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### ACA TRACK

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#### Form 1095-C Department of the Treasury

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

600115

OMB No. 1545-2251

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/f1095c.

CORRECTED

2014 Internal Revenue Service Employee Applicable Large Employer Member (Employer) Part I 1 Name of employee 2 Social security number (SSN) 7 Name of employer 8 Employer Identification number (EIN) 9 Street address (including room or suite no.) 3 Street address (including apartment 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 9 nd Coverage Feb Mar June July Aua Oct Nov Dec 14 Offer Lines 1-6 Coverag required Name, social security number and 15 Emp address of the employee Share of Cost Mo Premium. Self-Only Minimum Value \$ \$ \$ Coverage 16 Applicable Section 4980H Safe Harbor (enter code, if applicable) Covered Individuals Part II If Employer provided self-insured coverage, check the box and enter the information for each covered individual. (e) Months of Coverage (c) DOB (If SSN Is (d) Covered (a) Name of covered individual(s) (b) SSN not available) all 12 months Jan Feb Mar Apr May July Aug Sept Oct Nov Dec June 17 18 19 20 21

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internal Revenue Se	ervice																				
Part I Employee									Applicable Large Employer Member (Employer)												
1 Name of employ	yee			2	Social	security number	(SSN) 7	Name of	employer	- 1					8 1	Employer	Identifica	tion numb	oer (EIN)		
3 Street address	(including apart	ment no.)				40	9	9 Street address (including room or suite no.) 10 Contact telephone number													
4 City or town		5 State or provi	nce	6	Country	and ZIP or foreig	n postal code 1	11 City or town 12 State or province									13 Country and ZIP or foreign postal code				
Part II Em	ployee Off	er and Cov	erage		J																
	All 12 Months	Jan	Feb	M	ar	Apr	May	June		Τ.									ec		
14 Offer of									Lii	nes 7	<b>7-13</b>										
Coverage (enter required code)									Na	ame,	, em	ploy	er i	dent	tifica	atior	)				
15 Employee									ทเ	ımb	er. a	ddr	ess a	nd (	cont	act					
Share of Lowest Cost Monthly																					
Premium, for Self-Only Minimum Value									nu	ımb	er ic	or un	e en	ibio	yer						
	\$	\$	\$	\$		\$	\$	\$	\$		\$		\$	\$		\$		\$			
16 Applicable Section 4980H Safe Harbor (enter code, if																					
applicable)	and badi																				
	vered Indiv	<b>/Iduals</b> vided self-insi	ured coverag	e, chec	k the	box and ente	er the informa	tion for e	each co	vered in	ndividua										
(a) Nan	ne of covered in	ndividual(s)	(b)	SSN		DOB (If SSN Is not available)	(d) Covered all 12 months		L F - 1				Months (		_	0 1	0.1				
					- "	iot avaliable)	all 12 monus	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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Department of the Treasury

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Internal Revenue Service Employee Applicable Large Employer Member (Employer) 1 Name of employee 2 Social cation number (EIN Line 14 3 Street address (including apartment no.) 1A. Qualifying Offer: MEC providing MV Affordable coverage offered 4 City or town 5 State or province tal code to employee, spouse and dependents. 1B. MEC providing MV offered to employee only. Part II Employee Offer and Coverage 1C. MEC providing MV offered to employee and dependents (not All 12 Months Jan Feb spouse). 14 Offer of Coverage (enter 1D. MEC providing MV offered to employee and spouse (not required code) dependents). 15 Employee Share of Lowest 1E. MEC providing MV offered to employee and to dependent(s) and Cost Monthly Premium, for spouse. Self-Only Minimum Value 1F. MEC NOT providing MV offered to employee, or employee and \$ Coverage spouse or dependents, or employee, spouse and dependents. 16 Applicable 1G. Offer of coverage to employee who was not a full-time Section 4980H Safe Harbor employee for any month of the calendar year and who enrolled in (enter code, if applicable) self-insured coverage for one or more months of the calendar year. Covered Individuals Enter code 1G in the "All 12 Months" box and do not complete the If Employer provided self-insured coverage, of monthly boxes. (a) Name of covered individual(s) (b) SSN Dec 1H. No offer of coverage (employee not offered any health coverage or employee offered coverage that is not MEC). 11. Qualified Offer Transition Relief 2015: Employee (and spouse or 18 dependents) received no offer of coverage, received an offer that is 19 not a qualified offer, or received a qualified offer for less than 12 months. 20

