



New IRS Reporting Requirements

Forms 1094-C & 1095-C

October 22, 2015

Presented By:

Lee Centrone

Senior Vice President

BeneSys, Inc./A&I Benefit Plan Administrators, Inc.

Please note that this Trust fund cannot provide legal or tax advice to employers and that the foregoing is for informational purposes only. Each employer should consult its own legal and tax advisors for advice regarding compliance with Internal Revenue Service Requirements.

Outline

IRC
Section
6055
&
6056

Who is an
Applicable
Large
Employer?

Who is a
Full Time
Employee?

Form
1094-C
&
Form
1095-C

Penalties

New IRS Reporting Requirements

IRC Section 6055

- Section 6055 is reporting required by an Applicable Large Employer (ALE) (an employer with 50 or more employees).
- This reporting will be completed on Forms 1094-C and 1095-C.

New IRS Reporting Requirements

IRC Section 6056

- Section 6056 is reporting required by the Health Plan Sponsor.
- For Fully-Insured plans the reporting is required by the carrier and for Self-Funded plans the reporting is required by the Trust.
- This reporting will be completed on Forms 1094-B and 1095-B.

New IRS Reporting Requirements

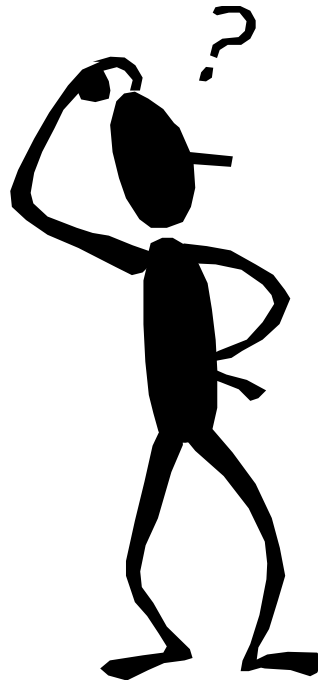
Why is this reporting required?

This reporting requirement determines:

- 1) If an employer must pay a penalty for failure to offer affordable health coverage that meets minimum value standards to its full-time employees.
- 2) If an individual must pay a penalty for not having minimum essential health coverage.
- 3) If individuals qualify for tax credits (subsidies) to buy health coverage in the public exchanges/marketplaces.

What is an Applicable Large Employer?

Am I a large employer?



What is an Applicable Large Employer?

How to Determine if you are a Large Employer

- ✓ Must have an equivalent of 50 Full-Time employees
- ✓ Part-Time employees are included in the calculation, but do not have to be offered coverage

What is an Applicable Large Employer?

How to Determine if you are a Large Employer

Step 1

- Add up the number of full time employees you have (anyone who works 30 hours per work or 130 hours in a month)

What is an Applicable Large Employer?

How to determine if you are Large Employer

Step 2

- Add the hours worked by each part-time employee in the month (do not count more than 120 hours for any one part-time employee) then divide by 120
- Add monthly totals of Full-Time and Part-Time employees and divide by 12

**If result is 50 or more, the employer is
subject to Pay or Play**

What is an Applicable Large Employer?

EMPLOYER AGGREGATION RULES!

Companies with a common owner or that are otherwise related under certain rules of section 414 of the Internal Revenue Code are generally combined and treated as a single employer for determining ALE status. If the combined number of full-time employees and full-time-equivalent employees for the group is large enough to meet the definition of an ALE, then each employer in the **group** (called an ALE member) is part of an ALE and is subject to the employer shared responsibility provisions, even if separately the employer would not be an ALE.

Who is a Full Time Employee?

Under the Affordable Care Act a full-time employee is defined as an employee employed **on average at least 30 hours of service per week, or 130 hours of service per month.**

Who is a Full Time Employee?

For every **Full Time Employee** you will need to complete the Form 1095-C.

