Greater Tompkins County Municipal Health Insurance Consortium

Audit and Finance Committee

Agenda

April 24, 2018 – 3:30 p.m.

Old Jail Conference Room

1. Call to Order (3:30) — M. Cook

2. 2017 External Financial Audit presentation Performed by Insero & Co. — J. Michelson/ M. Theusen
   a. **RESOLUTION**: Acceptance of External Audit Report

3. Changes to Agenda (3:50)

3. Approve Minutes of March 20, 2018 (3:52)

4. Executive Director's Report (3:55) — D. Barber
   a. DFS Communications
   b. Other Committees
   c. Wellness Consultant RFP update
   d. Director's and Officer's Liability and Errors and Omissions Policies
   e. Invoices
   f. Retreat

5. Financial Update- 1st Quarter results (4:10) — S. Locey

6. New Member Application (4:15) — S. Locey

7. Investment Policy Request for Proposals (4:30) — D. Barber

8. **RESOLUTION:** Executive Director Contract (4:40) — M. Cook

9. Retire Drug Subsidy and 1094 and 1095 Reporting (4:45) — S. Locey

10. Next Agenda Items: (4:55)
    a. Medical Claims Auditing

11. Adjourn (5:00)

Next Meeting: May 22, 2018

Greater Tompkins County Municipal Health Insurance Consortium

125 East Court Street • Ithaca, New York 14850 • (607)274-5590
www.tompkinscountyny.gov/hconsortium • consortium@tompkins-co.org

"Individually and collectively we invest in realizing high quality, affordable, dependable health insurance."

RESOLUTION TO ACCEPT 2017 EXTERNAL AUDIT REPORT PERFORMED BY INSERO & CO.

WHEREAS, the Board of Directors entered into a contract for auditing services with Insero & Co. (CDLM), for the purpose of conducting an external audit of the Consortium's financial records for fiscal year 2017, now therefore be it

RESOLVED, on recommendation of the Audit and Finance Committee, That the 2017 external audit report prepared and presented to the Audit and Finance Committee by Insero & Co. (CDLM) is hereby accepted.

* * * * * * * * *

Present: Mack Cook, Bud Shattuck, Olivia Hersey, Peter Salton, Rordan Hart, Laura Shawley (arrived at 3:35 p.m.), Steve Thayer, Ann Rider
Excused: Chuck Rankin
Guests: Judy Drake, Board of Directors Chair; Don Barber, Executive Director; Steve Locey, Consultant; Jessica Hobart, Rick Snyder, Treasurer, Finance Department

Call to Order

Mr. Cook called the meeting to order at 3:31 p.m.

Changes to the Agenda

The resolution entitled "Resolution of the Audit and Finance Committee to Accept Final Audit Report Presented by BMI – Prescription Drug Claims" was added to the agenda.

Approval of February 27, 2018 Minutes

It was MOVED by Ms. Hersey, seconded by Mr. Thayer, and unanimously adopted by voice vote by members present, to approve the minutes of February 27, 2018 as submitted. MINUTES APPROVED.

Executive Director's Report

DFS Communications

Mr. Barber reported there has been no communication with the Department since the last meeting; Mr. Snyder commented that the Jurat was finished today.

Other Committees

Mr. Barber reported the Joint Committee on Plan Structure and Design received a report from Mr. Locey on the actuarial values for Metal Level Plans. The Silver Plan is out of the required range; the Committee will be discussing options to bring it back into line at its next meeting. Although there have been no meetings of the Appeals Committee, Mr. Barber said there have been issues submitted and commented that once Excellus has become involved they have been resolved.

Mrs. Shawley arrived at this time.

Mr. Barber reminded members that the annual Retreat will be held on April 26th and will focus on utilization. He reported the March issue of Newsletter has been released and provided copies. Mr. Barber reported there was one qualified response to the Request for Proposals for a Wellness Consultant; the Review Committee has scheduled a meeting and will be meeting with the respondent as well. Mr. Barber reminded members that the Board of Directors meeting will be held at Tompkins Cortland Community College in the Sprole Conference Room.

Selection of Committee Vice Chair

It was MOVED by Ms. Hersey, seconded by Ms. Rider, and unanimously adopted by voice vote by members present, to appoint Laura Shawley as Vice Chair of the Audit and Finance Committee. MOTION CARRIED.

Invoices

It was MOVED by Mrs. Salton, seconded by Ms. Rider, and unanimously adopted by voice vote by members present, to approve payment of the invoice dated February 28, 2018 to Armory Associates in the amount of $8,150.00. MOTION CARRIED.

The following invoice was presented for information only:

TST BOCES – 2017-2018 Printing

Financial Update

Mr. Locey said financial information for 2018 is not yet available; however, he provided claims totals from January 2016 thru February 2018 showing what the Plan paid and what the member paid for both medical and drug based on information provided by Excellus and ProAct. On the medical side for the first two months of 2018 the Consortium is at $4.3 million in total claim payments. Mr. Locey said collectively claims are 8% below budget on total claims but noted generally claims amounts for January and February tend to be lower because members are paying deductibles and out-of-pocket maximums have been reset leaving the member's cost-share higher during this period.

Mr. Locey said they continue to monitor the HCRA Surcharge which he estimates to represent 2.65% of the Consortium's total budget. Mr. Barber said as a result of the Committee's discussion, he and Mr. Cook met with Assemblywoman Lifton and shared information about this. He received a call from Senator Seward's office and was told it was very unlikely that anything could be done about this in the 2018 State budget; however, they felt there is merit in discussing this further and asked that meeting be scheduled after the State budget is adopted. Mr. Barber said he sent a communication to other Article 47s in the State with information about this and he received responses indicating others are interested as well. He will be communicating with them again to provide an update on where this stands.

2017 Year-end and Jurat Report

Mr. Snyder provided an update on the status of the 2017 year-end financial report and said information was forwarded to the auditors, Insero & Co. today. He commented that if the Consortium moves forward with the Investment Policy there will be additional reporting work on the Jurat that will need to be done. The Committee will need to approve the audit report at its next meeting.

Director's and Officer's and Errors and Omissions Insurance

Mr. Cook said the Committee had a lengthy discussion on this topic at the last meeting and since that time has received correspondence from John Powers, the Consortium's legal counsel. Mr. Salton said Mr. Powers provided a good summary of the issues in his communication and said it is important to note that the Directors and Officers of the Consortium are municipal employees acting in their official capacity. He noted there are four main types of claims that could be brought forward but said it is important to understand that the Board is a mutually-cooperative decision-making process and doesn't believe there is a great financial risk for Directors. He referred to an incident that happened in the past involving an ethics matter that required a Director to obtain an attorney and said one thing he thinks should be considered is whether the Board would want to change the Municipal Cooperative Agreement to afford its Directors indemnification. Mr. Salton said he supports exploring whether the Consortium should afford its Directors and Officers protection from individual exposure relative to official

capacity and noted that current Director's and Officer's insurance policy does not cover the type of action that he referred to earlier that required a Director to obtain legal counsel.

Mr. Barber commented that Mr. Stoddard from Haylor, Freyer, and Coon is aware of Mr. Power's letter but he has not yet received a response from him. He said he also thinks there needs to be further discussion of indemnification of the Board of Directors. Mr. Locey recommended that if the Board wished to adopt a policy to indemnify the Board of Directors it should be done through an amendment of the Municipal Cooperative Agreement. He commented that in his 30 years of experience in working in this business he isn't aware of a time when a board member has been sued over a decision they made relative to operating a municipal cooperative.

A concern was expressed by Ms. Hersey that the communication from Mr. Powers does not reference labor directors. Other members shared in this concern and noted the uniqueness in the way labor Directors are appointed to the Board. Ms. Drake offered a suggestion to include language in the Municipal Cooperative Agreement. Mr. Locey said he would follow-up on this with Mr. Powers. Mr. Salton said he would like to look at whether the Director he referenced in the situation earlier would have been protected if the Board had an indemnification policy in place.

There was consensus that current policy limits will be maintained and the subject of indemnification of Directors will be included in the list of items to be reviewed during the next review of the Municipal Cooperative Agreement. Mr. Barber said he would take the lead in following-up with Mr. Powers.

Online Enrollment Process

Mr. Barber said the Committee has discussed having an online enrollment policy and he has developed a draft policy based on input he received. Today he received information from Excellus on how Ms. Hobart can have access to the necessary information. He explained the process and said municipalities will be asked whether they would like the Consortium to do online enrollment for them. If they do not wish to they will be informed of their responsibilities going forward and if they would like the Consortium to do this for them they will need to provide group information, authorization for the Consortium to do this on their behalf, and submit the proper forms going forward. Mr. Barber expects this policy to eliminate the occurrence of enrollment issues that have been occurring.

RESOLUTION NO. 003-2018 - ADOPTION OF CONSORTIUM ONLINE ENROLLMENT POLICY

MOVED by Ms. Ricer, seconded by Mr. Salton. Ms. Hobart said she thinks this policy will be helpful and save time as it will allow her to access information that she presently doesn't have access to. Mr. Barber said the issue of protecting information and being HIPPA compliant will be addressed through use of One Drive mailbox on the County's e-mail server. Ms. Drake said she thinks the Policy will be helpful and noted the responsibility to communicate the information will remain with the municipality.

A question was raised as to whether a threshold should be set on the number of enrollments a municipality can have the Consortium do before a fee is imposed. Mr. Cook suggested this could be included in the discussion of new member applications. Mr. Locey noted that if the policy is amended to address the size of the employer that the reference should

be on covered members and not employees as the County includes other entities such as TC3, the Public Library, and the Soil and Water Conservation District.

The resolution was unanimously adopted by voice vote by members present.

WHEREAS, non-online subscriber enrollment has many opportunities for things to slip through the cracks and can result in delays due to the length of time between when a subscriber submits their enrollment change and when it is in the "system", and

WHEREAS, the Consortium's vision statement includes: "*The Consortium administers operations by collaborating with claims administrators, providers, and employee representatives in an effort to manage its costs, efficiencies, and success," and*

WHEREAS, adopting a policy whereby all enrollment changes being submitted online complies with the Vision Statement and works in concert with the Excellus software system to optimize delivery of service, and

WHEREAS, Excellus has committed to process timelines for online enrollment, *now therefore be it*

RESOLVED, on recommendation of the Audit and Finance Committee, That the Board of Directors adopts the "Online Enrollment Policy" *ensure all enrollment changes as soon as practicable will be done "online".*

* * * * * * * * *

ONLINE ENROLLMENT POLICY
FOR
GREATER TOMPKINS COUNTY MUNICIPAL INSURANCE CONSORTIUM

Article I
Purpose and Objectives

A. Purpose

The Greater Tompkins Municipal Health Insurance Consortium adopts the Online Enrollment Policy to ensure that hence forth all new enrollment, additions, deletions, and changes will be done online.

B. Objectives

The Consortium adopts this policy for two reasons:

1. It is important to our subscribers and their employer that each knows that enrollment changes are in the Excellus software system. Only the online process allows this notification to happen in a timely manner.
2. It is important that the municipal partners have a record of enrollment changes: for accurate invoicing by the Consortium and for communication between the municipal benefit managers/clerks and the subscribers in their group(s).

Article II
Consortium Staffing

The Consortium recognizes that many of our partners would not have the occasion to use the online system on a frequent enough basis to feel comfortable accepting this mandated policy of only making online enrollment changes. Therefore, the Consortium will provide staff to conduct online enrollment for those municipal partners wishing that service with no fee.

Article III

Municipality Responsibility

A. To be clear, the Consortium is strictly providing a data entry function, NOT a human resource function. Municipal partners remain the direct contact with the subscriber. Therefore, the municipal partner is responsible for gathering all required information on the Excellus enrollment change form "SF FAP", ensuring its accuracy and completeness, and ensuring both the subscriber and the municipality have signed the Excellus enrollment change form" SF FAP". This ***SF FAP form*** is the information to be communicated to the Consortium and will be entered online.

B. For all new family plan enrollments, the municipal employer is responsible for verifying the eligibility of dependents via the ***Consortium's Dependent Certification Process***. Then signing and sending the ***Dependent Eligibility Verification Form*** to Consortium Enrollment along with form SF FAP.

C. Municipal partners are free to conduct their own online enrollment. Process expectations are outlined in the ***Excellus 2017 Memorandum of Understanding*** (MOU). These same employers are also responsible for dependent verification of any newly added dependents to the plan.

D. For any municipal partners using the Consortium's online enrollment data entry service, communicate the completed SF FAP form and the Dependent Verification Form to the Consortium through the Consortium's online web portal or fax: 607-274-5505.

If electronic submission is not possible, you may use mail but recognize an additional time lag built into this process.

US Mail: Greater Tompkins County Municipal Health Insurance Consortium
Attn: Enrollment
125 East Court Street
Ithaca, New York 14850

E. These applications will be handled with HIPAA compliance through the Consortium online enrollment portal. Paper records (fax and US Mail) will be digitized and retained for a period no less than required by the NYS Records and Retention Schedule.

Article IV
Confirming Municipal Online Enrollment Process

All municipal partners must state in writing their ***intention to make enrollments online***. Should a municipal partner wish the Consortium to provide their online data enrollment, the municipality will need to sign a ***Release*** so that Excellus can provide the Consortium with access to their account for online enrollment purposes.

Article V
Confirmation

Once the enrollment application is received by the Consortium, the enrollment data will be submitted online within three (3) business days. Confirmation of enrollment will be sent back by the Consortium within 3 days of observing the change in the Excellus enrollment software.

Article VI
Contact

All questions and information should be communicated to Consortium Enrollment. Phone (607) 274-5403, Fax (607)274-5505.

* * * * * * * * *

RESOLUTION OF THE AUDIT AND FINANCE COMMITTEE TO ACCEPT FINAL AUDIT REPORT PRESENTED BY BMI – PRESCRIPTION DRUG CLAIMS

Mr. Barber spoke of two remaining items needing more communication and an adjudication process going forward. The first area for clarification relates to certain pharmacy

management edits or protocols which include, but may not be limited to, Step-Therapy (ST), Prior Authorization (PA), and Quantity Limits (QL). The second area identified was the use of the $1,500 cost threshold for applying the Prior Authorization. While this edit is well within ProAct's, it is a new edit that the Consortium was unaware of. ProAct has stated the rationale behind the use of the $1,500 threshold, which is within its authority and responsibility to establish, is to safeguard against medications dramatically rising in price. It allows ProAct to suggest lower cost alternatives where they exist.

Mr. Barber commented that ProAct has been very responsive to the Consortium and received positive comments from BMI in the audit report.

MOVED by Ms. Hersey, seconded by Mr. Thayer, and unanimously adopted by voice vote by members present.

WHEREAS, the Consortium has determined there is value in conducting periodic medical and prescription drug claims adjudication process, and

WHEREAS, the Consortium's has developed a pattern of conducting these claims audits on alternate years for medical one year and then pharmaceutical claims the next, and

WHEREAS, Board of Directors Resolution No. 007-2017 authorized a contract with BMI Audit Services to perform an audit to ensure prescription drug claims paid by ProAct are in accordance with benefit plan documents, Federal and State Laws, Rules, and Regulations, and industry standard practices for years 2015 and 2016, and

WHEREAS, BMI has completed the prescription drug claims audit and presented the final report to the Audit and Finance Committee, now therefore be it

RESOLVED, That the Audit and Finance Committee accepts the final audit report presented by BMI on 2015-2016 prescription drug Claims.

* * * * * * * * *

RESOLUTION NO. 004-2018 - ADOPTION OF GREATER TOMPKINS COUNTY MUNICIPAL HEALTH INSURANCE CONSORTIUM INVESTMENT POLICY

MOVED by Ms. Rider, seconded by Mr. Shattuck. An amendment suggested by Mr. Snyder to amend: "A.The CFO shall prepare or have prepared an investment report each month" with "A. The CFO shall prepare or have prepared an investment report each quarter" was accepted as friendly. It was agreed that if the policy is approved by the Board of Directors the Request for Proposals will be presented to the Committee at its next meeting for discussion that will include concerns about the management fees. The resolution was unanimously adopted by voice vote by members present.

