifying event is not reported as an offer of coverage on Form 1095-C. Instead, codes 1H and 2A in Part II, Lines 14 and 16 respectively, will be used. The former employee or their dependents' enrollment information will be captured on Part III of Form 1095-C.

### How do I report a loss of coverage due to reduction in hours?

Unlike a termination of employment, if an employee loses health coverage due to a reduction in hours, the resulting offer of COBRA coverage **is reported as an offer of coverage** in Part II of Form 1095-C. Line 14 will reflect the employee's elected coverage. Line 15 will reflect the COBRA premium for the lowest cost self-only plan. If the employee enrolled in COBRA coverage, code 2C can continue to be used on line 16. If the employee did not elect COBRA, line 16 will either be left blank (most common) or coded with the appropriate affordability safe harbor should the COBRA premium be deemed affordable under section 4980H. Any of the former employee or his/her dependents' enrollment information will be captured in Part III of Form 1095-C.

### How do I report coverage of a family member who independently elects COBRA?

Every individual who loses coverage due to a qualifying event has an independent right to elect COBRA. In situations where an employee or former employee does not elect coverage, but a spouse or dependent does, Health e(fx) will either report the elected coverage on Part III of the employee's Form 1095-C or on Part IV of Form 1095-B, depending on the specific scenario.

For detailed information on all reporting, be sure to visit IRS.gov for more information on COBRA retiree reporting and eligibility.

# 2023 FORM 1094-C AT A GLANCE

A quick reference guide to Form 1094-C

Form 1094 is a cover sheet that must be transmitted to the IRS along with Forms 1095. Form 1094-C summarizes the data contained on all Forms 1095-C.

### Form 1094-C: The Basics

Form 1094-C is used by the IRS to determine whether:

- the ALE Member provided adequate offers of coverage to full-time employees
- employees who received premium tax credits from the Marketplace are eligible for them
- an individual had coverage for the 2023 tax year

#### Who files Form 1094-C?

Each ALE Member must file at least one Form 1094-C, one of which must be the Authoritative Transmittal (see Part I, line 19). The ALE Member must also file Form 1095-C for every full-time employee who was employed by the ALE Member for any month of the calendar year.

The employer needs to complete either a Form 1095-C or Form 1095-B for non-employees who enroll in employer-sponsored self-funded coverage.

epartment of the Treasury Iternal Revenue Service	Go to www.irs.gov	erage Information Retur		2023			
Applicable Li           1 Name of ALE Member (Empli	arge Employer Member (ALE I over)	Member)	2 Employer identificati	tion number (EIN)			
3 Street address (including roo	om or suite no.)						
4 City or town		5 State or province	6 Country and ZIP or for	vreign postal code			
7 Name of person to contact			8 Contact telephon	Form 1094-C has four sect	io		
9 Name of Designated Govern	ment Entity (only if applicable)		10 Employer identificat	Part I— Applicable Large Emplo	ονε		
11 Street address (including roo	om or suite no.)			Member (ALE Member): Provid	-		
12 City or town		13 State or province	14 Country and ZIP or f	demographic information about th	ographic information about the A		
15 Name of person to contact			16 Contact telephon	Member.			
17 Reserved				Part II— ALE Member Informat	ior		
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# FORM 1094 FILING

Review and approve Forms 1094 to file with ease

CREATE NEW REVIEW	Select Tax Year and Type
Create / Select Approval 🕒 1094-C 🕞 1094-B 🕞 Approval Summary	Please create a title for future reference       Tax Year:     2023        Type:     Electronic Filing
	<b>7</b> Title the Review
Please create a title for future reference     Image: Type: Electronic Filing       Type:     Electronic Filing	Title:
Please select which forms to review 1094-B/C: ☑ Federal   □ CA   □ DC   □ NJ   □ RI	3 Select the Appropriate FEINs
3       Please select which FEINs to review         ☑       Select All         □       Select None	FEINS     Sample Company (581519913)     Sample Company       Sample Company 3 (581651002)     Sample Company
Form type FEINs Sample Company-1 (10000001)	Start New Approval
4 BEGIN NEW APPROVAL	BEGIN NEW APPROVAL
REVIEW FORMS 1094	Verify Accuracy of All Parts I Pent Applicable Large Employer Member (ALE Member) I Name of ALE Member (Employer) Sample Company-1 3 Street address (including room or suite no.) 1 Main Street
View FEIN LIAI APPROVAL STATUS Recipient Federal FEIN: 100000001 In Progress	2 If All Is Accurate
Form       10994-C       CORRECTED       OMB No. 1545-22         Department of the Tassary Harman Revenue Service       > Go to www.isr.gov/Form1094C for instructions and the latest information       2023         Value Applicable Large Employer Member (ALE Member)       } Employer deemtication number (EIN)       2	
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A City or form     § State or province     6 Country and ZIP or foreign postal code     12345       Sample City     CA     US     12345       F Name of person to contact     0 Contact telephone number     12345       Sample City     CA     0 Employer identification number (EIN)       I Street address (including room or suite no.)     10 Employer identification number (EIN)       12 City or form     13 State or Province     14 Country and ZIP or foreign postal code	If Errors Exist         Approved?         Yes ● No         Comments:         Insert comments explaining error
Country Zip Code      16 Contact telephone number      17 Reserved	Repeat For All 1094-Cs
18 Total number of Forms 1055-C submitted with this transmittal 19 Is his the authoritative transmittal for this ALE Member? If "ries," check the box and continue. If "No," see instructions 20 Total number of Forms 1055-C for Store of S	
22 Certifications of Eliphiling (tested all that apply): Cartifications of Eliphiling (tested all that	
(a) Minimum Extendial Coverage Offer Indicator         (b) Full-Time Employee Count for ALE Member         (c) Total Employee Count for ALE Member         (d) Aggregated Group Indicator         (e) Reserved           23. All 12 Months	Repeat 1-4 For 1094-Bs
2 Approved?	1094B ►
Approved? ● Yes ® No Comments: Insert comments explaining error	Continue to Approval
A NEXT FEIN ►	APPROVAL SUMMARY ►

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### **REVIEW COMPLETED WITH ERRORS**



### **REVIEW COMPLETED WITHOUT ERRORS**

	Total # of Forms		Recipient	Result	Comment
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