- This form will be mailed to each Full Time Employee

AND

- Submitted to the IRS

The FORMS

1094-C

- Information about the Applicable Large Employer
- Submitted to the IRS

1095-C

- Information about the Full Time Employee and Covered Individuals
- Submitted to the IRS and each Full Time Employee

1094-C

Form **1094-C**

Department of the Treasury
Internal Revenue Service

Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns

Information about Form 1094-C and its separate instructions is at www.irs.gov/form1094c

CORRECTED

120116

OMB No. 1545-2251

2015

Part I Applicable Large Employer Member (ALE Member)

1 Name of ALE Member (Employer)		2 Employer identification number (EIN)	
3 Street address (including room or suite no.)			
4 City or town		5 State or province	6 Country and ZIP or foreign postal code
7 Name of person to contact		8 Contact telephone number	
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)	
11 Street address (including room or suite no.)			
12 City or town		13 State or province	14 Country and ZIP or foreign postal code
15 Name of person to contact		16 Contact telephone number	
17 Reserved			

For Official Use Only



18 Total number of Forms 1095-C submitted with this transmittal

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

Part II ALE Member Information

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

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

If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):

A. Qualifying Offer Method B. Qualifying Offer Method Transition Relief C. Section 4980H Transition Relief D. 98% Offer Method

Under penalties of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

Signature Title Date

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


Cat. No. 61571A

Form **1094-C** (2015)

1094-C – Part I

Form 1094-C Department of the Treasury Internal Revenue Service	Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns ▶ Information about Form 1094-C and its separate instructions is at www.irs.gov/form1094c	<input type="checkbox"/> CORRECTED	120116 OMB No. 1545-2251 2015
Part I Applicable Large Employer Member (ALE Member)			
1 Name of ALE Member (Employer)		2 Employer identification number (EIN)	
3 Street address (including room or suite no.)			
4 City or town		5 State or province	6 Country and ZIP or foreign postal code
7 Name of person to contact		8 Contact telephone number	
9 Name of Designated Government Entity (only if applicable)		10 Employer identification number (EIN)	
11 Street address (including room or suite no.)			
12 City or town		13 State or province	14 Country and ZIP or foreign postal code
15 Name of person to contact		16 Contact telephone number	
17 Reserved <input type="checkbox"/>			
18 Total number of Forms 1095-C submitted with this transmittal ▶			
19 Is this the authoritative transmittal for this ALE Member? If "Yes," check the box and continue. If "No," see instructions			<input type="checkbox"/>

For Official Use Only



1094-C – Part II

A. Qualifying Offer Method

B. Qualifying Offer Method
Transition Relief

Part II ALE Member Information

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

21 Is ALE Member a member of an Aggregated ALE Group? Yes No
If "No," do not complete Part IV.

22 Certifications of Eligibility (select all that apply):

A. Qualifying Offer Method B. Qualifying Offer Method Transition Relief C. Section 4980H Transition Relief D. 98% Offer Method

Under penalty of perjury, I declare that I have examined this return and accompanying documents, and to the best of my knowledge and belief, they are true, correct, and complete.

Signature _____ Title _____ Date _____

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 61571A Form **1094-C** (2015)

C. Section 4980H
Transition Relief

D. 98% Offer Method

1094-C – Part III

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Form 1094-C (2015)

Part III ALE Member Information – Monthly

		(a) Minimum Essential Coverage Offer Indicator		(b) Full-Time Employee Count for ALE Member	(c) Total Employee Count for ALE Member	(d) Aggregated Group Indicator	(e) Section 4980H Transition Relief Indicator
		Yes	No				
23	All 12 Months	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
24	Jan	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
25	Feb	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
26	Mar	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
27	Apr	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
28	May	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
29	June	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
30	July	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
31	Aug	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
32	Sept	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
33	Oct	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
34	Nov	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	
35	Dec	<input type="checkbox"/>	<input type="checkbox"/>			<input type="checkbox"/>	

Form 1094-C (2015)

1094-C – Part IV

Form 1094-C (2015)

120315

Page 3

Part IV Other ALE Members of Aggregated ALE Group

Enter the names and EINs of Other ALE Members of the Aggregated ALE Group (who were members at any time during the calendar year).