WHEREAS, Section E(9) of the Municipal Cooperation Agreement of the Greater Tompkins County Municipal Health Insurance Consortium ("GTCMHIC" or "Consortium"), provides that the Board of Directors of the Consortium shall "establish administrative guidelines for the efficient operation of the Plan"; and

WHEREAS, Section J(5) of the Municipal Cooperation Agreement provides that the "Chief Fiscal Officer may invest moneys not required for immediate expenditure in the types of investments specified in the General Municipal Law for temporary investments or as otherwise expressly permitted by the Superintendent"; and

WHEREAS, Section 4706(b) of the New York State Insurance Law provides that the Consortium's "reserve funds and surplus account" may be invested "in obligations specified in the general municipal law or education law (as applicable) for investment of moneys in reserve funds or as otherwise expressly permitted by the superintendent"; and

WHEREAS, the Consortium desires to adopt a formal "Investment Policy" whose primary objectives in priority order, are: (1) to conform with all applicable federal, state and other legal requirements; (2) to adequately safeguard principal; (3) to provide sufficient liquidity to meet all operating requirements of the Consortium; and (4) to obtain a reasonable rate of return.

now therefore be it

RESOLVED, that the Audit and Finance Committee hereby recommends that Board of Directors:

1. Adopts the *Investment Policy for the Greater Tompkins County Municipal Health Insurance Consortium* (the "Investment Policy") attached hereto as Exhibit "A"; and
2. Delegates to the Consortium's Chief Financial Officer the authority to: (i) administer the Consortium's investment program (the "Investment Program") pursuant to the terms and conditions of the Investment Policy; and (ii) to develop, recommend, and oversee such written procedures as are necessary for the operation of the Investment Program in compliance with the Investment Policy and all applicable federal and state laws; such written procedures becoming effective only upon approval by the Board.

* * * * * * * * *

EXHIBIT "A"

INVESTMENT POLICY
FOR
GREATER TOMPKINS COUNTY MUNICIPAL INSURANCE CONSORTIUM

Article I
Purpose and Objectives

A. The purpose of this Investment Policy (the "**Policy**") is to set forth the parameters within which the funds of the Greater Tompkins County Municipal Health Insurance Consortium (the "**Consortium**") are to be managed. In methods, procedures, and practices, the Policy formalizes the framework for the Consortium's investment activities that must be exercised to ensure effective and judicious management of its funds.

B. This Policy applies to all moneys and other financial resources of the Consortium with regard to depositing and investing its assets, and the Policy shall represent the investment constraints of all invested assets.

C. The primary objectives for implementation of the Policy, in priority order, are: (1) to conform with all applicable federal, state and other legal requirements; (2) to adequately safeguard principal; (3) to provide sufficient liquidity to meet all operating requirements of the Consortium; and (4) to obtain a reasonable rate of return.

Article II
Delegation of Authority

A. Pursuant to Section J(5) of the Municipal Cooperation Agreement of the Consortium,[1] the Board of Directors of the Consortium (the "**Board**") may delegate certain responsibilities set forth herein to the Chief Fiscal Officer of the Consortium (the "**CFO**").

B. As set forth in Article II, Section (A) above, the Board hereby delegates to the CFO, the authority to administer the Consortium's investment program (the "**Investment Program**"), and to establish written procedures for the operation of the Investment Program consistent with this Policy, and all applicable federal and state laws[2]. However, any such written procedures shall become effective only upon approval by the Board.

Article III
Standards of Care

A. Prudence.

1. Each person responsible for managing and investing the Consortium's financial assets shall act in good faith and with the care an ordinary prudent person in a like position would exercise under similar circumstances. When making investment and management decisions, the primary objectives for implementation of the Policy set forth in Article I, Section (C) above shall be considered.

2. In making decisions regarding management and investment of the Consortium's financial assets, the following non-exclusive factors shall be considered, if relevant:

i. general economic conditions;

ii. the possible effect of inflation or deflation;

iii. the role that each investment or course of action plays within the overall investment portfolio of the Consortium;

iv. the expected total return from income and the appreciation of its investments;

v. other resources of the Consortium;

vi. the needs of the Consortium and the specific funds to make distributions and to preserve capital; and

vii. an asset's special relationship or special value, if any, to the purposes of the Consortium.

B. Ethics and Conflicts of Interest. Officers, members, and employees of the Consortium involved in the investment process shall refrain from personal activity that could conflict with the proper execution and management of the Investment Program, or that could impair their ability to make impartial investment decisions. Officers, members, and employees

[1] See Section J(5) of the 2014 Amendment to the Municipal Cooperation Agreement.
[2] See Section 10 and 11 of the New York State (the "**State**") General Municipal Law, and Section 4706(b) of the State Insurance Law.

involved in the investment process shall disclose to the Consortium's Executive Director and the Board any material financial interests they have in financial institutions that conduct business with the Consortium, and shall further disclose any personal financial/investment positions that could be related to the performance of the Consortium's investment portfolio. Officers, members, and employees involved in the Investment Program shall refrain from undertaking any personal investment transactions with the same individual with whom business is conducted on behalf of the Consortium; and shall be bound by the Consortium's Code of Ethics Policy.

Article IV
Suitable and Authorized Investments

A. The following investments are permitted by the Policy:

1. U.S. Treasury & Government Guaranteed. Direct obligations of the United States of America and securities fully and unconditionally guaranteed as to the timely payment of principal and interest by the United States of America, provided that the Full Faith and Credit of the United States of America must be pledged to any such direct obligation or guarantee ("**Direct Obligations**").

2. Municipals. Obligations issued or guaranteed by any of the following:

   i. Obligations of the State; or

   ii. With the approval of the State Comptroller, obligations issued pursuant to Section 24.00 or 25.00 of the State Local Finance Law (i.e. Tax Anticipation Notes and Revenue Anticipation Notes), by any municipality, school district or district corporation in the State, other than the Consortium.

3. Time Deposits. Special time deposit accounts, or non-negotiable certificates of deposit ("**CD**") in a State "banking institution"[3] or federally chartered banks, savings and loans or credit unions in excess of insured amounts which are fully collateralized with securities in accordance with State Law.

Article V
Investment Parameters

A. Diversification. Investments of funds of the Consortium shall be diversified to limit the risk of loss resulting from the concentration of assets in a specific type of investment, specific maturity, specific issuer or specific sector. The diversification strategy shall be reviewed as frequently as circumstances require, but at least annually.

The following diversification parameters have been established:

Sector Type	Sector Max (%)	Issuer Max (%)	Ratings Requirement[1]	Max Maturity
US Treasury and Government Guaranteed	100%	N/A	N/A	10 Years[2]

[3] As such term is defined in Section 9-r of the State Banking Law.

Municipals	30%	5%	Top Three Ratings Categories	10 Years
Time Deposits and Certificates of Deposit	50%	FDIC Limit	N/A, so long as FDIC-guaranteed	5 Years
[1] By a Nationally Recognized Statistical Ratings Organization ("NRSRO") [2] Government guaranteed mortgage backed securities shall have a maximum weighted average life of 10 years				

B. Subsequent Credit Downgrades. In the event of a downgrade of a security below the minimum credit standards for a new investment of that security, the CFO shall evaluate the downgrade on a case-by-case basis, and promptly notify the Board and recommend a course of action. If the CFO and/or the Board has retained a professional investment advisor, the investment advisor shall promptly notify the CFO of any downgrade below the minimum credit standards and recommend a course of action.

Article VI
Investment Institutions

A. All financial institutions and dealers with which the Consortium transacts business shall be creditworthy, and have an appropriate level of experience, capitalization, size and other factors that make the financial institution or the dealer capable and qualified to transact business with the Consortium.

B. The CFO shall evaluate the financial position of all financial institutions and dealers with which the Consortium transacts business, and maintain a listing of proposed depositaries, trading partners, and custodians. Recent Reports of Condition and Income (i.e. call reports) shall be obtained for proposed banks, and security dealers that are not affiliated with a bank, shall be required to be classified as reporting dealers affiliated with the New York Federal Reserve Bank, as "primary dealers."

Article VII
Qualifications of Broker-Dealers

A. The Consortium shall maintain a list of approved security broker-dealers selected by a process of due diligence, which process shall require all broker-dealer candidates to supply the following:

1. Audited financial statements demonstrating compliance with State and federal capital adequacy guidelines;
2. Proof of certification from the Financial Industry Regulatory Authority;
3. Proof of State Registration required by the State General Municipal Law;
4. Evidence of adequate insurance coverage; and
5. Certification and acknowledgement of having read, understood and agreeing to comply with this Policy.

B. Approved security broker-dealers may include primary dealers or regional dealers registered with the Securities Exchange Commission ("**SEC**") that comply with SEC net capital standards under Section 15c3-1 of the Securities Exchange act of 1934 (the "**Exchange Act**").

C. The Consortium is authorized to employ an external investment advisor that shall maintain its own list of approved and qualified security broker-dealers, subject to the same process of due diligence set forth in Article VII, Section (A) above.

Article VIII
Competitive Transactions

A. To ensure that transactions meet best execution requirements, the Consortium has established the following procedures:

1. The CFO or the investment advisor, to the extent applicable, shall seek to obtain at least three (3) competitive bids or offers on any necessary contract related to the purchase and sale of investments; and

2. The CFO or the investment advisor, to the extent applicable, shall document any competitive bids, offers, or quotations received in reliance on this Article.

B. If the Consortium hires an external investment advisor as permitted by Article VII, Section C of this Policy, the advisor must retain documentation demonstrating compliance with this Article, to the extent it is applicable, and provide such documentation to the Consortium upon request.

Article IX
Securing Deposits and Investments

A. All deposits and investments at a bank or trust company, including all demand deposits, certificates of deposit and special time deposits (hereinafter, collectively, the "**Deposits**") made by officers of the Consortium that are in excess of the amount insured under the provisions of the Federal Deposit Insurance Act, including pursuant to a Deposit Placement Program in accordance with applicable law, shall be secured by:

1. A pledge of "***eligible securities***"[4] with an aggregate market value that is at least equal to the aggregate amount of the Deposits;

2. A pledge of a pro rata portion of a pool of eligible securities, having in the aggregate a market value at least equal to the aggregate amount of the Deposits;

3. An "***eligible surety bond***"[5] payable to the government for an amount at least equal to one hundred percent (100%) of the aggregate amount of the Deposits and the agreed-upon interest, if any, executed by an insurance company authorized to do business in the State, whose claims-paying ability is rated in the highest rating category by at least two (2) nationally recognized statistical rating organizations;

4. An "***eligible letter of credit***,"[6] payable to the Consortium as security for the payment of one hundred forty percent (140%) of the aggregate amount of the Deposits and the agreed-upon interest, if any. An "eligible letter of credit" shall be an irrevocable letter of credit issued in favor of the Consortium for a term not to exceed ninety (90) days, by a qualified bank (other than the bank where the secured money is deposited). A qualified bank is either one

[4] As defined in Section 10(1)(f) of the State General Municipal Law, and as further set forth in Schedule "A" attached hereto and made a part hereof.
[5] See State General Municipal Law Section 11(1)(g).
[6] See State General Municipal Law Section 11(1)(h).

whose commercial paper and other unsecured short-term debt obligations (or, in the case of a bank which is the principal subsidiary of a holding company, whose holding company's commercial paper and other unsecured short-term debt obligations) are rated in one (1) of the three (3) highest rating categories by at least one (1) nationally recognized statistical rating organization, or one that is in compliance with applicable federal minimum risk-based capital requirements; and/or

5. An irrevocable letter of credit issued in favor of the Consortium by a federal home loan bank whose commercial paper and other unsecured short-term debt obligations are rated in the highest rating category by at least one (1) nationally recognized statistical rating organization, as security for the payment of one hundred percent (100%) of the aggregate amount of the Deposits, and the agreed-upon interest, if any.

Article X
Safekeeping and Custody

A. Third-Party Safekeeping. All investment securities purchased for or held as collateral on deposits or investments shall be held by an independent third-party safekeeping institution, such as a bank, trust company, or third-party custodial agent who may not otherwise be a counter-party to an investment transaction, selected by the Consortium (the "**Independent Safekeeping Institution**"), and subject to security and custodial agreements as follows:

1. Consistent with Section 10(3)(a) of the State General Municipal Law, the security agreement shall provide that eligible securities are being pledged to secure the Deposits together with agreed-upon interest, if any, and any costs or expenses arising out of the collection of the Deposits upon a default. It shall also provide the conditions under which the securities held may be sold, presented for payment, substituted or released and the events of default which will enable the local government[7] to exercise its rights against the pledged securities. Such agreement shall include all provisions deemed necessary and sufficient to secure in a satisfactory manner the local government's interest in the collateral.

2. The custodial agreement shall provide that the pledged securities will be held by the Independent Safekeeping Institution as agent of, and custodian for, a local government, and will be kept separate and apart from the general assets of the Independent Safekeeping Institution, and it shall also provide for the manner in which the Independent Safekeeping Institution shall confirm the receipt, substitution or release of the collateral. Such agreement shall further provide for the frequency of revaluation of collateral by the Independent Safekeeping Institution, and the substitution of collateral when a change in the rating of a security causes ineligibility pursuant to the State General Municipal Law.[8]

4. The security and custodial agreements shall also include all other provisions necessary to provide the Consortium with a perfected security interest in the eligible securities and to otherwise secure the local government's interest in the collateral, and may contain other provisions that the Board deems necessary.

B. Internal Controls. The CFO shall establish a system of internal controls, which shall be documented in writing. The internal controls shall be designed to prevent the loss of funds arising from fraud, employee error, and misrepresentation by third-parties, unanticipated changes in financial markets, or imprudent actions by employees and officers of the

[7] As such term is defined in Section 10(1)(a) of the State General Municipal Law.
[8] See Section 10(3)(a) of the State General Municipal Law.

Consortium. The system of internal controls shall further provide a satisfactory level of accountability based upon records incorporating the description and amounts of investments, the fund(s) for which they are held, the place(s) where such funds are kept, and other relevant information, including dates of sale or other dispositions and amounts realized. In addition, the internal control procedures shall describe the responsibilities and levels of authority for key individuals involved in the Investment Program.

Article XI
Performance Standards/Evaluation

A. Assets will be managed in accordance with the parameters specified within this Policy. Performance should be compared to a relevant benchmark or benchmark(s), at regular intervals, but at least on a quarterly basis.

B. Prior to any reporting period, a performance benchmark or benchmarks will be established by the Board. The benchmark(s) shall be reflective of the actual securities being managed and risks undertaken; and the benchmark(s) shall have a similar weighted average maturity and credit profile as the portfolio.

Article XII
Reporting/Disclosure

A. The CFO shall prepare or have prepared an investment report each quarter, including a summary that provides an analysis of current investments (the "**Investment Report**"). The Investment Report shall be prepared in a manner that will allow the Board to ascertain whether investment activities during the reporting period have conformed to the Policy.

B. The Investment Report shall include, at a minimum, the following:

1. An asset listing showing par value, cost and accurate and complete market value of each security, type of investment, issuer, and interest rate;
2. Average maturity and duration of investments;
3. Maturity distribution; and
4. Average portfolio credit quality.

Article XIII
Review of Policy

The Board shall review the Policy at least annually, within one hundred twenty (120) days of the end of the fiscal year, to reflect developments affecting the Consortium's finances and activities, and to ensure its consistency with the primary objectives set forth in Article I, Section (C) herein.

Article XIV
Policy Adoption

This Policy is adopted by the Board this ___ day of _____, 2018.