#### Form 1095-C

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

600115 OMB No. 1545-2251

Department of the Treat Internal Revenue Service		►Info	ormation about For	nation about Form 1095-C and its separate instructions is at www.irs.gov/f1095c.													
Part I Emplo	yee				-		Applic	cable l	arge I	Emplo	yer Me	ember	(Empl	loyer)			
1 Name of employee				Social security number	(SSN) 7	Name of	employer					4	8	Employer	Identifica	tion numi	ber (EIN)
3 Street address (incli	uding apartn	nent no.j		Line 15						Y			10	Contact t	elephone	number	
4 City or town		5 State or provin	nce	Only used it	the cove	rage	offer	ed			ovince		13	Country ar	nd ZIP or fo	reign post	tal code
Part II Emplo	yee Offe	er and Cove	erage	provided M entered on						S							
14 Offer of Coverage (enter required code)	All 12 Months	Jan	Feb	Months" bo boxes. Enter the ar		•					Sep	ot	Oct		Nov	С	Dec
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value				of the lowe self-only mi providing m	st-cost mo nimum es ninimum v	onthl senti	y pre ial co	miun verag	for ge								
Coverage \$  16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		\$	\$	including ce If coverage not provide do not com	is not offe MEC or d	id no					\$	\$		\$		\$	
7 (a) (b) (b) (c)	ed Indiv loyer prov		ired coverage, che	ck the box and ente	er the informati	on for e	ach co	vered II	naividua	al.							
(a) Name o	of covered in	dividual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e May	) Months (	of Covera	age Aug	Sept	Oct	Nov	Dec
17																	
18																	
19																	
20																	

Form 1095	reasury	Employer-Provi										
Part I Emp	oloyee											
Name of employ     Street address (ii		ment no.										
4 City or town		5 State	or provin	ce								
Part II Emp	oloyee Off	er and	Cove	rage		L						
	All 12 Months	3 .	Jan	Fel	5	'						
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)												
	ered Indiv ployer prov			red cov	era							
(a) Nam	e of covered in	ndividual(	(S)		(b) S							
17												
18												

19

20

21

Line 16

2A. If the employee was not employed on any day of the month.

2B. If the employee is not a full-time employee for the month and did not enroll in minimum essential coverage, if offered for the month.

2C. If, for any month, the employee enrolled in health coverage, regardless of whether any other code in Code Series 2 might also apply.

2D. If an employee is in a Limited Non-Assessment Period for the month. If an employee is in an initial measurement period, not code . 2E. If, for any month, the multiemployer interim guidance applies for that employee, not codes 2F, 2G, or 2H.

2F. If the employer used the section 4980H Form W-2 safe harbor to determine affordability for purposes of section 4980H(b) for this employee for the year. If used, this safe harbor must be used for all months of the calendar year for which the employee is offered health coverage.

2G. If the employer used the section 4980H federal poverty line safe harbor to determine affordability for purposes of section 4980H(b) for this employee for any month(s).

2H. If the employer used the section 4980H rate of pay safe harbor to determine affordability for purposes of section 4980H(b) for this employee for any month(s).