Name		EIN	Name		EIN
36			51		
37			52		
38			53		
39			54		
40			55		
41			56		
42			57		
43			58		
44			59		
45			60		
46			61		
47			62		
48			63		
49			64		
50			65		

Form 1094-C (2015)

1095-C

Form **1095-C** **Employer-Provided Health Insurance Offer and Coverage**

Department of the Treasury
Internal Revenue Service

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

VOID
 CORRECTED

OMB No. 1545-0045
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.)			10 Contact telephone number				
4 City or town		5 State or province		6 Country and ZIP or foreign postal code		11 City or town		12 State or province		13 Country and ZIP or foreign postal code	

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number): _____

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

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each covered individual.

(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Cat. No. 60705M Form **1095-C** (2015)

1095-C

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		<input type="checkbox"/> VOID <input type="checkbox"/> CORRECTED	L00116 OMB No. 1545-2251 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.)		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

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

Line 14 – 1H

Line 16 – 2E

1095-C

DO NOT NEED TO COMPLETE!

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each covered individual. <input type="checkbox"/>															
(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage											
				Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17			<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** (2015)

When are these due?

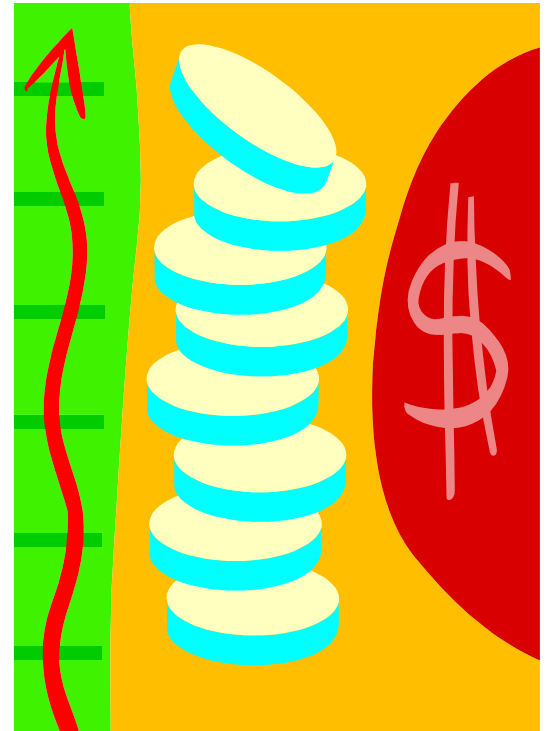
When to complete the forms?

Form	Due Date	Send to
1094-C Transmittal	February 29, 2016 or March 31, 2016 (if reporting electronically*)	IRS
1095-C Employee Statement	February 1, 2016	Each Full Time Employee
1095-C Employee Statement	February 29, 2016 or March 31, 2016 (if reporting electronically*)	IRS