SCHEDULE "A"

Schedule of Eligible Securities for Collateralizing Deposits and Investments in Excess of FDIC Coverage [9]

"Eligible Securities" for Collateral	For purposes of determining aggregate "market value," eligible securities shall be valued at these percentages of "market value":
(i) Obligations issued, or fully insured or guaranteed as to the payment of principal and interest, by the United States of America, an agency thereof or a United States government-sponsored corporation.	100%
(ii) Obligations issued or fully guaranteed by the International Bank for Reconstruction and Development, the Inter-American Development Bank, the Asian Development Bank and the African Development Bank.	100%
(iii) Obligations partially insured or guaranteed by any agency of the United States of America, at a proportion of the market value of the obligation that represents the amount of the insurance or guaranty.	100%
(iv) Obligations issued or fully insured or guaranteed by the State of New York, obligations issued by a municipal corporation, school district or district corporation of this State or obligations of any public benefit corporation which under a specific State statute may be accepted as security for deposit of public moneys.	100%
(v) Obligations of counties, cities and other governmental entities of another state having the power to levy taxes that are backed by the full faith and credit of such governmental entity and rated in one of the three highest rating categories by at least one nationally recognized statistical rating organization.	100% if rated in the highest category; 90% for 2nd highest; 80% for 3rd highest.

[9] See State General Municipal Law Subsections (10)(1)(f)(i)-(iv) and (vii).

New Member Applications

Mr. Cook said there is a probability that at some point the Consortium will be presented with an application for a large group to join the Consortium that could impact its risk profile. He thinks the Consortium needs to prepare for measuring that risk and establish what requirements and controls should be in place on the admission of a new member. Mr. Locey said the biggest things the Consortium should look for are anomalies in risk such as whether they are purchasing care under a different cost structure or within a different region that has different costs, and are they or are they not providing coverage to a different demographic. He said the Consortium cannot have a rate based on each municipality but can do regional rating based on geographic location.

Mr. Locey said he could prepare a questionnaire and a list of things that should be vetted to see if there should be any risk adjustment prior to accepting a new group. He noted that if a different rate is applied it would have to be applied to all of the groups within that area. Mr. Cook asked if there is a threshold that Mr. Locey would recommend that would trigger the requirement for additional information; he suggested an employer with a range of 5-10% of the Consortium's current covered lives.

.

Mr. Locey was asked to draft a policy statement for the Committee to discuss that would include the components to be measured and any requirements or procedures the Consortium should have in place.

Committee Vision: Responsibility, Membership and Leadership

Mr. Barber said this item came out of the Executive Committee asking committees to review their charge and to review membership to make sure it is in-line with the charge. He said at the Board of Directors meeting Ms. Drake will announce that all of the Chairs of committees will be invited to attend the Executive Committee meetings. Mr. Cook commented that this Committee is functioning well and has the membership and staffing with the proper skill sets to handle its charge.

Next Agenda Items

The following items will be included on the next agenda:

A recap of the concerns expressed earlier in the meeting relating to labor representatives on the Board and indemnification of Directors;
Approval of External Audit Report;
Investment Policy Request for Proposals; and
New member applications.

Adjournment

The meeting adjourned at 5:09 p.m.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
D.	Record Retention	
	It is recommended that the Plan comply with Part 243.2(b)(2) of Insurance Regulation No. 152 and maintain all applications for coverage, regardless of whether a policy was actually issued. Such applications should be maintained for six calendar years or until after the filing of the report on examination in which the record was subject to review.	18

Wellness Consultant First Year Work Plan

Consortium Supplied Vision of Wellness Strategy: (builds on current Board commitments to Consortium vision statement)

1. Increase awareness and usage of Flu Clinics and Blue4U
2. Increase the number of partners with wellness policies
3. Increase the number of work sites with wellness champions
4. Establish Wellness/Preventative Health Care brand language

Consortium supplied Year One Wellness Consultant Evaluation Criteria:

1. Increase number of subscribers receiving flu vaccines by 10% to 1588
2. There are currently 304 subscribers on metal plans with Blue4U benefit. Four subscribers participated in 2017 and 2018 (1.3 %). Goal: 7% of 2019 subscriber count participates in Blue4U in March 2019 (>21)
3. Archive the wellness policies, resolutions, and/or wellness programs from 50% of employers (partners plus Bolton Point, TC3, TCPL, & TCSWCD= 35)
4. There are >40 worksites within Consortium. Identify six (6) wellness champions (~15%)
5. Present work plan status reports at all OYOH meetings (attend as many as possible)
6. Present status report to Board of Directors with suggestion of wellness "language/brand" that motivates subscribers and partners at its March 2019 meeting
7. Currently five partners and one labor are represented on OYOH committee. Increase that number to eight (wellness champions from same employer will satisfy this goal).
8. After Board presentation, meet with all Consortium partners (can be in groups of partners) with the goal of establishing wellness contacts with all employers, documenting all existing wellness programs throughout the Consortium, and laying the ground work for establishing wellness champions at work sites
9. Evaluate "Annual Physicals" as a measure of wellness
10. Establish a work plan for year 2
11. Provide wellness content to quarterly newsletter
12. Create the Consortium's wellness presence at existing municipal benefit fairs in the Fall (Tompkins County, City of Ithaca, Town of Ithaca, TC3, and possibly City of Cortland)

WORK PLAN

1. Document existing foundation by developing baseline of usage of wellness programs (both Consortium and partner) and gathering copies of partner's wellness policies, resolutions, and program documents. Identify existing wellness champions and catalogue their activities. [eval criteria #3,4,5]
    a. Activity: Gather documents and information from municipal partners, Excellus, and other sources
        i. Resolutions

ii. Minutes
iii. Documents and materials
iv. Findings
v. Wellness Champions
vi. Current wellness marketing strategies used by Consortium

b. Product: Findings report as guidance for next steps

2. Develop wellness "language/brand, logo, and sample colloquial material (for review and feedback from OYOH Committee) that motivates subscribers and partners and that can be easily adapted and incorporated in website and newsletter [eval criteria #5,6 7,,8,11]
    a. Activity: Building on information gathered in Step 1 and knowing that personal contact of the work site Wellness Champions is the foundation to building a culture of wellness, develop initial language to motivate leadership to embrace wellness culture. Work with OYOH Committee on this language and future/ongoing marketing campaign.
    b. Product:
        i. Branding language and colloquia shared with OYOH committee, a couple identified municipal partners, and then shared broadly at March 2019 Board meeting.
        ii. Build awareness through Consortium media
        iii. Triggering additional interest in OYOH committee participation by partners
3. Establish wellness contacts with all employers and develop customized strategies for establishing wellness champions at work sites [eval criteria #4,5, 7,8]
    a. Activity: Recruiting and Incentivizing Wellness Champions requires buy-In from the very top. To be successful, Wellness Champions also cannot be an island to themselves. Health cultures that are supported bottom-up and top-down require both time and patience. Based on step 1 research, identify partners with top support and staff with wellness champion experience at some level
    b. Product: Wellness champions with a support structure, systems, and templates in place.
4. Work with partners to discover best methods to market the Consortium wellness initiatives of flu vaccines and Blue4U. [eval criteria #1,2, 5,12]
    a. Activity: Evaluate previous marketing efforts for Blue4U. Examine previous flu vaccine promotional efforts. Work with identified Excellus partner to devise roll-out plan for increasing participation in Blue4U.
    b. Product: Marketing campaign to increase subscriber participation in obtaining flu vaccines and in Blue 4U. Targeted communications plans and strategy roll-out shared with OYOH.
5. Establish baseline data of number of subscribers that have annual or regular physicals [eval criteria #9]
    a. Activity: Work with Excellus and CAPA to establish baseline data and assess Consortium programs to increase participation in annual physicals or regular physicals
    b. Product: Increasing numbers of subscribers receiving physicals

Small Employers (less than 50 full-time equivalent employees)

Sample Resolution Authorizing Municipality to Apply for Acceptance into the GTCMIC

RESOLVED, that the [municipal employer's name] [legislative body's name] hereby authorizes the [municipality's chief executive] to apply to become a "Participant" in the Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC);

RESOLVED FURTHER, this authorization grants permission to the [municipality's chief executive] to:

1. Submit the [municipal employer's name] most recent two years of State Comptroller AUD reports;

2. Submit the [municipal employer's name] most recent monthly premium billing statements from all health insurance carriers providing benefits to active employees and retirees.

   Said premium billing statements should include the name of the municipality and the month for the which the billing is related. In addition, said premium bills must include the number of contracts (employee, employee + spouse, employee + child (children), and family) and monthly premium rate for each plan of benefit.

3. Seek a waiver from the GTCMHIC Board of Directors for the payment of the Surplus Reserve payment (5% of annualized premium) as required Article 47 of the New York State Insurance Law and the rules of the Consortium. If the waiver is not granted, the [municipality's chief executive] is authorized to pay the Consortium the Surplus Reserve payment equal to 5% of anticipated annual premium, as determined by the GTCMHIC Board of Directors.

4. Sign the Municipal Cooperative Agreement of the GTCMIC upon notification that the GTCMHIC Board of Directors has approved the [municipal employer's name]'s application to become a Participant in the Consortium.

5. Notify the GTCMHIC's Executive Director in writing by November 1st as to which Consortium health insurance plan the [municipal employer's name]'s employees and retirees will be participating in upon the effective date of participation in the Consortium.

6. Notify the Consortium of the name and contact information for the person within your organization for benefit administration.

7. Take the steps necessary to comply with the GTCMHIC's dependent verification and other membership eligibility rules and requirements, including the [municipal employer's name]'s commitment to utilize the Consortium's on-line enrollment process or authorize the Consortium to provide this function directly to the [municipal employer's name]'s employees and retirees.

Mid-Size Employers (between 51 and 100 full-time equivalent employees)

Sample Resolution Authorizing Municipality to Apply for Acceptance into the GTCMIC

RESOLVED, that the [municipal employer's name] [legislative body's name] hereby authorizes the [municipality's chief executive] to apply to become a "Participant" in the Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC);

RESOLVED FURTHER, this authorization grants permission to the [municipality's chief executive] to:

1. Submit the [municipal employer's name] most recent two years of State Comptroller AUD reports;

2. Submit the [municipal employer's name] most recent monthly premium billing statements from all health insurance carriers providing benefits to active employees and retirees.

   Said premium billing statements should include the name of the municipality and the month for the which the billing is related. In addition, said premium bills must include the number of contracts (employee, employee + spouse, employee + child (children), and family) and monthly premium rate for each plan of benefit.

3. If currently an experience-rated or self-insured employer-sponsored health insurance plan, submit a minimum of three (3) years of monthly paid claims (medical and pharmacy separately) data and monthly covered lives counts.

4. Seek a waiver from the GTCMHIC Board of Directors for the payment of the Surplus Reserve payment (5% of annualized premium) as required Article 47 of the New York State Insurance Law and the rules of the Consortium. If the waiver is not granted, the [municipality's chief executive] is authorized to pay the Consortium the Surplus Reserve payment equal to 5% of anticipated annual premium, as determined by the GTCMHIC Board of Directors.

5. Sign the Municipal Cooperative Agreement of the GTCMIC upon notification that the GTCMHIC Board of Directors has approved the [municipal employer's name]'s application to become a Participant in the Consortium.

6. Notify the GTCMHIC's Executive Director in writing by November 1st as to which Consortium health insurance plan or plans (not to exceed three options) the [municipal employer's name]'s employees and retirees will be participating in upon the effective date of participation in the Consortium.

7. Notify the Consortium of the name and contact information for the person within your organization for benefit administration.

8. Take the steps necessary to comply with the GTCMHIC's dependent verification and other membership eligibility rules and requirements, including the [municipal employer's name]'s commitment to utilize the Consortium's on-line enrollment process or authorize the Consortium to provide this function directly to the [municipal employer's name]'s employees and retirees.

Large Employers (101 or More full-time equivalent employees)

Sample Resolution Authorizing Municipality to Apply for Acceptance into the GTCMIC

RESOLVED, that the [municipal employer's name] [legislative body's name] hereby authorizes the [municipality's chief executive] to apply to become a "Participant" in the Greater Tompkins County Municipal Health Insurance Consortium (GTCMHIC);

RESOLVED FURTHER, this authorization grants permission to the [municipality's chief executive] to:

1. Submit the [municipal employer's name] most recent two years of State Comptroller AUD reports;

2. Submit the [municipal employer's name] most recent monthly premium billing statements from all health insurance carriers providing benefits to active employees and retirees.

   Said premium billing statements should include the name of the municipality and the month for the which the billing is related. In addition, said premium bills must include the number of contracts (employee, employee + spouse, employee + child (children), and family) and monthly premium rate for each plan of benefit.

3. If currently an experience-rated or self-insured employer-sponsored health insurance plan, submit a minimum of three (3) years of monthly paid claims (medical and pharmacy separately) data and monthly covered lives counts; along with any other data and information required by the Consortium as part of the application process.

4. Seek a waiver from the GTCMHIC Board of Directors for the payment of the Surplus Reserve payment (5% of annualized premium) as required Article 47 of the New York State Insurance Law and the rules of the Consortium. If the waiver is not granted, the [municipality's chief executive] is authorized to pay the Consortium the Surplus Reserve payment equal to 5% of anticipated annual premium, as determined by the GTCMHIC Board of Directors.

5. Sign the Municipal Cooperative Agreement of the GTCMIC upon notification that the GTCMHIC Board of Directors has approved the [municipal employer's name]'s application to become a Participant in the Consortium.

6. Notify the GTCMHIC's Executive Director in writing by November 1st as to which Consortium health insurance plan or plans the [municipal employer's name]'s employees and retirees will be participating in upon the effective date of participation in the Consortium.

7. Notify the Consortium of the name and contact information for the person within your organization for benefit administration.

8. Take the steps necessary to comply with the GTCMHIC's dependent verification and other membership eligibility rules and requirements, including the [municipal employer's name]'s commitment to utilize the Consortium's on-line enrollment process or authorize the Consortium to provide this function directly to the [municipal employer's name]'s employees and retirees.

RESOLUTION NO. – EXTENSION OF CONTRACT FOR EXECUTIVE DIRECTOR SERVICES – DONALD L. BARBER

WHEREAS, it was determined in 2013 that based on the increased responsibilities placed on the Consortium by the State and Federal governments, the Affordable Care Act, and the managing of an increased number of contracts it was in the Consortium's best interest to contract for services of an Executive Director, and

WHEREAS, following the issuance of a request for proposals in 2014 seeking contractors who could fulfil the responsibilities of Executive Director a contract was entered into with Donald L. Barber in 2014 and was extended in 2016, and

WHEREAS, the extended contract will expire on June 30, 2018, and

WHEREAS, the Consortium's Executive Committee which meets with Mr. Barber quarterly to review a work plan and the Consortium's operations believes the Executive Director services provided to the Consortium by Mr. Barber are valuable and important for the Consortium's stability, and has recommended the contract be continued for a two-year period, now therefore be it

RESOLVED, on recommendation of the Executive and Audit and Finance Committees, That the contract for Executive Director Services with Donald Barber be extended through June 30, 2020 under the terms and conditions in the recommended contract.

****

CMS-RDS PROGRAM

SERVICES LOCEY AND CAHILL PROVIDES

The services to be provided pursuant to this agreement are those necessary for the Client to participate in Centers of Medicare and Medicaid Services (CMS) Retiree Drug Subsidy (RDS) Program as authorized by the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and any subsequent amendments (collectively referred to as the MMA), hereinafter referred to as "RDS." Said services will include the following:

1. Gather information necessary to complete the CMS RDS application, including general plan information, contact information, banking information, and service provider information.

2. Complete the CMS RDS application and assist the Client in the submission of said application.

3. Work with Client to identify those retirees who qualify for the CMS RDS.

4. Preparation of retiree spreadsheet files for submission to CMS RDS.

5. Assist Client in the gathering of paid claims data from Client's third-party administrator, insurance carrier, and/or prescription benefit manager in the proper format required to submit to CMS RDS.

