Employer ACA Reporting Requirements

March 26, 2015

Assurex GLOBAL

Employer ACA Reporting Requirements

- Welcome! We will begin at 3 p.m. Eastern
- There will be no sound until we begin the webinar. When we begin, you can listen to the audio portion through your computer speakers or by calling into the phone conference number provided in your confirmation email.
- You will be able to submit questions during the webinar by using the “questions” box located on your webinar control panel.

Employer ACA Reporting Requirements

March 26, 2015

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Background and Basic Rules

Background

- Employer reporting of plan and coverage information will provide the IRS with the information necessary to administer and regulate:
  - Individual compliance with the requirement to have minimum essential coverage ("individual mandate")
  - Individual eligibility for a premium tax credit/subsidy for coverage through a public marketplace
  - Employer compliance with the requirement to offer coverage to full-time employees and their dependent children under the employer shared responsibility rules (Section 4980H)

Who Must Report?

- All "applicable large employers" (ALE = 50 or more FTEs) must report plan and offer of coverage information (§6056)
  - Even ALEs that do not provide health insurance must report
  - Employers with 50-99 FTEs satisfying the transition relief criteria to delay compliance until 2016 must still report for 2015
- All employers offering self-funded plans (large and small) must report participant coverage information for any individual covered by the self-funded plan (§6055)
  - Insurance companies will report this coverage information to the IRS for fully-insured plans

Timing Requirements

- When Must Employers Report?
  - Reporting first required in 2016 for the 2015 calendar year
    - Reporting is based on data from the previous calendar year regardless of the employer's plan year
  - Employers may voluntarily report in 2015 (for the 2014 calendar year)
  - Annual timeframes for reporting (same as for W-2s)
    - Annual employer returns must be filed with the IRS by Feb. 28 (Mar. 31, if filed electronically)
    - Corresponding employee statements must be provided annually to employees by Jan. 31
      - The first employee statements must be provided by Feb. 1, 2016 (Jan. 31, 2016 is a Sunday)

Form Details

- Form 1095-C or 1095-B Employee Statement
  - Used to report employee-specific and covered individual information
  - In general, one is required for:
    - Each full-time employee; and
    - Each covered individual under a self-funded plan
- Form 1094-C or 1094-B Employer Summary & Transmittal Form
  - Used to report employer summary information to the IRS
    - Think of it as a cover sheet for the individual employee statements
- 2014 forms and instructions on the IRS website at:
  - http://www.irs.gov/Forms-&-Pubs

Report on Who?

- Reporting must be provided on the following individuals:
  - All ALEs (fully-insured or self-funded)
    - Any employee who is full-time for at least 1 month during the year
  - Any employer with a self-funded plan
    - Must also reporting on any individual covered by the self-funded plan for at least one month (full-time, part-time, or non-employee) including information on any covered spouse and dependents
      - 1095-C for employees
      - 1095-B optionally for non-employees

	ALE Fully-Insured Plan	ALE Self-Funded Plan	Small Employer Self-Funded Plan
1095 - C	**Part I** - Employee & Employer Info **Part II** - Offer of Coverage (eligibility) Info	**Part I** - Employee & Employer Info **Part II** - Offer of Coverage (eligibility) Info **Part III** - Info on Covered Individuals	
1094 - C	**Part I & II** - Employer Info **Part III** - Monthly Employer Related Information **Part IV** – Aggregated Group Information		
1095-B		Self-Funded employers may optionally use 1095-B to report covered "non-employees" (Retirees, COBRA, etc.)	**Part I, II, III** - Employer Info **Part IV** - Info on Covered Individuals
1094-B		Basic Employer Information (No plan or offer of coverage info)	Basic Employer Information (No plan or offer of coverage info)

Special Reporting Rules

- Qualifying Offer
  - Offer of MV coverage with employee cost less than 9.5% of FPL ($93.18 in 2015)
  - Benefits to employer:
    - Enter code 1A in line 14 of 1095 and employer does not have to provide cost of lowest cost plan on line 15
    - Can provide a simplified statement to employees instead of a copy of the 1095
  - Problem with the simplified statement approach
    - Employer still has to provide a 1095 to the IRS…why not just give the employees a copy?
    - Self-funded employers cannot use the simplified statement for anyone who has elected coverage