Penalties

Penalties

- *The assessment varies from \$2,000-\$3,000 per full time employee per month.*



Penalties

Penalties

- **No Coverage Penalty:**

Monthly Penalty = \$166.67 x Number of Full-Time Employees

Penalties

Penalties

- **Unaffordable Coverage Penalty:**

Monthly Penalty = \$250 x Number of Full-Time
Affected Employees

Penalties

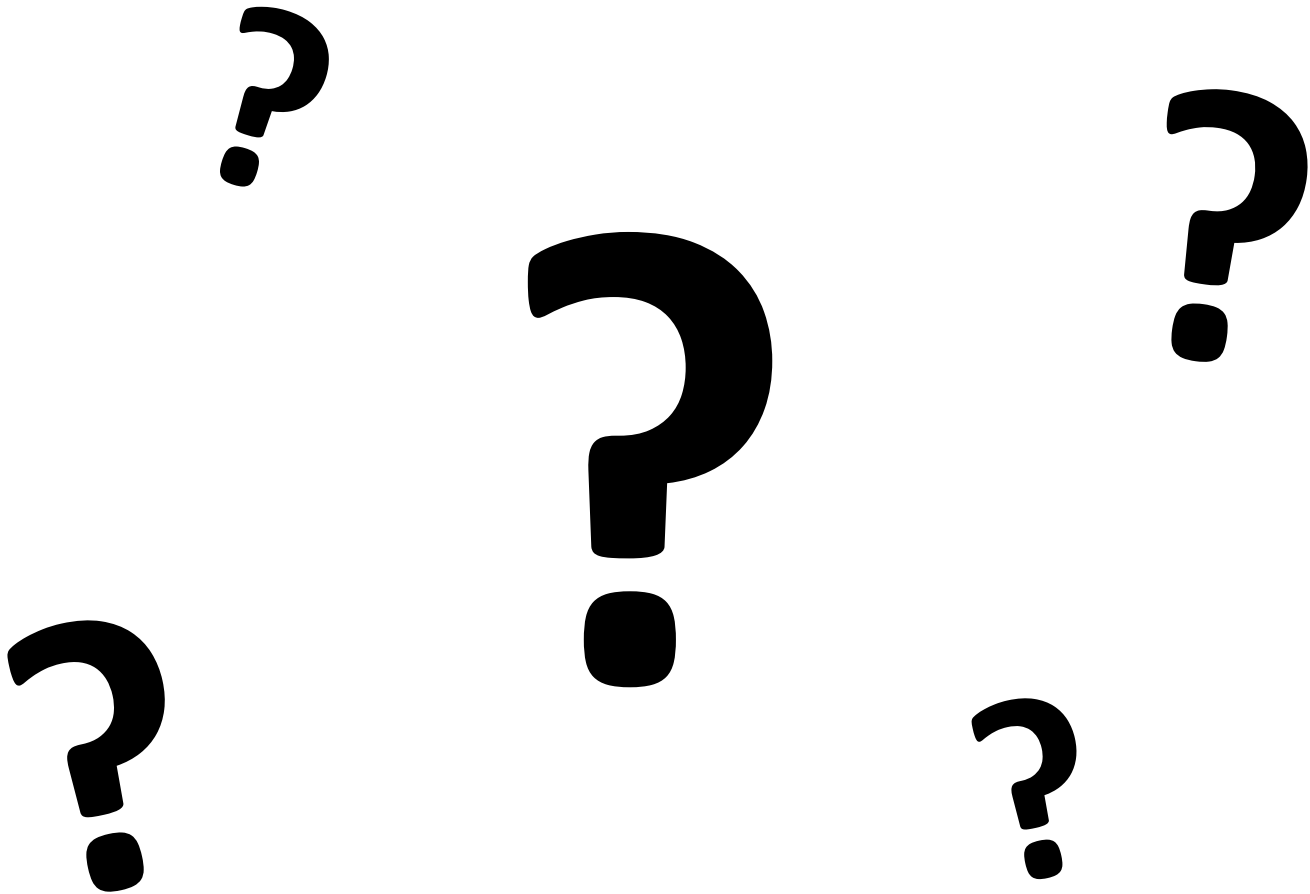
Penalties for not completing the reporting requirement under IRC Section 6055 & 6056:

- **General Penalty Amount: \$250 per return**
- **Violations, corrected within 30 days: \$50 per return**
- **Violations, corrected before Aug, 1: \$100 per return**
- **Violations due to intentional disregard: \$500 per return**

What is the Trust doing?

- **The Trust and/or Carrier will complete Forms 1094-B and 1095-B**
- **Mailed a letter to all Employers explaining their reporting requirements**
- **Education to Employees so they know what to do with the Form 1095-B and Form 1095-C they will receive**

Questions



Resources

For information about Form 1094-C please visit:

[http://www.irs.gov/uac/About-Form-1094-C.](http://www.irs.gov/uac/About-Form-1094-C)

For information about the Form 1095-C please visit:

[http://www.irs.gov/uac/About-Form-1095-C.](http://www.irs.gov/uac/About-Form-1095-C)

For information about the IRS guidelines for electronic reporting please visit the IRS website at [www.irs.gov/](http://www.irs.gov) and search for Publication 5164.

For information about IRC Section 6055 please visit:

<http://www.irs.gov/Affordable-Care-Act/Questions-and-Answers-on-Information-Reporting-by-Health-Coverage-Providers-Section-6055>

For information about IRC Section 6056 please visit:

<http://www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-on-Reporting-of-Offers-of-Health-Insurance-Coverage-by-Employers-Section-6056>