6. Prepare claims files and cost reports for submission to CMS RDS.

7. Assist Client in the submission of eligible claims for reimbursement through CMS RDS.

8. Assist Client with the reconciliation process.

9. Respond to emails sent by RDS.

THE RETIREE DRUG SUBSIDY

The retiree drug subsidy (RDS) is one of several options available under Medicare that enables employers and unions to continue assisting their Medicare eligible retirees in obtaining more generous drug coverage. It is generally considered the easiest and most straightforward of the available options, and can often be implemented with little or no benefit design changes to current coverage. The primary web site for the RDS program, including the online tool for submitting subsidy applications, is hosted by the RDS Center. http://rds.cms.hhs.gov/

AUTHORIZED REPRESENTATIVE

The Authorized Representative, often referred to as the AR, is required to be assigned to the Plan Sponsor. The AR is responsible for signing the Plan Sponsor Agreement and the Reconciliation Agreement for each RDS Application.

The AR must be an employee of the Plan Sponsor. The AR is required to be a registered RDS Secure Website User. He or She must maintain an active user account in the system. The AR cannot be assigned any other user role such as Account Manager or Actuary.

CLIENT ROLES AND RESPONSIBILITIES

1. To keep their Current Retiree List (CRL) updated, this must be done by using the CMS RDS website.

2. The Authorized Representative Requests Payments during the Application cycle which in most cases is 30 days after each quarter.

3. The Authorized Representative completes Step 8 of all the New Applications before the following dates: (from time to time this date can be extended by 30 days).

   January 1st – December 31st: October 2nd

   April 1st – March 31st: December 31st

   May 1st – April 30th: January 31st

   July 1st – June 30th: April 1st

4. Creditable Coverage Letters must be sent to all of the Retiree Drug Subsidy (RDS) beneficiaries before October 15th each year. (Locey and Cahill LLC will contact each client in September with details of the Creditable Coverage Letter).

5. CMS RDS Reconciliation Step 12 must be completed by the Authorized Representative before the following deadlines:

   January 1st – December 31st: April 1st

   April 1st – March 31st: June 30th

   May 1st – April 30th: January 31st

   July 1st – June 30th: September 30th

SUBSIDY PAYMENT

On Average, it has been our experience that most municipal employers who qualify to participate in the CMS-RDS Program receive between $500 and $600 per year per eligible member.

LOCEY & CAHILL, LLC

120 WALTON STREET, SUITE 500
ARMORY SQUARE
SYRACUSE, NY 13202-1180
TEL. 315-425-1424
FAX. 315-425-1394

MEMORANDUM

DATE: DECEMBER 16, 2015

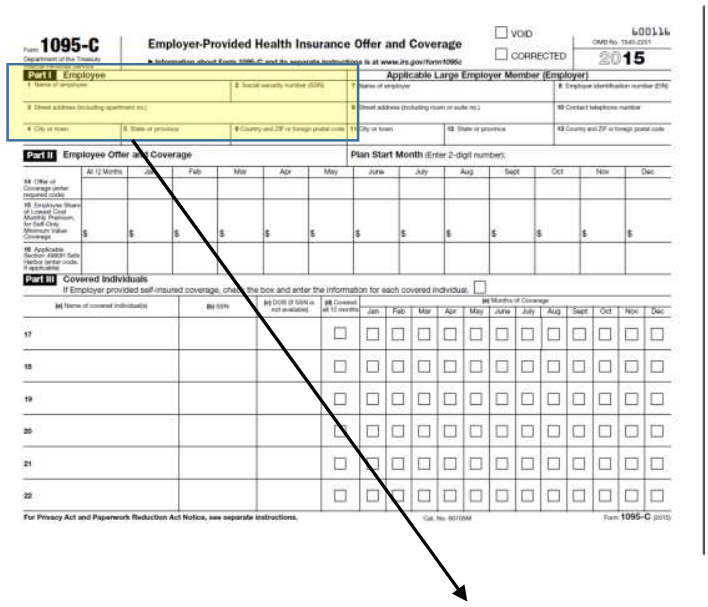
TO: LOCEY & CAHILL, LLC FULLY-INSURED (MINIMUM PREMIUM) CLIENTS

FROM: LOCEY & CAHILL, LLC

RE: IRS FORM 1095-C PREPARATION

As you are acutely aware at this time, the Patient Protection and Affordable Care Act (ACA) Employer Shared Responsibility provisions place a great burden on employers relative to the health insurance plans offered to employee and retirees. One of the greatest burdens associated with these provisions are the filing of the United States Department of the Treasury Internal Revenue Service (IRS) Forms 1094-C and 1095-C.

This memo is designed to assist you by providing an overview of the information necessary to complete the IRS Form 1095-C. Please keep in mind that as an employer who provides a fully-insured health insurance you are only responsible for the completion of Parts I and II of the IRS Form 1095-C.


Form 1095-C
Employer-Provided Health Insurance Offer and Coverage
VOID
CORRECTED
2015
Part I Employee
Applicable Large Employer Member (Employer)
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
Part III Covered Individuals
If Employer provided self-insured coverage, check the box and enter the information for each covered individual.
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.
Form 1095-C (2015)

2017

Instructions for Forms 1094-C and 1095-C

Department of the Treasury
Internal Revenue Service

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about developments related to Form 1094-C, Transmittal of Employer-Provided Health Insurance Offer and Coverage Information Returns, and Form 1095-C, Employer-Provided Health Insurance Offer and Coverage, and instructions, such as legislation enacted after they were published, go to *IRS.gov/form1094c* and *IRS.gov/form1095c*.

What's New

Section 4980H transition relief. Several forms of transition relief were available to some employers under section 4980H for 2016. No section 4980H transition relief is available for 2017. Therefore, these instructions have been revised to remove discussion of section 4980H transition relief, and Form 1094-C has also been revised. Specifically, Form 1094-C, line 22, box C is designated "Reserved"; Part III, column (e) is designated "Reserved"; and the entry rows in Part III, column (e) are shaded.

Additional Information

For information related to the Affordable Care Act, visit *www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions-Home*. For the final regulations under section 6056, Information Reporting by Applicable Large Employers on Health Insurance Coverage Offered Under Employer-Sponsored Plans, see T.D. 9661, 2014-13 I.R.B. 855, at *www.irs.gov/irb/2014-13_IRB/ar09.html*. For the final regulations under section 6055, Information Reporting of Minimum Essential Coverage, see T.D. 9660, 2014-13 I.R.B.842, at *www.irs.gov/irb/2014–13_IRB/ar08.html*. For the final regulations under section 4980H, Shared Responsibility for Employers Regarding Health Coverage, see T.D. 9655, 2014-9 I.R.B. 541, at *www.irs.gov/irb/2014-9_IRB/ar05.html*. For answers to frequently asked questions regarding the employer shared responsibility provisions and related information reporting requirements, visit IRS.gov.

For information related to filing Forms 1094-C and 1095-C electronically visit *www.irs.gov/e-file-providers/air/affordable-care-act-information-return-air-program*. For FAQs specifically related to completing Forms 1094-C and 1095-C, go to *www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-about-Information-Reporting-by-Employers-on-Form-1094-C-and-Form-1095-C*.

For additional guidance and proposed regulatory changes relating to section 6055, including clarifications regarding the reporting requirements for providers of minimum essential coverage and the requirement to solicit the TIN of each covered individual for purposes of the reporting of health coverage information, see Proposed Regulations section 1.6055-1(h) and Regulations section 301.6724-1.

General Instructions for Forms 1094-C and 1095-C

See *Definitions*, later, for key terms used in these instructions.

Purpose of Form

Employers with 50 or more full-time employees (including full-time equivalent employees) in the previous year use Forms 1094-C and 1095-C to report the information required under sections 6055 and 6056 about offers of health coverage and enrollment in health coverage for their employees. Form 1094-C must be used to report to the IRS summary information for each ALE Member and to transmit Forms 1095-C to the IRS. Form 1095-C is used to report information about each employee to the IRS and to the employee. Forms 1094-C and 1095-C are used in determining whether an ALE Member owes a payment under the employer shared responsibility provisions under section 4980H. Form 1095-C is also used in determining the eligibility of employees for the premium tax credit.

ALE Members that offer employer-sponsored self-insured coverage also use Form 1095-C to report information to the IRS and to employees about individuals who have minimum essential coverage under the employer plan and therefore are not liable for the individual shared responsibility payment for the months that they are covered under the plan.

Who Must File

An ALE Member must file one or more Forms 1094-C (including a Form 1094-C designated as the Authoritative Transmittal, whether or not filing multiple Forms 1094-C), and must file a Form 1095-C for each employee who was a full-time employee of the ALE Member for any month of the calendar year. Generally, the ALE Member is required to furnish a copy of the Form 1095-C (or a substitute form) to the employee.

An ALE Member is, generally, a single person or entity that is an Applicable Large Employer, or if applicable, each person or entity that is a member of an Aggregated ALE Group. An Applicable Large Employer, generally, is an employer with 50 or more full-time employees (including full-time equivalent employees) in the previous year. For purposes of determining if an employer or group of employers is an Applicable Large Employer, all ALE Members under common control (an Aggregated ALE Group) are aggregated together. If the Aggregated ALE Group, taking into account the employees of all ALE Members in the group, employed on average 50 or more full-time employees (including full-time equivalent employees) on business days during the preceding calendar year, then the Aggregated ALE Group is an Applicable Large Employer and each separate employer within the group is an ALE Member. Each ALE Member is required to file Forms 1094-C and 1095-C reporting offers of coverage to its full-time employees (even if the ALE Member has fewer than 50 full-time employees of its own).

For more information on which employers are subject to the employer shared responsibility provisions of section 4980H, see *Employer* in the *Definitions* section of these instructions. For more information on determining full-time employees, see *Full-Time Employee* in the *Definitions* section of these instructions, which includes information on the treatment of new hires and employees in Limited Non-Assessment Periods.

TIP *For purposes of reporting on Forms 1094-C and 1095-C, an employee in a Limited Non-Assessment Period is not considered a full-time employee during that period.*

Reporting by Employers That Sponsor Self-Insured Health Plans

An employer that offers health coverage through a self-insured health plan must report information about each individual enrolled in such coverage. For an employer that is an ALE Member, this information must be reported on Form 1095-C, Part III, for any employee who is enrolled in coverage (and any spouse or dependent of that employee). See below for the option to file Form 1094-B and Form 1095-B, rather than Form 1094-C and Form 1095-C, to report coverage of certain non-employees.

ALE Members that offer health coverage through an employer-sponsored self-insured health plan must complete Form 1095-C, Parts I, II, and III, for any employee who enrolls in the health coverage, whether or not the employee is a full-time employee for any month of the calendar year.

For full-time employees enrolled in an ALE Member's self-insured coverage, including an employee who was a full-time employee for at least one month of the calendar year, the ALE Member must complete Form 1095-C, Part II, according to the generally applicable instructions, and should not enter code 1G on line 14 for any month. For an employee enrolled in an ALE Member's self-insured coverage who is not a full-time employee for any month of the calendar year (meaning that for all 12 calendar months the employee was not a full-time employee), for Form 1095-C, Part II, the ALE Member must enter code 1G on line 14 in the "All 12 Months" column or in the separate monthly boxes for all 12 calendar months, and the ALE Member need not complete Part II, lines 15 and 16.

An employer that offers employer-sponsored self-insured health coverage but is not an ALE Member should not file Forms 1094-C and 1095-C, but should instead file Forms 1094-B and 1095-B to report information for employees who enrolled in the employer-sponsored self-insured health coverage.

Note. If an ALE Member is offering health coverage to employees other than under a self-insured plan, such as through an insured health plan or a multiemployer health plan, the issuer of the insurance or the sponsor of the plan providing the coverage is required to furnish the information about their health coverage to any enrolled employees, and the ALE Member should not complete Form 1095-C, Part III, for those employees.

Reporting of Enrollment Information for Non-Employees: Option To Use Forms 1094-B and 1095-B

ALE Members that offer employer-sponsored self-insured health coverage to non-employees who enroll in the coverage may use Forms 1094-B and 1095-B, rather than Form 1095-C, Part III, to report coverage for those individuals and other family members. For this purpose, a non-employee includes, for example, a non-employee director, an individual who was a retired employee during the entire year, or a non-employee COBRA beneficiary, including a former employee who terminated employment during a previous year.

For information on reporting for non-employees enrolled in an employer-sponsored self-insured health plan using Forms 1094-B and 1095-B, see the instructions for those forms.

For ALE Members that choose to use Form 1095-C to report coverage information for non-employees enrolled in an employer-sponsored self-insured health plan, see the specific instructions for Form 1095-C, Part III—Covered Individuals (Lines 17–22), later. Form 1095-C may be used only if the individual identified on line 1 has an SSN.

Substitute Statements to Recipients

If you are not using the official IRS form to furnish statements to recipients, see Pub. 5223, General Rules and Specifications for Affordable Care Act Substitute Forms 1095-A, 1094-B, 1095-B, 1094-C, and 1095-C, which explains the requirements for format and content of substitute statements to recipients. You may develop them yourself or buy them from a private printer. Substitute statements furnished to recipients may be in portrait format; however, substitute returns filed with the IRS using paper must be printed in landscape format.

Authoritative Transmittal for ALE Members Filing Multiple Forms 1094-C

A Form 1094-C must be filed when an ALE Member files one or more Forms 1095-C. An ALE Member may choose to file multiple Forms 1094-C, each accompanied by Forms 1095-C for a portion of its employees, provided that a Form 1095-C is filed for each employee for whom the ALE Member is required to file. If an ALE Member files more than one Form 1094-C, one (and only one) Form 1094-C filed by the ALE Member must be identified on line 19, Part I as the Authoritative Transmittal, and, on the Authoritative Transmittal, the ALE Member must report certain aggregate data for all full-time employees and all employees, as applicable, of the ALE Member.

Example 1. Employer A, an ALE Member, files a single Form 1094-C, attaching Forms 1095-C for each of its 100 full-time employees. This Form 1094-C should be identified as the Authoritative Transmittal on line 19, and the remainder of the form completed as indicated in the instructions for line 19, later.

Example 2. Employer B, an ALE Member, files two Forms 1094-C, one for each of its two operating divisions, Division X and Division Y. (Division X and Division Y are units of the same ALE Member, and thus both report under the same employer identification number (EIN); they are not members of an Aggregated ALE Group.) Attached to one Form 1094-C are Forms 1095-C for the 200 full-time employees of Division X, and attached to the other Form 1094-C are Forms 1095-C for the 1,000 full-time employees of Division Y. One of these Forms 1094-C should be identified as the Authoritative Transmittal on line 19, and should include aggregate employer-level data for all 1,200 full-time employees of Employer B as well as the total number of employees of Employer B, as applicable, as required in Parts II, III, and IV of Form 1094-C. The other Form 1094-C should not be identified as the Authoritative Transmittal on line 19, should report on line 18 only the number of Forms 1095-C that are attached to that Form 1094-C, and should leave the remaining sections of the form blank as indicated in the instructions for line 19, later.

Note. Each ALE Member must file its own Forms 1094-C and 1095-C under its own separate EIN, even if the ALE Member is part of an Aggregated ALE Group. No Authoritative Transmittal should be filed for an Aggregated ALE Group.

Example 3. Assume that Employer A from *Example 1* is a member of the same Aggregated ALE Group as Employer B from *Example 2*. Accordingly, Employer A and Employer B are separate ALE Members filing under separate EINs. Forms 1094-C should be filed in the same manner indicated in Examples 1 and 2. Employer A should include only information about employees of Employer A in its Authoritative Transmittal, and Employer B should include only information about employees of Employer B in its Authoritative Transmittal. No Authoritative Transmittal should be filed for the Aggregated ALE Group reporting combined data for employees of both Employer A and Employer B.