21. If non-calendar year transition relief for section 4980H(b) applies to this employee for the month.

#### Form 1095-C

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

600115 OMB No. 1545-2251

Part   Employee   2   Bodes security number (\$300)   7   Name of amployer   8   2   Bodes security number (\$300)   7   Name of amployer   8   2   Bodes security number (\$300)   7   Name of amployer   8   2   Bodes security number (\$300)   7   Name of amployer   8   2   Bodes security number (\$300)   7   Name of amployer   8   2   Bodes security number (\$300)   7   Name of amployer   8   2   Bodes security number (\$300)   7   Name of amployer   8   2   Bodes security number (\$300)   10   Contact beightone number (\$300)   10   Country and 2P or foreign postal code   11   City or town   12   State or province   13   Country and 2P or foreign postal code   14   City or foreign postal code   15   C	Department of the Internal Revenue S	Treasury Service	►Inform	nation abou	t Form	1095	-C and its sep	arate instruc	tions is at	www.i	irs.gov/f1	095c.			CORRE	ECTED		20	14		
3 Steel address (including spartment no.)  4 Otty or flowin  5 State or province  6 Country and 2/P or foreign postal code  11 City or flowin  12 State or province  13 Country and 2/P or foreign postal code  14 Otter of Coverage (enter required code)  15 Employee  16 Employee  17 — 22  The province  18 State or province  19 State or province  19 Oct. Nov. Dec.  10 Coverage (enter required code)  10 Coverage (enter required code)  11 Employee  12 State or province  13 Country and 2/P or foreign postal code  14 Offer of Coverage (enter required code)  15 Employee  16 Employee  17 Employee provided self-insured coverage, check the box and enter the information for each covered individual.  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage (e) Months of Coverage  19 One of the required coverage (e) Months of Coverage (e) Months	Part I Em	ployee						_		Appli	icable L	arge	Emplo	yer Me	ember	r (Empl	loyer)				
4 City or town 5 State or province 8 Country and ZIP or tonign postal code 11 City or town 12 State or province 13 Country and ZIP or tonign postal code 14 City or town 12 State or province 13 Country and ZIP or tonign postal code 14 City or town 12 State or province 13 Country and ZIP or tonign postal code 14 City or town 12 State or province 13 Country and ZIP or tonign postal code 14 City or town 12 State or province 14 City or town 12 State or province 13 Country and ZIP or tonign postal code 14 City or town 12 State or province 14 City or town 12 State or province 13 Country and ZIP or tonign postal code 14 City or town 12 State or province 13 Country and ZIP or tonign postal code 14 City or town 12 State or province 14 City or town 12 State or province 13 Country and ZIP or tonign postal code 14 City or town 12 State or province 14 City or town 12 State or province 14 City or town 12 State or province 15 City or town	1 Name of emplo	oyee			2 5	Social	security number	(SSN)	7 Name of	employe	r	7				8	Employer	Identifica	tion numi	oer (EIN)	
Part II Employee Offer and Coverage  At 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  Coverage (enter required code)  15 Employee  Inces 17 — 22  Inces 17 — 22  Inces 18 — Sept Sept Oct Nov Dec  Coverage (enter code)  Inces 19 — 22  Inception of Coverage (enter code)  Inception of Coverage (enter code	3 Street address	(including apart	ment no.)						9 Street ad	dress (in	cluding ro	om or su	te no.)			10	10 Contact telephone number				
A 12 Months	4 City or town		5 State or province		60	country	and ZIP or foreig	n postal code 1	1 City or to	wn		12 S	tate or pr	ovince	vince 13 Country and ZIP or foreign postal code					al code	
14 Offer of Coverage (enter required code)  15 Employee  16 Employee  17 — 22  The provided plans.  Safe (enter code)  18 S S S S S S S S S S S S S S S S S S S	Part II Em	ployee Off	er and Covera	ige			-1						_								
coverage (enter required code)  15 Employee  15 Employee  16 Employee  17 — 22  18 S S S S S S S S S S S S S S S S S S S		All 12 Months	Jan	Feb	Ma	ir	Apr	May	June		July	7	Aug	Sep	ot	Oct		Nov		ec	
mes 17 – 22  Complete Part III ONLY for self- sured plans.  Safe No. Safe N	Coverage (enter																				
pmplete Part III ONLY for self-sured plans.  Safe Note (enter obappicable)  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 (ff SSN is not available)  (d) Covered Individual.  (e) Months of Coverage  (e) Months of Coverage  (not available)  17  18  19  20	15 Employee																				
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  (e) Months of Coverage  (f) Mary June July Aug Sept Oct Nov Dec Individual	Safe (enter co	ans.		self-			\$	\$	\$	\$		\$		\$	4	\$	\$		\$		
(a) Name of covered individual(s)  (b) SSN  not available)  all 12 months  Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  17  18  19  20				d coverage	, check	the	box and ente	r the informa	ation for	each c	overed in	ndividu	al.								
17 18 19 20	(a) Nar	me of covered in	ndividual(s)	(b) SS	SN					Feb	Mar	Apr		_			Sept	Oct	Nov	Dec	
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#### Department of the Treasur