Special Reporting Rules

- 98% Offer
  - Employer offers affordable MV coverage to 98% of full-time employees
  - Benefits to employer:
    - Employer does not have to provide number of full-time employees by month in column (b) of 1094-C
- Electronic Reporting
  - Employers who file 250 or more 1095s must file electronically

The 1095-C

Information Required

- All Applicable Large Employers (self-funded or fully-insured)
  - 1095-C Parts I & II Specific Information for Each Employee
    - Part I
      - Name, SSN, address for each full-time employee
      - Employer Information
    - Part II – for each calendar month
      - Line 14 - Offer of coverage code
      - Line 15 - Employee cost for single coverage on lowest cost plan
        - Only use if line 14 is Line 14 is 1B, 1C, 1D, 1E, or 1G
        - Qualifying offer - remember 9.5% of 2015 FPL = $93.18
      - Line 16 - Safe harbor codes
  - Alternative "simplified" statement may be used instead of 1095 in certain cases

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/f1095c.*

☐ VOID
☐ CORRECTED

600115
OMB No. 1545-2251
2014

Part I Employee

1 Name of employee	2 Social security number (SSN)
Bob Radecki	
3 Street address (including apartment no.)	
4 City or town	5 State or province

6 Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Benefit Comply	
9 Street address (including room or suite no.)	10 Contact telephone number
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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Fully-Insured Plan Employer does not fill out Part III

Information Required

- All Applicable Large Employers (self-funded or fully-insured)
  - Line 14 Code Series 1 (Offer of coverage codes)

Code	Description	How Common
1A	**MV offered at less than 9.5% of FPL ($93.18/mo)**	**Common**
1B	MV Offer to EE only	Rare
1C	MV Offer to EE + Dependent (not spouse)	Rare
1D	MV Offer to EE + Spouse (non dependent)	Rare
1E	**MV offered to EE, at least MEC offered to spouse & deps**	**Common**
1F	MEC that is not MV offered to employee	Some
1G	Self-funded offered to part-time EE and non-employees	Some
1H	**No offer of coverage to full-time employee**	**Common**
1I	No offer to employee but employer using qualifying offer relief	?

Information Required

- All Applicable Large Employers (self-funded or fully-insured)
  - Line 16 Code Series 2 (safe harbor codes)

Code	Description
2A	Not employed any day that month
2B	Part-time or termination month when not covered all month
2C	**Enrolled in coverage (Use over any other code if applicable)**
2D	EE in non-assessment period (e.g. waiting period)
2E	Multi-employer plan interim relief
2F	W-2 Safe harbor
2G	FPL safe-harbor
2H	Rate of pay safe harbor
2I	Non-calendar year plan employer transition relief

1095-C

- All Employers for <u>Self-Funded Plans Only</u>
  - 1095-C Part III - Additional coverage related information required for all covered individuals including employees, non-employees, spouses, & dependents:
    - Name
    - SSN (or DOB if SSN is not available)
      - Rules require employer to attempt to obtain SSN numbers for spouses and dependents
    - If individual had coverage in any employer sponsored Minimum Essential Coverage (MEC) for each calendar month (Y or N)
      - Individual is considered to have coverage for the month if covered any day during the month

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/f1095c.*

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600115
OMB No. 1545-2251
2014

Part I Employee

1 Name of employee	2 Social security number (SSN)
Bob Radecki	
3 Street address (including apartment no.)	
4 City or town	5 State or province / 6 Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Benefit Comply	
9 Street address (including room or suite no.)	10 Contact telephone number
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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

The 1095-C Examples

Covered all Year

- Employee, spouse covered on self-funded plan all year, child added in July
- $100 per month to participate in single coverage

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/f1095c.***

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600115
OMB No. 1545-2251
2014

Part I Employee

1 Name of employee	2 Social security number (SSN)
3 Street address (including apartment no.)	
4 City or town	**5** State or province / **6** Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	**10** Contact telephone number
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)	1E												
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	$ 100	$	$	$	$	$	$	$	$	$	$	$	$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)	2C												

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	Employee Name	123-45-6789		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18	Spouse Name	987-65-4321		☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19	Child Name		7/1/2015	☐	☐	☐	☐	☐	☐	☐	☒	☒	☒	☒	☒	☒

Terminated Employee

- Fully-insured plan
- Employee has waived coverage
- Employee was terminated August 15th and plan offers coverage only until the date of termination
  - Even though employee waived coverage, the plan cannot claim an offer of coverage for the entire month of August since coverage would have terminated on the date of termination
- Employee cost for lowest cost MV plan = $110 per month
- Employer has set contributions for this class of employee based on the W-2 employer safe harbor

Terminated Employee (cont.)