Similar rules apply for a Governmental Unit that has delegated its reporting responsibilities for some of its employees to another Governmental Unit—see *Designated Governmental Entity (DGE)* in the *Definitions* section of these instructions for more information. In the case of a Governmental Unit that has delegated its reporting responsibilities for some of its employees, the Governmental Unit must ensure that among the multiple Forms 1094-C filed by or on behalf of the Governmental Unit transmitting Forms 1095-C for the Governmental Unit's employees, one of the filed Forms 1094-C is designated as the Authoritative Transmittal and reports aggregate employer-level data for the Governmental Unit, as required in Parts II, III, and IV of Form 1094-C.

Example. County is an Aggregated ALE Group made up of ALE Members School District, Police District, and County General Office. School District designates the state to report on behalf of the teachers and reports for itself for its remaining full-time employees. In this case, either the School District or the state must file an Authoritative Transmittal reporting aggregate employer-level data for the School District.

One Form 1095-C for Each Employee of ALE Member

For each full-time employee of an ALE Member, there must be only one Form 1095-C filed for employment with that ALE Member. For example, if an ALE Member separately reports for each of its two divisions, the ALE Member must combine the offer and coverage information for any employee who worked at both divisions during the calendar year so that a single Form 1095-C is filed for the calendar year for that employee which reports information for all 12 months of the calendar year from that ALE Member.

In contrast, a full-time employee who works for more than one ALE Member that is a member of the same Aggregated ALE Group must receive a separate Form 1095-C from each ALE Member. For any calendar month in which a full-time employee works for more than one ALE Member of an Aggregated ALE Group, only one ALE Member is treated as the employer of that employee for reporting purposes (generally, the ALE Member for whom the employee worked the greatest number of hours of service), and only that ALE Member reports for that employee for that calendar month. The other ALE Member is not required to report for that employee for that calendar month, unless the other ALE Member is otherwise required to file Form 1095-C for that employee because the individual was a full-time employee of that ALE Member for a different month of the same calendar year. In this case, the individual may be treated as not employed by that ALE Member for that calendar month. If under these rules, an ALE Member is not required to report for an employee for any month in the calendar year, the ALE Member is not required to report for that full-time employee for that calendar year. For a description of the rules related to determining which ALE Member in an Aggregated ALE Group is treated as the employer for a month in this situation, see the definition of *Employee*.

Example. Employer A and Employer B are separate ALE Members that belong to the same Aggregated ALE Group. Both Employer A and Employer B offer coverage through the AB health plan, which is an insured plan. In January and February, Employee has 130 hours of service for Employer A and no hours of service for Employer B. In March, Employee has 100 hours of service for Employer A and 30 hours of service for Employer B. In April through December, Employee has 130 hours of service for Employer B and no hours of service for Employer A. Employer A is the employer of Employee for filing purposes for January, February, and March. Employer A should file Form 1095-C for Employee reporting offers of coverage using the appropriate code on line 14 for January, February, and March, should complete lines 15 and 16 per the instructions, and should include Employee in the count of total employees and full-time employees reported for those months on Form 1094-C. For the months April through December, on Form 1095-C, Employer A should enter code 1H (no offer of coverage) on line 14, leave line 15 blank, and enter code 2A (not an employee) on line 16 (since Employee is treated as an employee of Employer B and not as an employee of Employer A in those months), and should exclude Employee from the count of total employees and full-time employees reported for those months on Form 1094-C.

When To File

You will meet the requirement to file Forms 1094-C and 1095-C if the forms are properly addressed and mailed on or before the due date. If the due date falls on a weekend or legal holiday, then the due date is the following business day. A business day is any day that is not a Saturday, Sunday, or legal holiday.

Generally, you must file Forms 1094-C and 1095-C by February 28 if filing on paper (or March 31 if filing electronically) of the year following the calendar year to which the return relates. For calendar year 2017, Forms 1094-C and 1095-C are required to be filed by February 28, 2018, or April 2, 2018, if filing electronically.

See *Furnishing Forms 1095-C to Employees* for information on when Form 1095-C must be furnished.

Extensions

You can get an automatic 30-day extension of time to file by completing Form 8809, Application for Extension of Time To File Information Returns. The form may be submitted on paper, or through the FIRE System either as a fill-in form or an electronic file. No signature or explanation is required for the extension. However, you must file Form 8809 on or before the due date of the returns in order to get the 30-day extension. Under certain hardship conditions you may apply for an additional 30-day extension. See the instructions for Form 8809 for more information.

How to apply. As soon as you know that a 30-day extension of time to file is needed, file Form 8809. See the instructions for Form 8809. Mail or fax Form 8809 using the address and phone number listed in the instructions. You can submit the extension request online through the FIRE System. You are encouraged to submit requests using the online fill-in form. See Pub. 1220, Part B, for more information on filing online or electronically.

Where To File

Send all information returns filed on paper to the following:

If your principal business, office or agency, or legal residence in the case of an individual, is located in: ▼	Use the following address: ▼
Alabama, Arizona, Arkansas, Connecticut, Delaware, Florida, Georgia, Kentucky, Louisiana, Maine, Massachusetts, Mississippi, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, Texas, Vermont, Virginia, West Virginia	Department of the Treasury Internal Revenue Service Center Austin, TX 73301

If your principal business, office or agency, or legal residence in the case of an individual, is located in: ▼	Use the following address: ▼
Alaska, California, Colorado, District of Columbia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Maryland, Michigan, Minnesota, Missouri, Montana, Nebraska, Nevada, North Dakota, Oklahoma, Oregon, South Carolina, South Dakota, Tennessee, Utah, Washington, Wisconsin, Wyoming	Department of the Treasury Internal Revenue Service Center PO Box 219256 Kansas City, MO 64121-9256

If your legal residence or principal place of business or principal office or agency is outside the United States, file with the Department of the Treasury, Internal Revenue Service Center, Austin, TX 73301.

Shipping and mailing. If you are filing on paper, send the forms to the IRS in a flat mailing (not folded), and do not paperclip or staple the forms together. If you are sending many forms, you may send them in conveniently sized packages. On each package, write your name, number the packages consecutively, and place Form 1094-C in package number one. Postal regulations require forms and packages to be sent by First-Class Mail. Returns filed with the IRS must be printed in landscape format.

Keeping copies. Generally, keep copies of information returns you filed with the IRS or have the ability to reconstruct the data for at least three years, from the due date of the returns.

Electronic Filing

If you are required to file 250 or more information returns, you must file electronically. The 250-or-more requirement applies separately to each type of form filed and separately for original and corrected returns. For example, if you must file 500 Forms 1095-B and 100 Forms 1095-C, you must file Forms 1095-B electronically, but you are not required to file Forms 1095-C electronically. If you have 150 Forms 1095-C to correct, you may file the corrected returns on paper because they fall under the 250 threshold. However, if you have 300 Forms 1095-C to correct, they must be filed electronically. The electronic filing requirement does not apply if you apply for and receive a hardship waiver. The IRS encourages you to file electronically even though you are filing fewer than 250 returns.

Waiver. To receive a waiver from the required filing of information returns electronically, submit Form 8508. You are encouraged to file Form 8508 at least 45 days before the due date of the returns, but no later than the due date of the return. The IRS does not process waiver requests until January 1st of the calendar year the returns are due. You cannot apply for a waiver for more than one tax year at a time. If you need a waiver for more than one tax year, you must reapply at the appropriate time each year. If a waiver for original returns is approved, any corrections for the same types of returns will be covered under the waiver. However, if you submit original returns electronically but you want to submit your corrections on paper, a waiver must be approved for the corrections if you must file 250 or more corrections. If you receive an approved waiver, do not send a copy of it to the service center where you file your paper returns. Keep the waiver for your records only.

If you are required to file electronically but fail to do so, and you do not have an approved waiver, you may be subject to a penalty of $260 per return for failure to file electronically unless you establish reasonable cause. However, you can file up to 250 returns on paper; those returns will not be subject to a penalty for failure to file electronically. The penalty applies separately to original returns and corrected returns.

Pub. 5165, Guide for Electronically Filing Affordable Care Act (ACA) Information Returns for Software Developers and Transmitters, specifies the communication procedures, transmission formats, business rules, validation procedures, and explains when a return will be accepted, accepted with errors or rejected for returns filed electronically through the ACA Information Return (AIR) system. To develop software for use with the AIR system, software developers, transmitters, and issuers, including ALE Members filing their own Forms 1094-C and 1095-C, should use the guidelines provided in Pub. 5165 along with the Extensible Markup Language (XML) Schemas published on IRS.gov.

Reminder. The formatting directions in these instructions (for example, the directions to enter the 9 digit EIN including the dash on line 2 of Form 1094-C) are for the preparation of paper returns. When filing forms electronically, the formatting set forth in the XML Schemas and Business Rules published on IRS.gov must be followed rather than the formatting directions in these instructions. For more information regarding electronic filing, see Pubs. 5164 and 5165.

Substitute Returns Filed with the IRS

If you are filing your returns on paper, see Pub. 5223 for specifications for private printing of substitute information returns. You may not request special consideration. Only forms that conform to the official form and the specifications in Pub. 5223 are acceptable for filing with the IRS. Substitute returns filed with the IRS must be printed in landscape format.

VOID Box

Do not use this box on Form 1095-C.

Corrected Forms 1094-C and 1095-C

TIP *For information about filing corrections electronically, see section 7.1 of Pub. 5165.*

Corrected Returns

A corrected return should be filed as soon as possible after an error is discovered. File the corrected returns as follows.

Form 1094-C. If correcting information on the Authoritative Transmittal (identified on Part I, line 19, as the Authoritative Transmittal, one (and only one) of which must be filed for each ALE Member reporting aggregate employer-level data for all full-time employees and employees of the ALE Member), file a standalone fully completed Form 1094-C including the correct information and enter an "X" in the CORRECTED checkbox. Do not file a return correcting information on a Form 1094-C that is not the Authoritative Transmittal.

CAUTION ***Do not*** *file any other documents (e.g. Form 1095-C) with the corrected Authoritative Transmittal.*

Form 1095-C. If correcting information on a Form 1095-C that was previously filed with the IRS, file a fully completed Form 1095-C including the correct information and enter an "X" in the CORRECTED checkbox. File a Form 1094-C (**Do not** mark the CORRECTED checkbox on Form 1094-C) with corrected Form(s) 1095-C. Furnish the employee a copy of the corrected Form 1095-C, unless the ALE Member was and continues to be

eligible for and used the alternative method of furnishing under the Qualifying Offer Method for that employee for that year's furnishing. For more information, see *Alternative Method of Furnishing Form 1095-C to Employees under the Qualifying Offer Method*.

Forms 1095-C filed with incorrect dollar amounts on line 15, Employee Required Contribution, may fall under a safe harbor for certain de minimis errors. The safe harbor generally applies if no single amount in error differs from the correct amount by more than $100. If the safe harbor applies, you will not have to correct Form 1095-C to avoid penalties. However, if the recipient elects for the safe harbor not to apply, you may have to issue a corrected Form 1095-C to avoid penalties. For more information, see Notice 2017-9, 2017-4 I.R.B. 542 , at *IRS.gov/irb/2017-04 IRB/ar11.html*.

Note. Enter an "X" in the CORRECTED checkbox only when correcting a Form 1095-C previously filed with the IRS. If you are correcting a Form 1095-C that was previously furnished to a recipient, but not filed with the IRS, write, type, or print CORRECTED on the new Form 1095-C furnished to the recipient.

Correcting information affecting statement furnished to employee using an Alternative Furnishing Method under the Qualifying Offer Method. If an ALE Member eligible to use the Qualifying Offer Method had furnished the employee an alternative statement, the ALE Member must furnish the employee a corrected statement if it filed a corrected Form 1095-C correcting the ALE Member's name, EIN, address or contact name and telephone number. If the ALE Member is no longer eligible to use an alternative furnishing method for the employee for whom it filed a corrected Form 1095-C, it must furnish a Form 1095-C to the employee and advise the employee that Form 1095-C replaces the statement it had previously furnished.

CAUTION *If you fail to file correct information returns or fail to furnish a correct recipient statement, you may be subject to a penalty. However, you are not required to file corrected returns for missing or incorrect TINs if you meet the reasonable cause criteria. For additional information, see Pub. 1586, Reasonable Cause Regulations and Requirements for Missing and Incorrect Name/TINs.*

TIP *See the charts for examples of errors and step by step instructions for filing corrected returns.*

Original Authoritative Transmittal Form 1094-C	
IF any of the following are incorrect	**THEN** ...
ALE Member or Designated Government Entity (Name and/or EIN) Total Number of Forms 1095-C filed by and/or on behalf of ALE Member Aggregated ALE Group Membership Certifications of Eligibility Minimum Essential Coverage Offer Indicator Section 4980H Full-Time Employee Count for ALE Member Aggregated Group Indicator Other ALE Members of Aggregated ALE Group (Name and/or EIN)	1. Prepare a new Authoritative Transmittal, Form 1094-C 2. Enter an "X" in the "CORRECTED" box at the top of the form 3. Submit the standalone corrected Form 1094-C with the correct information present

Original Form 1095-C Submitted to IRS and Furnished to Employee	
IF any of the following are incorrect	**THEN** ...
Name, SSN, ALE Member EIN Offer of Coverage Employee Required Contribution Section 4980H Safe Harbor and Other Relief Codes Covered Individuals Information	1. Prepare a new Form 1095-C 2. Enter an "X" in the "CORRECTED" box at the top of the form 3. Submit corrected Form 1095-Cs with a non-authoritative Form 1094-C transmittal to the IRS 4. Furnish a corrected Form 1095-C to the employee

Original Alternative Furnishing Method under the Qualifying Offer Method Statement Furnished to Employee	
IF any of the following are incorrect	**THEN** ...
Name, SSN, ALE Member EIN Offer of Coverage	• Submission to IRS: 1. Prepare a new Form 1095-C 2. Enter an "X" in the "CORRECTED" box at the top of the form 3. Submit corrected Form 1095-Cs with a non-authoritative Form 1094-C transmittal to the IRS • Furnish to employee If after the correction the ALE Member is still eligible to use the alternative furnishing method under the Qualifying Offer Method, furnish the employee either a Form 1095-C or corrected statement. If the ALE Member is no longer eligible to use the alternative furnishing method with respect to the employee, furnish a Form 1095-C to the employee.

Furnishing Forms 1095-C To Employees

You will meet the requirement to furnish Form 1095-C to an employee if the form is properly addressed and mailed on or before the due date. If the due date falls on a weekend or legal holiday, then the due date is the following business day. A business day is any day that is not a Saturday, Sunday, or legal holiday.

An ALE Member must furnish a Form 1095-C to each of its full-time employees by January 31 of the year following the year to which the Form 1095-C relates.

Forms 1095-C for the 2017 calendar year must be furnished by January 31, 2018.

For more information on alternative furnishing methods for employers, see *A. Qualifying Offer Method*.

Filers of Form 1095-C may truncate the social security number (SSN) of an individual (the employee or any family member of the employee receiving coverage) on Form 1095-C statements furnished to employees by showing only the last four digits of the SSN and replacing the first five digits with asterisks (*) or Xs. Truncation is not allowed on forms filed with the IRS. In addition, an ALE Member's EIN may not be truncated on the statements furnished to employees or the forms filed with the IRS.

Except as provided below, statements must be furnished on paper by mail (or hand delivered), unless the recipient affirmatively consents to receive the statement in an electronic format. If mailed, the statement must be sent to the employee's last known permanent address, or if no permanent address is known, to the employee's temporary address.

Consent to furnish statement electronically. An ALE Member is required to obtain affirmative consent to furnish a statement electronically. This requirement ensures that statements are furnished electronically only to individuals who are able to access them. The consent must relate specifically to receiving the Form 1095-C electronically. An individual may consent on paper or electronically, such as by email. If consent is on paper, the individual must confirm the consent electronically. A statement may be furnished electronically by email or by informing the individual how to access the statement on the ALE Member's website. Statements reporting coverage and offers of coverage under an expatriate health plan, however, may be furnished electronically unless the recipient explicitly refuses to consent to receive the statement in an electronic format. Specific information on consents to furnish statements electronically can be found in Regulations section 301.6056-2.