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

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Part I Employee								Applicable Large Employer Member (Employer)										
1 Name of employ	99			2 Socia	security number	r (SSN)	7 Name of employer 8 Employer Identification number (E											
3 Street address (	Street address (including apartment no.)								Street address (including room or suite no.)     10 Contact telephone number									
4 City or town	6 Countr	6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP							d ZIP or fo	reign pos	tal code							
Part II Emp	oloyee Off	er and Cov	verage									•						
	All 12 Months	s Jan	Feb	Mar	Apr	May	June	- July	Aug	Sep	ot	Oct		Nov		Dec		
14 Offer of Coverage (enter required code)		IH	   1H	   1H	1H	1H	1H	1H	1H	   1A		1A		1A	1	Α		
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	2D	2D	2D	2D	2D	2D	2D	2C	;	2C		2C	2	С		
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like earns	. <b>311.</b> 0	o per n	our as a	a variat	ne noui	910			<del></del>	e) Months o				-	Lu. Lo			
mployee.						ent	hs Jan I	Feb Mar	Apr May	June	July	Aug	Sept	Oct	Nov	Dec		

Mike is hired on February 1.

The employer has a 6 month measurement period and 2 month administration period Mike averages over 130 hours in the first 6 months of employment.

Mike is made an offer of coverage September 1 Coverage is MEC, MV & Affordable.

ormati	rmation for each covered individual.													
ered						Months								
onths	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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#### Department of the Treasury

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Part I Em	ployee		\	Applicable Large Employer Member (Employer)												
1 Name of employ	yee			2 Social	security number	r (SSN)	7 Name of emp	ployer				8 Employ	yer identifica	tion num	ber (EIN)	
3 Street address (	including apartn	nent no.)					9 Street addre	ss (including roo	m or suite no.)			10 Contac	t telephone	number		
4 City or town		5 State or prov	ince	6 Country	and ZIP or fore	gn postal code	11 City or town		12 State or pr	rovince		13 Country	and ZIP or f	oreign pos	tal code	
Part II Em	ployee Offe	er and Cov	erage													
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept		Oct	Nov	1	)ec	
14 Offer of																
Coverage (enter required code)	1G															
15 Employee																
Share of Lowest Cost Monthly																
Premium, for Self-Only																
Minimum Value Coverage	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	9	6	\$		
4C Applicable																
16 Applicable Section 4980H																
Safe Harbor (enter code, if	200			_												
applicable)	2C vered Indiv	iduale	Sally	earns Ś	11.00 ı	er hou	ır as a v	<i>r</i> ariable	hour							
	nployer provi		•		•		ber 201									
(a) Nan	ne of covered in	dividual(s)		-							verage	6	1 0-1	Mari	D	
			The e	employe	er has a	12 mc	onth me	easurer	nent	Ju	lly A	ug Sep	t Oct	Nov	Dec	
17			perio	d and 1	. montl	n admi	nistrati	on peri	od.							
18			Sally	average	ed ovei	130 h	ours in	the loo	kback							
10																
19				uremei	•								<u> </u>			
20			Sally	does no	ot aver	age ov	er 130 ł	nours ir	i the							
stability period.																
Sallly is made an offer of							coverag	e Janua	arv 1		-   -					
22		_														
For Privacy Act	r Privacy Act and Paperwork Reduction Coverage is MEC, MV & A												Form	1095-	C (2014)	

2014 Health Care Reform

## ACA TRACK Administrative Capabilities

- Attain Dependent Social Security Numbers
  - Regulations require reporting entities to make reasonable efforts to collect social security numbers
  - Regulations allow reporting entities to use a date of birth if a SSN is not available
    - This alternative should not be used unless the reporting entity has made reasonable efforts to obtain the SSN

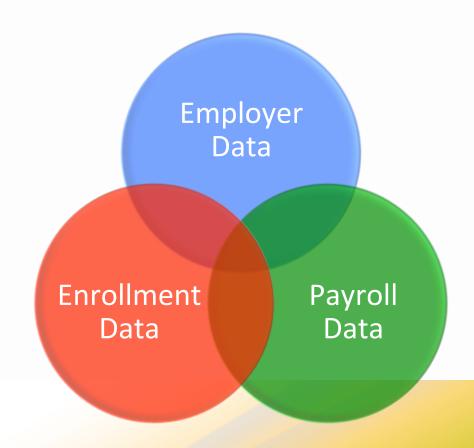


## ACA TRACK "Administrative Capabilities"

- ACA TRACK will administer and digitally track all dependent information required
  - After an initial attempt to collect a SSN, the employer must make two additional (consecutive) annual attempts
  - If an employer makes the two additional attempts, no penalty will be imposed for failing to provide all required information



## ACA TRACK "Bringing It All Together"



APPLE
GROW+H
PARTNERS
Healthy Growth.