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

Employer-Provided Health Insurance Offer and Coverage

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600115
OMB No. 1545-2251
2014

Part I Employee

1 Name of employee	2 Social security number (SSN)
Regan Blomme	1234567890
3 Street address (including apartment no.)	
1205 Wonderland Dr	

4 City or town	5 State or province	6 Country and ZIP or foreign postal code
Paradise	MN	55333

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
Benefit Comply, LLC	0987654321
9 Street address (including room or suite no.)	10 Contact telephone number
1303 Compliance Ct	5325600507

11 City or town	12 State or province	13 Country and ZIP or foreign postal code
Resource	MN	55133

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)		1E	1E	1E	1E	1E	1E	1E	1H	1H	1H	1H	1H
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	$	$ 110.10	$ 110.10	$ 110.10	$ 110.10	$ 110.10	$ 110.10	$ 110.10	$	$	$	$	$
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2F	2F	2F	2F	2F	2F	2F	2B	2A	2A	2A	2A

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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Copies of this presentation are available through your benefits advisor.

New Hire

- New employee hired Feb. 15th with coverage offered May 1st after waiting period of 1st of the month following 60 days – employee waives coverage
- Lowest cost MV plan = $100

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

Employer-Provided Health Insurance Offer and Coverage

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600115
OMB No. 1545-2251
2014

Part I Employee

1 Name of employee	2 Social security number (SSN)
3 Street address (including apartment no.)	
4 City or town	**5** State or province	**6** Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	**10** Contact telephone number
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)		1H	1H	1H	1H	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	$	$	$	$	$	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100	$ 100
16 Applicable Section 4980H Safe Harbor (enter code, if applicable)		2A	2D	2D	2D								

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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Qualifying Offer Covered All Year

- Qualifying offer of MV coverage to employee (single cost less than $93.18 per month)
- Employee elects and is covered all year

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												
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												

The 1094-C

Information Required

- All Applicable Large Employers (self-funded or fully-insured)
  - 1094-C Page 1
    - Part I – Basic employer information
    - Part II
      - Employer's status if a member of a controlled group/affiliated service group (list other member employers in the controlled group on page 3 of 1094)
      - Qualifying offer and transition rules eligibility indicator

1094-C Page 1

120115

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/f1094c.***

☐ CORRECTED

OMB No. 1545-2251

2014

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

For Official Use Only

17 Reserved . . . . . ☐

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

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 . . . . . ▶

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

Page 2 Information Required

- All Applicable Large Employers (self-funded or fully-insured)
  - 1094-C Page 2 employer plan information by month
    - Column (a) – Did employer offer coverage to 95% of full-time?
    - Column (b) – Number of full-time employees
    - Column (c) – Total number of employees
    - Column (d) – Is employer part of a controlled group?
    - Column (e) – Transition relief code
      - Code A for 50-99 FTE relief
      - Code B for employer that fails to offer coverage to 70% of full-time employees

1094-C page 2

Form 1094-C (2014) Page 2

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	☐	☐			☐	
24	Jan	☐	☐			☐	
25	Feb	☐	☐			☐	
26	Mar	☐	☐			☐	
27	Apr	☐	☐			☐	
28	May	☐	☐			☐	
29	June	☐	☐			☐	
30	July	☐	☐			☐	
31	Aug	☐	☐			☐	
32	Sept	☐	☐			☐	
33	Oct	☐	☐			☐	
34	Nov	☐	☐			☐	
35	Dec	☐	☐			☐	

1094-C page 3

Form 1094-C (2014) 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		

The 1095-B and 1094-B

Audio trouble? Dial 1-719-867-1571 Access Code 265313
Copies of this presentation are available through your benefits advisor.