Extensions of time to furnish statement to recipients. You may request an extension of time to furnish the statements to recipients by sending a letter to Internal Revenue Service, Attn: Extension of Time Coordinator, 240 Murall Drive, Mail Stop 4360, Kearneysville, WV 25430. The letter must include (a) filer name, (b) filer TIN, (c) filer address, (d) type of return, (e) a statement that extension request is for providing statements to recipients, (f) reason for delay, and (g) the signature of the filer or authorized agent. Your request must be postmarked by the date on which the statements are due to the recipients. If your request for an extension is approved, generally you will be granted a maximum of 30 extra days to furnish the recipient statements. For purposes of requesting an extension of time to furnish the statements, the term filer means the ALE Member, or the Designated Government Entity, if applicable.

Information reporting penalties. All employers subject to the employer shared responsibility provisions and other employers that sponsor self-insured group health plans that fail to comply with the applicable information reporting requirements may be subject to the general reporting penalty provisions for failure to file correct information returns and failure to furnish correct payee statements. For returns required to be made and statements required to be furnished for 2017 tax year returns, the following apply.

- The penalty for failure to file a correct information return is $260 for each return for which the failure occurs, with the total penalty for a calendar year not to exceed $3,218,500.
- The penalty for failure to provide a correct payee statement is $260 for each statement for which the failure occurs, with the total penalty for a calendar year not to exceed $3,218,500.
- Special rules apply that increase the per-statement and total penalties if there is intentional disregard of the requirement to file the returns and furnish the required statements.

Waiver of penalties. Penalties may be waived if the failure was due to reasonable cause and not willful neglect. See section 6724 and Regulations section 301.6724-1 and Proposed Regulations section 1.6055-1(h) (which relate to Form 1095-C, Part III). For additional information, see Pub. 1586.

Specific Instructions for Form 1094-C

Part I—Applicable Large Employer Member (ALE Member)

Line 1. Enter employer's name. The employer is the ALE Member.

Line 2. Enter the ALE Member's EIN. Do not enter an SSN. Enter the 9-digit EIN including the dash.

If you are filing Form 1094-C, a valid EIN is required at the time the form is filed. If a valid EIN is not provided, Form 1094-C will not be processed. If you do not have an EIN, you may apply for one online. Go to IRS.gov and enter "EIN" in the search box. You may also apply by faxing or mailing Form SS-4, Application for Employer Identification Number, to the IRS. See the Instructions for Form SS-4 and Pub. 1635, Employer Identification Number.

Lines 3–6. Enter the ALE Member's complete address (including room or suite no., if applicable). This address should match the ALE Member's address used on Form 1095-C.

Lines 7 and 8. Enter the name and telephone number of the person to contact who is responsible for answering any questions from the IRS regarding the filing of or information reported on Forms 1094-C or 1095-C. This may be different than the contact information on line 10 of Form 1095-C.

Note. If you are a Designated Governmental Entity (DGE) filing on behalf of an ALE Member, complete lines 9–16. If you are not a DGE filing on behalf of an ALE Member do not complete lines 9–16. Instead, skip to line 18. See *Designated Governmental Entity (DGE)* in the *Definitions* section of these instructions.

Line 9. If a DGE is filing on behalf of the ALE Member, enter the name of the DGE.

Line 10. Enter the DGE's EIN (including the dash). Do not enter an SSN.

If you are a DGE that is filing Form 1094-C, a valid EIN is required at the time the return is filed. If a valid EIN is not provided, the return will not be processed. If the DGE does not have an EIN when filing Form 1094-C it can get an EIN by applying online at IRS.gov or by faxing or mailing a completed Form SS-4. See the Instructions for Form SS-4 and Pub. 1635.

Lines 11–14. Enter the DGE's complete address (including room or suite no.).

Lines 15 and 16. Enter the name and telephone number of the person to contact who is responsible for answering any questions from the IRS regarding the filing of or information reported on Form 1094-C.

Line 17. Reserved.

Line 18. Enter the total number of Forms 1095-C (not counting continuation sheets) submitted with this Form 1094-C transmittal.

Line 19. If this Form 1094-C transmittal is the Authoritative Transmittal that reports aggregate employer-level data for the ALE Member, check the box on line 19 and complete Parts II, III, and IV, to the extent applicable. Otherwise, complete the signature portion of Form 1094-C and leave the remainder of Parts II, III, and IV blank.

There must be only one Authoritative Transmittal filed for each ALE Member. If this is the only Form 1094-C being filed for the ALE Member, this Form 1094-C must report aggregate employer-level data for the ALE Member and be identified on line 19 as the Authoritative Transmittal. If multiple Forms 1094-C are being filed for an ALE Member so that Forms 1095-C for all full-time employees of the ALE Member are not attached to a single Form 1094-C transmittal (because Forms 1095-C for some full-time employees of the ALE Member are being transmitted separately), one (and only one) of the Forms 1094-C must report aggregate employer-level data for the ALE Member and be identified on line 19 as the Authoritative Transmittal. For more information, see *Authoritative Transmittal for ALE Members Filing Multiple Forms 1094-C*, earlier.

Part II—ALE Member Information

Reminder. Lines 20–22 should be completed only on the Authoritative Transmittal for the ALE Member. For more information, see *Authoritative Transmittal for ALE Members Filing Multiple Forms 1094-C*, earlier.

Line 20. Enter the total number of Forms 1095-C (not counting continuation sheets) that will be filed by and/or on behalf of the ALE Member. This includes all Forms 1095-C that are filed with this transmittal including those filed for individuals who enrolled in the employer-sponsored self-insured plan, if any, and for any Forms 1095-C filed with a separate transmittal filed by or on behalf of the ALE Member.

Line 21. If during any month of the calendar year the ALE Member was a member of an Aggregated ALE Group, check "Yes." If you check "Yes," also complete the "Aggregated Group Indicator" in Part III, column (d), and then complete Part IV to list the other members of the Aggregated ALE Group. If, for all 12 months of the calendar year, the employer was not a member of an Aggregated ALE Group, check "No," and do not complete Part III, column (d), or Part IV.

Line 22. If the ALE Member meets the eligibility requirements and is using one of the Offer Methods, it must check the applicable box. See the descriptions of Qualifying Offer Method and 98% Offer Method, below.

A. Qualifying Offer Method. Check this box if the ALE Member is eligible to use and is using the Qualifying Offer Method to report the information on Form 1095-C for one or more full-time employees. Under the Qualifying Offer Method there is an alternative method of completing Form 1095-C and an alternative method for furnishing Form 1095-C to certain employees. If the ALE Member is using either of these alternative rules, check this box. To be eligible to use the Qualifying Offer Method, the ALE Member must certify that it made a Qualifying Offer to one or more of its full-time employees for all months during the year in which the employee was a full-time employee for whom an employer shared responsibility payment could apply. Additional requirements described below must be met to be eligible to use the alternative method for furnishing Form 1095-C to employees under the Qualifying Offer Method.

Alternative Method of Completing Form 1095-C under the Qualifying Offer Method. If the ALE Member reports using this method, it must not complete Form 1095-C, Part II, line 15, for any month for which a Qualifying Offer is made. Instead it must enter the Qualifying Offer code 1A on Form 1095-C, line 14, for any month for which the employee received a Qualifying Offer (or in the all 12 months box if the employee received a Qualifying Offer for all 12 months), and must leave line 15 blank for any month for which code 1A is entered on line 14. The ALE Member may, but is not required, to enter an applicable code on line 16 for any month for which code 1A is entered on line 14; a Qualifying Offer is, by definition, treated as an offer that falls within an affordability safe harbor even if no code is entered on line 16.

An ALE Member is not required to use the Qualifying Offer Method, even if it is eligible and instead may enter on line 14 the applicable offer code and then enter on line 15 the Employee Required Contribution.

If the ALE Member is eligible to use the Qualifying Offer Method, it may report on Form 1095-C by entering the Qualifying Offer code 1A on Form 1095-C, line 14, for any month for which it made a Qualifying Offer to an employee, even if the employee did not receive a Qualifying Offer for all 12 calendar months. However, if an employee receives a Qualifying Offer for less than all 12 months, the ALE Member must furnish a copy of Form 1095-C to the employee (rather than using the alternative method of furnishing Form 1095-C described below).

Example. Employee's employment with Employer begins on January 1. Employee is in a health coverage waiting period (and an employer shared responsibility payment could not apply with respect to Employee, because Employee is in a Limited Non-Assessment Period) until April 1 and is a full-time employee for the remainder of the calendar year. Employer makes a Qualifying Offer to Employee for coverage beginning on April 1 and for the remainder of the calendar year. Employer is eligible to use the Qualifying Offer method because it has made a Qualifying Offer to at least one full-time employee for all months in which both (1) the employee was a full-time employee and (2) an employer shared responsibility payment could apply with

respect to the employee. Employer may use the alternative method of completing Form 1095-C under the Qualifying Offer Method for this Employee. However, Employer may not use the alternative method of furnishing Form 1095-C to Employee under the Qualifying Offer Method because Employee did not receive a Qualifying Offer for all 12 months of the calendar year.

Alternative Method of Furnishing Form 1095-C to Employees under the Qualifying Offer Method. An ALE Member that is eligible to use the Qualifying Offer Method may use the alternative method of furnishing Form 1095-C only for a full-time employee who: (1) received a Qualifying Offer for all 12 months of the calendar year, and (2) did not enroll in employer-sponsored self-insured coverage. For such an employee, an ALE Member meets its obligation to furnish a Form 1095-C to the employee if it furnishes the employee a statement containing the following information.

- Employer/ALE Member name, address, and EIN.
- Contact name and telephone number at which the employee may receive information about the offer of coverage and the information on the Form 1095-C filed with the IRS for that employee.
- Notification that, for all 12 months of the calendar year, the employee and his or her spouse and dependents, if any, received a Qualifying Offer and therefore are not eligible for a premium tax credit.
- Information directing the employee to see Pub. 974, Premium Tax Credit (PTC), for more information on eligibility for the premium tax credit.

An ALE Member is not required to use the alternative method of furnishing for an employee even if the alternative method would be allowed. Instead, the ALE Member may furnish a copy of Form 1095-C as filed with the IRS (with or without the statement described above).

As stated above, an ALE Member may **not** use the alternative furnishing method for a full-time employee who enrolled in self-insured coverage. Rather, the ALE Member must furnish Form 1095-C, including the information reporting enrollment in the coverage on Form 1095-C, Part III.

B. **Reserved.**

C. **Reserved.**

D. 98% Offer Method. Check this box if the employer is eligible for and is using the 98% Offer Method. To be eligible to use the 98% Offer Method, an employer must certify that, taking into account all months during which the individuals were employees of the ALE Member and were not in a Limited Non-Assessment Period, the ALE Member offered affordable health coverage providing minimum value to at least 98% of its employees for whom it is filing a Form 1095-C employee statement, and offered minimum essential coverage to those employees' dependents. The ALE member is not required to identify which of the employees for whom it is filing were full-time employees, but the ALE Member is still required, under the general reporting rules, to file Forms 1095-C on behalf of all its full-time employees who were full-time employees for one or more months of the calendar year. To ensure compliance with the general reporting rules, an ALE Member should confirm for any employee for whom it fails to file a Form 1095-C that the employee was not a full-time employee for any month of the calendar year. (For this purpose, the health coverage is affordable if the ALE Member meets one of the section 4980H affordability safe harbors.)

Example. Employer has 325 employees. Of those 325 employees, Employer identifies 25 employees as not possibly being full-time employees because they are scheduled to work 10 hours per week and are not eligible for additional hours. Of the remaining 300 employees, 295 are offered affordable minimum value coverage for all periods during which they are employed other than any applicable waiting period (which qualifies as a Limited Non-Assessment Period). Employer files a Form 1095-C for each of the 300 employees (excluding the 25 employees that it identified as not possibly being full-time employees). Employer may use the 98% Offer Method because it makes an affordable offer of coverage that provides minimum value to at least 98% of the employees for whom Employer files a Form 1095-C. Using this method, Employer does not identify whether each of the 300 employees is a full-time employee. However, Employer must still file a Form 1095-C for all of its full-time employees. Employer chooses to file a Form 1095-C on behalf of all 300 employees, including the five employees to whom it did not offer coverage, because if one or more of those employees was, in fact, a full-time employee for one or more months of the calendar year, Employer would be required to have filed a Form 1095-C on behalf of those employees.

Note. If an ALE member uses the 98% offer method, it is not required to complete the "Section 4980H Full-Time Employee Count for ALE Member" in Part III, column (b).

Part III—ALE Member Information—Monthly (Lines 23–35)

Column (a) Minimum Essential Coverage Offer Indicator.

- If the ALE Member offered minimum essential coverage to at least 95% of its full-time employees and their dependents for the entire calendar year, enter "X" in the "Yes" checkbox on line 23 for "All 12 Months" or for each of the 12 calendar months.
- If the ALE Member offered minimum essential coverage to at least 95% of its full-time employees and their dependents only for certain calendar months, enter "X" in the "Yes" checkbox for each applicable month.
- For the months, if any, for which the ALE Member did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents, enter "X" in the "No" checkbox for each applicable month.
- If the ALE Member did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents for any of the 12 months, enter "X" in the "No" checkbox for "All 12 Months" or for each of the 12 calendar months.

Note. For purposes of column (a), an employee in a Limited Non-Assessment Period is not counted in determining whether minimum essential coverage was offered to at least 95% of an ALE Member's full-time employees and their dependents. For a description of the differences between the definition of the term Limited Non-Assessment Period used with respect to section 4980H(a) and the definition used with respect to section 4980H(b), relating to whether the ALE Member offers minimum value coverage at the end of the Limited Non-Assessment Period, see the *Definitions* section.

An employee who is treated as having been offered health coverage for purposes of section 4980H (even though not actually offered) is treated as offered minimum essential coverage for this purpose. For example, for the months for which the ALE Member is eligible for multiemployer arrangement interim guidance (if the ALE Member is contributing on behalf of an employee whether or not the employee is eligible for coverage under the multiemployer plan) with respect to an employee, that employee should be treated as having been offered minimum essential coverage for purposes of column (a). For different rules for purposes of reporting offers of coverage on Form 1095-C, see the specific instructions for Form 1095-C, Part II, line 14.

For purposes of column (a), if the ALE Member offered minimum essential coverage to all but five of its full-time employees and their dependents, and five is greater than 5% of the number of full-time employees of the ALE Member, the ALE Member may report in column (a) as if it

offered health coverage to at least 95% of its full-time employees and their dependents (even if it offered health coverage to less than 95% of its full-time employees and their dependents, for example to 75 of its 80 full-time employees and their dependents).

See *Definitions*, later, for more information on an offer of health coverage.

Column (b) Section 4980H Full-Time Employee Count for ALE Member. Enter the number of full-time employees for each month, but do not count any employee in a Limited Non-Assessment Period. If the number of full-time employees (excluding employees in a Limited Non-Assessment Period) for a month is zero, enter "0." An employee should be counted as a full-time employee for a month if the employee satisfied the definition of full-time employee under the monthly measurement method or the look-back measurement method (as applicable) on any day of the month. See *Full-time employee* and *Limited Non-Assessment Period* in the *Definitions* section. Be sure to use the section 4980H definition and not any other definition of the term full-time employee that you may use for other purposes.

Example. Employer uses the look-back measurement method to determine the full-time status of its employees. Employee, who is not in a Limited Non-Assessment Period, averaged over 130 hours of service per month during the measurement period that corresponds with the stability period starting January 1, 2017, and ending December 31, 2017. Employee terminates employment with Employer on February 15, 2017. Employer must include Employee in the number of full-time employees reported in column (b) for January and February. See the description of code 2B in the instructions for line 16 of Form 1095-C, later, for rules for reporting an offer of coverage in an employee's final month of employment.