1095-B and 1094-B

- When to Use
  - Small employers (not an ALE) for individuals covered by a self-funded plan
  - ALEs for certain individuals covered by a self-funded plan
    - The 1095-B can only be used if the individual was not a full-time employee for any month during the year
    - Part-time employees covered by self-funded plan
    - Non-employees covered by self-funded plan
      - COBRA, retirees, board of directors, etc.

1095-B

560115

Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

► **Information about Form 1095-B and its separate instructions is at *www.irs.gov/form1095b.***

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OMB No. 1545-2252

2014

Part I **Responsible Individual** (Policy Holder)

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (If SSN is not available)
4 Street address (including apartment no.)	**5** City or town	**6** State or province	**7** Country and ZIP or foreign postal code

8 Enter letter identifying Origin of the Policy (see instructions for codes): . . . . . ► ☐

9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable

Part II **Employer Sponsored Coverage** (If Line 8 is A or B, complete this part.)

10 Employer name			11 Employer identification number (EIN)
12 Street address (including room or suite no.)	**13** City or town	**14** State or province	**15** Country and ZIP or foreign postal code

Part III **Issuer or Other Coverage Provider**

16 Name		17 Employer identification number (EIN)	18 Contact telephone number
19 Street address (including room or suite no.)	**20** City or town	**21** State or province	**22** Country and ZIP or foreign postal code

Part IV **Covered Individuals** (Enter the information for each covered individual(s).)

	(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	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

1094-B

1115

Form **1094-B**

Department of the Treasury
Internal Revenue Service

Transmittal of Health Coverage Information Returns

► **Information about Form 1094-B and its separate instructions is at *www.irs.gov/form1094b.***

OMB No. 1545-2252

2014

1 Filer's name	**2** Employer identification number (EIN)
3 Name of person to contact	**4** Contact telephone number
5 Street address (including room or suite no.)	**6** City or town
7 State or province	**8** Country and ZIP or foreign postal code
9 Total number of Forms 1095-B submitted with this transmittal . . . . . ►	

For Official Use Only

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. 61570P Form **1094-B** (2014)

Miscellaneous Issues

Miscellaneous

- Separate Employers in an “Aggregated Group”
  - Each must file separately with their own 1094
- Multiple Employer Plans (Typically Union Trust Fund Plans)
  - Employer still required to file necessary 1095s
  - Trust administrator will provide coverage statement (i.e. 1095-B)
    - Employers may not know detailed coverage information to fill out part III of the 1095-C

Summary

- All ALEs - What kind of offer of coverage was made to employees who were full-time for at least one month?
- Self-funded plans - What months were employees, non-employees, their spouses, and their dependents covered by an employer sponsored self-funded plan?
- Is the employer a part of an aggregated group of employers?
- How does the employer define full-time for ACA purposes (i.e. on a monthly basis or the optional look-back measurement period)?
- Is the employer taking advantage of any of the 4980H transition relief available?
- Is the employer using any of the IRS affordability safe harbors to set employer contribution rates?

Employer ACA Reporting Requirements

March 26, 2015

Assurex Global Partners:

- Catto & Catto
- Celedinas Insurance Group
- Cragin & Pike, Inc.
- The Crichton Group
- The Daniel & Henry Co.
- Engle-Hambright & Davies
- Frenkel Benefits
- Gillis, Ellis & Baker, Inc.
- Haylor, Freyer & Coon, Inc.
- The HDH Group
- The Horton Group
- INSURICA
- Kapnick Insurance Group
- Kinney Pike Insurance
- Lipscomb & Pitts Insurance
- LMC Insurance & Risk Management
- Lyons Companies
- The Mahoney Group
- MJ Insurance
- Parker, Smith & Feek, Inc.
- PayneWest Insurance
- R&R/The Knowledge Brokers
- RCM&D
- Roach Howard Smith & Barton
- The Rowley Agency
- Starkweather & Shepley Insurance Brokerage
- The Underwriters Group
- Woodruff-Sawyer & Co.
- Wortham Insurance & Risk Management

Thank you!

Assurex GLOBAL

Employer ACA Reporting Requirements

March 26, 2015

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