Note. If the ALE Member certified that it was eligible for the 98% Offer Method by selecting box D, on line 22, it is not required to complete column (b).

Column (c) Total Employee Count for ALE Member. Enter the total number of all of the ALE Member's employees, including full-time employees and non-full-time employees, and employees in a Limited Non-Assessment Period, for each calendar month. An ALE Member must choose to use one of the following days of the month to determine the number of employees per month and must use that day for all months of the year: (1) the first day of each month; (2) the last day of each month; (3) the 12th day of each month; (4) the first day of the first payroll period that starts during each month; or (5) the last day of the first payroll period that starts during each month (provided that for each month that last day falls within the calendar month in which the payroll period starts). If the total number of employees was the same for every month of the entire calendar year, enter that number in line 23, column (c) "All 12 Months" or in the boxes for each month of the calendar year. If the number of employees for any month is zero, enter "0."

Column (d) Aggregated Group Indicator. An ALE Member must complete this column if it checked "Yes" on line 21, indicating that, during any month of the calendar year, it was a member of an Aggregated ALE Group. If the ALE Member was a member of an Aggregated ALE Group during each month of the calendar year, enter "X" in the "All 12 Months" box or in the boxes for each of the 12 calendar months. If the ALE Member was not a member of an Aggregated ALE Group for all 12 months but was a member of an Aggregated ALE Group for one or more month(s), enter "X" in each month for which it was a member of an Aggregated ALE Group. If an ALE Member enters "X" in one or more months in this column, it must also complete Part IV.

Part IV—Other ALE Members of Aggregated ALE Group (Lines 36–65)

An ALE Member must complete this section if it checks "Yes" on line 21. If the ALE Member was a member of an Aggregated ALE Group (with other ALE Members) for any month of the calendar year, enter the name(s) and EIN(s) of up to 30 of the other Aggregated ALE Group members (not including the reporting ALE Member). If there are more than 30 members of the Aggregated ALE Group (not including the reporting ALE Member), enter the 30 with the highest monthly average number of full-time employees (using the number reported in Part III, column (b), if a number was required to be reported) for the year or for the number of months during which the ALE Member was a member of the Aggregated ALE Group. If any member of the Aggregated ALE Group uses the 98% Offer Method and thus is not required to identify which employees are full-time employees, all ALE Members of the Aggregated ALE Group should use the monthly average number of total employees rather than the monthly average number of full-time employees for this purpose. Regardless of the number of members in the Aggregated ALE Group, list only the 30 members in descending order, listing first the member with the highest average monthly number of full-time employees (or highest average number of total employees, if any member of the Aggregated ALE Group uses the 98% Offer Method), but do not include the reporting ALE Member. The reporting ALE Member must also complete Part III, column (d), to indicate which months it was part of an Aggregated ALE Group.

If you are filing Form 1094-C, a valid EIN is required at the time it is filed. If a valid EIN is not provided, Form 1094-C will not be processed. If you do not have an EIN, you may apply for one online. Go to IRS.gov and enter "EIN" in the search box. You may also apply by faxing or mailing Form SS-4 to the IRS. See the Instructions for Form SS-4 and Pub. 1635.

Specific Instructions for Form 1095-C

Part I—Employee

Line 1. Enter the name of the employee (first name, middle initial, last name).

Line 2. Enter the 9-digit SSN of the employee (including the dashes).

Lines 3–6. Enter the employee's complete address, including apartment no., if applicable. A country code is not required for U.S. addresses.

Part I—Applicable Large Employer Member (Employer)

Line 7. Enter the name of the ALE Member.

Line 8. Enter the ALE Member's EIN. Do not enter an SSN. Enter the 9-digit EIN including the dash. The ALE Member's name and EIN should match the name and EIN of the ALE Member reported on lines 1 and 2 of Form 1094-C.

If you are filing Form 1095-C, a valid EIN is required at the time it is filed. If a valid EIN is not provided, Form 1095-C will not be processed. If you do not have an EIN, you may apply for one online. Go to IRS.gov and enter "EIN" in the search box. You may also apply by faxing or mailing Form SS-4 to the IRS. See the Instructions for Form SS-4 and Pub. 1635.

Lines 9 and 11–13. Enter the ALE Member's complete address (including room or suite no., if applicable). This address should match the address reported on lines 3–6 of the Form 1094-C.

Line 10. Enter the telephone number of the person to contact whom the recipient may call about the information reported on the form. This may be different than the contact information entered on line 8 of Form 1094-C.

Part II—Employee Offer of Coverage

Plan Start Month. This box is optional for the 2017 Form 1095-C and the ALE Member may leave it blank. This box may be mandatory for the 2018 Form 1095-C. To complete the box, enter the two-digit number (01 through 12) indicating the calendar month during which the plan year begins of the health plan in which the employee is offered coverage (or would be offered coverage if the employee were eligible to participate in the plan). If more than one plan year could apply (for instance, if the ALE Member changes the plan year during the year), enter the earliest applicable month. If there is no health plan under which coverage is offered to the employee, enter "00."

Line 14. For each calendar month, enter the applicable code from Code Series 1. If the same code applies for all 12 calendar months, you may enter the applicable code in the "All 12 Months" box and not complete the individual calendar month boxes, or you may enter the code in each of the boxes for the 12 calendar months. If an employee was not offered coverage for a month, enter code 1H. Do not leave line 14 blank for any month (including months when the individual was not an employee of the ALE Member). An ALE Member offers health coverage for a month only if it offers health coverage that would provide coverage for every day of that calendar month. Thus, if coverage terminates before the last day of the month (because, for instance, the employee terminates employment with the ALE Member, or otherwise loses eligibility for coverage under the plan), the employee does not actually have an offer of coverage for that month (and code 1H should therefore be entered on line 14). See line 16, code 2B, later, for how the ALE Member may complete line 16 in the event that coverage terminates before the last day of the month.

A code must be entered for each calendar month January through December, even if the employee was not a full-time employee for one or more of the calendar months. Enter the code identifying the type of health coverage actually offered by the ALE Member (or on behalf of the ALE Member) to the employee, if any. If the employee was not actually offered coverage, enter code 1H (no offer of coverage) on line 14.

For reporting offers of coverage for 2017, an ALE Member relying on the multiemployer arrangement interim guidance should enter code 1H on line 14 for any month for which the ALE Member enters code 2E on line 16 (indicating that the ALE Member was required to contribute to a multiemployer plan on behalf of the employee for that month and therefore is eligible for multiemployer interim rule relief). For a description of the multiemployer arrangement interim guidance, see *Offer of health coverage* in the *Definitions* section. For reporting for 2017, code 1H may be entered without regard to whether the employee was eligible to enroll or enrolled in coverage under the multiemployer plan. For reporting for 2018 and future years, ALE Members relying on the multiemployer arrangement interim guidance may be required to report offers of coverage made through a multiemployer plan in a different manner.

Indicator Codes for Employee Offer of Coverage (Form 1095-C, Line 14)

Code Series 1— Offer of Coverage. The Code Series 1 indicator codes specify the type of coverage, if any, offered to an employee, the employee's spouse, and the employee's dependents. The term "dependent" has the specific meaning set forth in the *Definitions* section of these instructions. In addition, for this purpose an offer of coverage is treated as made to an employee's dependents only if the offer of coverage is made to an unlimited number of dependents regardless of the actual number of dependents, if any, an employee has during any particular calendar month.

If the type of coverage, if any, offered to an employee was the same for all 12 months in the calendar year, enter the Code Series 1 indicator code corresponding to the type of coverage offered either in the "All 12 Months" box or in each of the 12 boxes for the calendar months.

Conditional offer of spousal coverage. Codes 1J and 1K address conditional offers of spousal coverage (also referred to as coverage offered conditionally). A conditional offer is an offer of coverage that is subject to one or more reasonable, objective conditions (for example, an offer to cover an employee's spouse only if the spouse is not eligible for coverage under Medicare or a group health plan sponsored by another employer). Using codes 1J and 1K, an ALE Member may report a conditional offer to a spouse as an offer of coverage, regardless of whether the spouse meets the reasonable, objective condition. A conditional offer generally would impact a spouse's eligibility for the premium tax credit under section 36B only if all conditions to the offer are satisfied (that is, the spouse was actually offered the coverage and eligible for it). To help employees (and spouses) who have received a conditional offer determine their eligibility for the premium tax credit, the ALE Member should be prepared to provide, upon request, a list of any and all conditions applicable to the spousal offer of coverage. As is noted in the definition of dependent in the *Definitions* section, a spouse is not a dependent for purposes of section 4980H.

An ALE Member may not report a conditional offer of coverage to an employee's dependents as an offer to the dependents, unless the ALE Member knows that the dependents met the condition to be eligible for the ALE Member's coverage. Further, an offer of coverage is treated as made to an employee's dependents only if the offer of coverage is made to an unlimited number of dependents regardless of the actual number of dependents, if any, an employee has during any particular calendar month.

COBRA continuation coverage. An offer of COBRA continuation coverage is reported differently depending on whether or not the offer is made due to an employee's termination of employment.

An offer of COBRA continuation coverage that is made to a former employee (or to a former employee's spouse or dependents) due to termination of employment should not be reported as an offer of coverage on line 14. In this situation, code 1H (No offer of coverage) must be entered on line 14 for any month for which the offer of COBRA continuation coverage applies, and code 2A (Employee not employed during the month) must be entered on line 16 (see the instructions for line 16), without regard to whether the employee or spouse or dependents enrolled in the COBRA coverage. However, for the month in which the employee terminates employment with the ALE Member, see the instructions for line 16, code 2B.

An offer of COBRA continuation coverage that is made to an employee who remains employed by the ALE Member (or to that employee's spouse and dependents) should be reported on line 14 as an offer of coverage, but only for any individual who receives an offer of COBRA continuation coverage (or an offer of similar coverage that is made at the same time as the offer of COBRA continuation coverage is made to enrolled individuals). Generally, an offer of COBRA continuation coverage is required to be made only to individuals who were enrolled in coverage and would lose eligibility for coverage due to the COBRA

qualifying event, but an ALE Member may choose to extend a similar offer of coverage to a spouse or dependent even if the offer is not required by COBRA.

Example. During the applicable open enrollment period for its health plan, Employer makes an offer of minimum essential coverage providing minimum value to Employee and to Employee's spouse and dependents. Employee elects to enroll in employee-only coverage starting January 1. On June 1, Employee experiences a reduction in hours that results in loss of eligibility for coverage under the plan. As of June 1, Employer terminates Employee's existing coverage and makes an offer of COBRA continuation coverage to Employee, but does not make an offer to Employee's spouse and dependents. Employer should enter code 1E (Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse) on line 14 for months January – May, and should enter code 1B (Minimum essential coverage providing minimum value offered to employee only) on line 14 for months June – December.

Note. Notwithstanding the preceding instructions for completing line 14 of Form 1095-C, for purposes of section 4980H, an ALE Member is treated as having made an offer to the employee's dependents for an entire plan year if the ALE Member provided the employee an effective opportunity to enroll the employee's dependents at least once for the plan year, even if the employee declined to enroll the dependents in the coverage and, as a result, the dependents later did not receive an offer of COBRA coverage.

Post-employment (non-COBRA) coverage. An offer of post-employment coverage to a former employee (or to that former employee's spouse or dependent(s)) for coverage that would be effective after the employee has terminated employment (such as at retirement) should not be reported as an offer of coverage on line 14. If the ALE Member is otherwise required to file Form 1095-C for the former employee (because, for example, the individual was a full-time employee for one or more months in the calendar year in which the termination of employment occurred), the ALE Member should enter code 1H (no offer of coverage) on line 14 for any month to which an offer of post-employment coverage applies, and should also enter code 2A (not an employee) on line 16 (see the instructions for line 16).

TIP *For additional information including examples about reporting offers of COBRA continuation coverage and post-employment coverage, go to www.irs.gov/Affordable-Care-Act/Employers/Questions-and-Answers-about-Information-Reporting-by-Employers-on-Form-1094-C-and-Form-1095-C.*

- **1A.** Qualifying Offer: Minimum essential coverage providing minimum value offered to full-time employee with Employee Required Contribution equal to or less than 9.5% (as adjusted) of mainland single federal poverty line and at least minimum essential coverage offered to spouse and dependent(s).

TIP *This code may be used to report for specific months for which a Qualifying Offer was made, even if the employee did not receive a Qualifying Offer for all 12 months of the calendar year. However, an ALE Member may not use the Alternative Furnishing Method for an employee who did not receive a Qualifying Offer for all 12 calendar months.*

- **1B.** Minimum essential coverage providing minimum value offered to employee only.
- **1C.** Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) (not spouse).
- **1D.** Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to spouse (not dependent(s)). Do not use code 1D if the coverage for the spouse was offered conditionally. Instead use code 1J.
- **1E.** Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage offered to dependent(s) and spouse. Do not use code 1E if the coverage for the spouse was offered conditionally. Instead use code 1K.
- **1F.** Minimum essential coverage NOT providing minimum value offered to employee; employee and spouse or dependent(s); or employee, spouse and dependents.
- **1G.** Offer of coverage for at least one month of the calendar year to an individual who was not an 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 (which may include one or more months in which the individual was not an employee) and who enrolled in self-insured coverage for one or more months of the calendar year.

Note. Code 1G applies for the entire year or not at all. Therefore, if code 1G applies, an ALE Member must enter code 1G on line 14 in the "All 12 Months" column or in each separate monthly box (for all 12 months).

- **1H.** No offer of coverage (employee not offered any health coverage or employee offered coverage that is not minimum essential coverage, which may include one or more months in which the individual was not an employee).
- **1I.** Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to employee and at least minimum essential coverage conditionally offered to spouse; minimum essential coverage not offered to dependent(s). (See *Conditional offer of spousal coverage*, above, for an additional description of conditional offers.)
- **1K.** Minimum essential coverage providing minimum value offered to employee; at least minimum essential coverage offered to dependents; and at least minimum essential coverage conditionally offered to spouse. (See *Conditional offer of spousal coverage*, above, for an additional description of conditional offers.)

Line 15. Complete line 15 only if code 1B, 1C, 1D, 1E, 1J, or 1K is entered on line 14 either in the "All 12 Months" box or in any of the monthly boxes. Enter the amount of the Employee Required Contribution, which is, generally, the employee share of the monthly cost for the lowest-cost self-only minimum essential coverage providing minimum value that is offered to the employee. For additional details on how to determine the Employee Required Contribution, see the *Definitions* section, later. Enter the amount including any cents. If the employee is offered coverage but the Employee Required Contribution is zero, enter "0.00" (do not leave blank). If the Employee Required Contribution was the same amount for all 12 calendar months, you may enter that monthly amount in the "All 12 Months" box and not complete the monthly boxes. If the Employee Required Contribution was not the same for all 12 months (for instance, if an ALE Member has a non-calendar year plan and the employee share of the premium changes with the new plan year that starts in 2017), enter the amount in each calendar month for which the employee was offered minimum value coverage. See the definition of *Employee Required Contribution* in the *Definitions* section, for more information, including on how to determine the monthly required contribution from annual data.

TIP *For line 15, the amount entered might not be the amount the employee is paying for the coverage, for example, if the employee chose to enroll in more expensive coverage such as family coverage or if the employee is eligible for certain other healthcare arrangements.*

Line 16. For each calendar month, enter the applicable code, if any, from Code Series 2. Enter only one code from Code Series 2 per calendar month. The instructions below address which code to use for a month if more than one code from Series 2 could apply. If the same code applies for all 12 calendar months, you may enter the code in the "All 12 Months" box and not complete the monthly boxes. If none of the codes apply for a calendar month, leave the line blank for that month.

Code Series 2—Section 4980H Safe Harbor Codes and Other Relief for ALE Members. An ALE Member enters the applicable Code Series 2 indicator code, if any, on line 16 to report for one or more months of the calendar year that one of the following situations applied to the employee.

- The employee was not employed or was not a full-time employee;
- The employee enrolled in the minimum essential coverage offered;
- The employee was in a Limited Non-Assessment Period with respect to section 4980H(b);
- The ALE Member met one of the section 4980H affordability safe harbors with respect to this employee; or
- The ALE Member was eligible for multiemployer interim rule relief for this employee.

If no indicator code applies, leave line 16 blank. In some circumstances more than one indicator code could apply to the same employee in the same month. For example, an employee could be enrolled in health coverage for a particular month during which he or she is not a full-time employee. However, only one code may be used for a particular calendar month. For any month in which an employee enrolled in minimum essential coverage, in general, indicator code 2C reporting enrollment is used instead of any other indicator code that could also apply (but see the exceptions to this rule below, regarding the multiemployer interim rule relief and enrollment in COBRA continuation coverage or other post-employment coverage). For an employee who did not enroll in health coverage, there are some specific ordering rules for which code to use. See the descriptions of the codes.

Note. There is no specific code to enter on line 16 to indicate that a full-time employee offered coverage either did not enroll in the coverage or waived the coverage.

- **2A.** Employee not employed during the month. Enter code 2A if the employee was not employed on any day of the calendar month. Do not use code 2A for a month if the individual was an employee of the ALE Member on any day of the calendar month. Do not use code 2A for the month during which an employee terminates employment with the ALE Member.
- **2B.** Employee not a full-time employee. Enter code 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. Enter code 2B also if the employee is a full-time employee for the month and whose offer of coverage (or coverage if the employee was enrolled) ended before the last day of the month solely because the employee terminated employment during the month (so that the offer of coverage or coverage would have continued if the employee had not terminated employment during the month).
- **2C.** Employee enrolled in health coverage offered. Enter code 2C for any month in which the employee enrolled for each day of the month in health coverage offered by the ALE Member, regardless of whether any other code in Code Series 2 might also apply (for example, the code for a section 4980H affordability safe harbor) except as provided below. Do not enter code 2C in line 16 for any month in which the multiemployer interim rule relief applies (enter code 2E). Do not enter code 2C in line 16 if code 1G is entered in line 14. Do not enter code 2C in line 16 for any month in which a terminated employee is enrolled in COBRA continuation coverage or other post-employment coverage (enter code 2A). Do not enter code 2C in line 16 for any month in which the employee enrolled in coverage that was not minimum essential coverage.
- **2D.** Employee in a section 4980H(b) Limited Non-Assessment Period. Enter code 2D for any month during which an employee is in a section 4980H(b) Limited Non-Assessment Period. If an employee is in an initial measurement period, enter code 2D (employee in a section 4980H(b) Limited Non-Assessment Period) for the month, and not code 2B (employee not a full-time employee). For an employee in a section 4980H(b) Limited Non-Assessment Period for whom the ALE Member is also eligible for the multiemployer interim rule relief for the month, enter code 2E (multiemployer interim rule relief) and not code 2D (employee in a section 4980H(b) Limited Non-Assessment Period).
- **2E.** Multiemployer interim rule relief. Enter code 2E for any month for which the multiemployer arrangement interim guidance applies for that employee, regardless of whether any other code in Code Series 2 (including code 2C) might also apply. This relief is described under *Offer of Health Coverage* in the *Definitions* section of these instructions.

Note. Although ALE Members may use the section 4980H affordability safe harbors to determine affordability for purposes of the multiemployer arrangement interim guidance, an ALE Member eligible for the relief provided in the multiemployer arrangement interim guidance for a month for an employee should enter code 2E (multiemployer interim rule relief), and not codes 2F, 2G, or 2H (codes for section 4980H affordability safe harbors).

- **2F.** Section 4980H affordability Form W-2 safe harbor. Enter code 2F if the ALE Member 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 an ALE Member uses this safe harbor for an employee, it must be used for all months of the calendar year for which the employee is offered health coverage.
- **2G.** Section 4980H affordability federal poverty line safe harbor. Enter code 2G if the ALE Member 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.** Section 4980H affordability rate of pay safe harbor. Enter code 2H if the ALE Member 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).

Note. An affordability safe harbor code should not be entered on line 16 for any month that the ALE member did not offer minimum essential coverage to at least 95% of its full-time employees and their dependents (that is, any month for which the ALE member checked the "No" box on Form 1094-C, Part III, column (a)). For more information, see the instructions for Form 1094-C, Part III, column (a).

- **2I.** Reserved.

Note. References to 9.5% in the section 4980H affordability safe harbors and Qualifying Offer Method are applied based on the percentage as indexed for purposes of applying the affordability thresholds under section 36B (the premium tax credit). The percentage, as adjusted, is 9.66% for plan years beginning in 2016, and 9.69% for plan years beginning in 2017.

Part III—Covered Individuals (Lines 17–22)

Complete Part III ONLY if the ALE Member offers employer-sponsored self-insured health coverage in which the employee or other individual enrolled. For this purpose, employer-sponsored self-insured health coverage does not include coverage under a multiemployer plan. Do not complete Part III if the ALE Member offers coverage only under an insured

group health plan. If an ALE Member offers both insured and self-insured coverage, complete Part III only for employees who enroll in the self-insured coverage.

An ALE Member with a self-insured major medical plan and a health reimbursement arrangement (HRA) that has an individual who enrolls in both types of minimum essential coverage is required to report the individual's coverage under only one of the arrangements in Part III. An ALE Member with an insured major medical plan and an HRA that has an individual who enrolls in both types of minimum essential coverage is not required to report in Part III the HRA coverage of an individual if the individual is eligible for the HRA because the individual enrolled in the insured major medical plan. An ALE Member with an HRA must report coverage under the HRA in Part III for any individual who is not enrolled in a major medical plan of the ALE Member (for example, if the individual is enrolled in a group health plan of another employer (such as spousal coverage)). For additional information on the reporting of supplemental coverage, see Proposed Regulations section 1.6055-1(d)(2) and (3).

If the ALE Member is completing Part III, enter "X" in the check box in Part III. If the ALE Member is not completing Part III, do not enter "X" in the check box in Part III.

This part **must** be completed by an ALE Member offering self-insured health coverage for any individual who was an employee for one or more calendar months of the year, whether full-time or non-full-time, and who enrolled in the coverage. The employee (if enrolled in self-insured coverage) should be listed on line 17; any other family members who enrolled in coverage offered to the employee should be listed on subsequent lines.

TIP *All employee family members that are covered individuals through the employee's enrollment (for example, because the employee elected family coverage) must be included on the same form as the employee (or any other individual to whom the offer was made). For example, if the employee is offered family coverage by his or her employer under a self-insured health plan and enrolls in the family coverage, the employee and the employee's family members that are covered under the plan must all be reported on the same Form 1095-C.*

If two or more employees employed by the same ALE Member are spouses or an employee and his or her dependent, and one employee enrolled in a coverage option under the plan that also covered the other employee(s) (for example, one employee spouse enrolled in family coverage that provided coverage to the other employee spouse and their employee dependent child), the enrollment information should be reflected only on Form 1095-C for the employee who enrolled in the coverage. (However, it would report the other employee family members as covered individuals).

Coverage of Non-Employee. This part **may** be completed by an ALE Member offering self-insured health coverage for any other individual who enrolled in the coverage under the plan for one or more calendar months of the year but was not an employee for any calendar month of the year, such as a non-employee director, a retired employee who retired in a previous year, a terminated employee receiving COBRA continuation coverage (or any other form of post-employment coverage) who terminated employment during a previous year, and a non-employee COBRA beneficiary (but not including an individual who obtained coverage through the employee's enrollment, such as a spouse or dependent obtaining coverage when an employee elects COBRA continuation coverage that is family coverage). If Form 1095-C is used with respect to an individual who was not an employee for any month of the calendar year, Part II must be completed by using code 1G in the "All 12 Months" box or the separate monthly boxes for all 12 calendar months. The employer must report for these individuals using Form 1095-B, if it chooses not to use Form 1095-C.

TIP *If a non-employee individual enrolls in the coverage under a self-insured health plan, all family members that are covered individuals because of the individual's enrollment must be included on the same Form 1095-B or Form 1095-C as the individual who is offered, and enrolls in, the coverage.*

Columns (a) through (e), as applicable, must be completed for each individual enrolled in the coverage, including the employee reported on line 1. Enter the nine-digit SSN or other TIN for each covered individual in column (b). Enter a date of birth in column (c) only if an SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, complete this information on the additional covered individuals on Part III Covered Individuals — Continuation Sheet(s). Do not count the continuation sheet(s) as additional Forms 1095-C in the count of forms submitted with the accompanying Form 1094-C.

TIP *Governmental Unit employers offering self-insured health coverage that have delegated another governmental unit (DGE) for purposes of reporting and furnishing enrollment information (meaning the information that otherwise would be reported on Form 1095-C, Part III), but have not designated a DGE for purposes of reporting and furnishing offer of coverage information (meaning the information that is reported on Form 1095-C, Part II), should file and furnish Forms 1095-C with a completed Part I and Part II, but not a completed Part III, and* ***should not check the box indicating that the Governmental Unit offers self-insured health coverage****. In this case, the DGE should file Forms 1094-B and 1095-B to report enrollment information for employees on behalf of the Governmental Unit. See FAQs on IRS.gov.*

A DGE that has been delegated by a Governmental Unit for purposes of reporting and furnishing both offer of coverage and enrollment information (meaning the information that would be reported on Parts II and III of Form 1095-C) should file Forms 1094-C and 1095-C to report the information for employees on behalf of the Governmental Unit.

Column (a). Enter the name of each covered individual (including the employee, if the employee is enrolled in self-insured coverage).

Column (b). Enter the 9-digit SSN for each covered individual, including the dashes. For covered individuals who are not the employee listed in Part I, a taxpayer identification number (TIN), rather than an SSN, may be entered if the covered individual does not have an SSN, or the field may be left blank if the covered individual does not have a TIN.

Column (c). Enter a date of birth (YYYY-MM-DD) for the covered individual only if column (b) is blank.

Column (d). Check this box if the individual was covered for at least **one day** per month for all 12 months of the calendar year.

Column (e). If the individual was not covered for all 12 months of the calendar year, check the applicable box(es) for the month(s) in which the individual was covered for at least one day in the month.

Definitions

This section contains the definitions of key terms used in Forms 1094-C and 1095-C and these instructions. For definitions of

terms not included in this section, see the final regulations under section 4980H, T.D. 9655, 2014-9 I.R.B. 541, at www.irs.gov/irb/2014-9_IRB/ar05.html and section 6056, T.D. 9661, 2014-13 I.R.B. 855, at www.irs.gov/irb/2014-13_IRB/ar09.html.

Aggregated ALE Group. An Aggregated ALE Group refers to a group of ALE Members treated as a single employer under section 414(b), 414(c), 414(m), or 414(o). An ALE Member is a member of an Aggregated ALE Group for a month if it is treated as a single employer with the other members of the group on any day of the calendar month. If an ALE is made up of only one person or entity, that one ALE Member is not a part of an Aggregated ALE Group. Government entities and churches or conventions or associations of churches may apply a reasonable, good faith interpretation of the aggregation rules under section 414 in determining their status as an ALE or member of an Aggregated ALE Group. For more information on how the aggregation rules apply to government entity employers, see Notice 2015–87, Q&A 18, at www.irs.gov/irb/2015–52_IRB/ar11.html.

Applicable Large Employer (ALE). An ALE is, for a particular calendar year, any single employer, or group of employers treated as an Aggregated ALE Group, that employed an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the preceding calendar year. For purposes of determining an employer's average number of employees, disregard an employee for any month in which the employee has coverage under a plan described in section 4980H(c)(2)(F) (generally, TRICARE or Veterans Administration coverage). A new employer (that is, an employer that was not in existence on any business day in the prior calendar year) is an ALE for the current calendar year if it reasonably expects to employ, and actually does employ, an average of at least 50 full-time employees (including full-time equivalent employees) on business days during the current calendar year. For information on a special rule for certain employers with seasonal workers, see the final regulations under section 4980H and FAQs on IRS.gov.

Applicable Large Employer Member (ALE Member). An ALE Member is a single person or entity that is an ALE, or if applicable, each person or entity that is a member of an Aggregated ALE Group. A person or entity that does not have employees or only has employees with no hours of service (for example, only employees whose entire service consists of work outside of the United States that does not count as hours of service under section 4980H) is not an ALE Member.

Bona fide volunteer. A bona fide volunteer is an employee of a government entity or tax-exempt organization whose only compensation from that entity or organization is (1) reimbursement for (or reasonable allowance for) reasonable expenses incurred in the performance of services by volunteers, or (2) reasonable benefits (including length of service awards), and nominal fees, customarily paid by similar entities in connection with the performance of services by volunteers.

COBRA continuation coverage. COBRA continuation coverage is health coverage that is required to be offered under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) in certain circumstances in which an employee or other individual covered under a health plan loses eligibility for coverage under that health plan (for example, because the employee terminates employment or has a reduction in hours). For purposes of these instructions, COBRA continuation coverage also includes coverage required under any other federal or state law that provides continuation coverage comparable to that provided under COBRA. For additional details, see section 4980B and Regulations sections 54.4980B-1 through 54.4980B-10.

Dependent. A dependent is an employee's child, including a child who has been legally adopted or legally placed for adoption with the employee, who has not reached age 26. A child reaches age 26 on the 26th anniversary of the date the child was born and is treated as a dependent for the entire calendar month during which he or she reaches age 26. For this purpose, a dependent does not include stepchildren, foster children, or a child that does not reside in the United States (or a country contiguous to the United States) and who is not a United States citizen or national. For this purpose, a dependent does not include a spouse.

Designated Governmental Entity (DGE). A DGE is a person or persons that are part of or related to the Governmental Unit that is the ALE Member and that is appropriately designated for purposes of these reporting requirements. For a Governmental Unit that has delegated some or all of its reporting responsibilities to a DGE for some or all of its employees, one Authoritative Transmittal must still be filed for that Governmental Unit reporting aggregate employer-level data for all employees of the Governmental Unit (including those for whom the Governmental Unit has delegated its reporting responsibilities). For more information, see *Authoritative Transmittal for Employers Filing Multiple Forms 1094-C*.

Eligible Employer-Sponsored Plan. An eligible employer-sponsored plan refers to group health coverage for employees under (1) a governmental plan, such as the Federal Employees Health Benefits Program (FEHB), (2) an insured plan or coverage offered in the small or large group market within a state, (3) a grandfathered health plan offered in a group market, or (4) a self-insured group health plan for employees.

Employee. An employee is an individual who is an employee under the common-law standard for determining employer-employee relationships. An employee does not include a sole proprietor, a partner in a partnership, an S corporation shareholder who owns at least 2-percent of the S corporation, a leased employee within the meaning of section 414(n), or a worker that is a qualified real estate agent or direct seller.

If an employee is an employee of more than one ALE Member of the same Aggregated ALE Group during a calendar month, the employee is treated as an employee of the ALE Member for whom the employee has the greatest number of hours of service for that calendar month; if the employee has an equal number of hours of service for two or more ALE Members of the same Aggregated ALE Group for the calendar month, those ALE Members must treat one of the ALE Members as the employer of that employee for that calendar month. See *One Form 1095-C for Each Employee of Each Employer* for a discussion of reporting in these circumstances. See Pub.15-A, Employer's Supplemental Tax Guide, for more information on determining who is an employee.

Note. In certain circumstances, an employee may have a break in service (including a break in service due to a termination of employment) during which the individual does not earn hours of service, but upon beginning to earn hours of service again the ALE Member must treat the individual as a continuing employee rather than a new hire for purposes of certain rules under the regulations under section 4980H. See Regulations sections 54.4980H-3(c)(4) and 54.4980H-3(d)(6). These rules do not impact whether the individual was an employee during the break in service, so the individual should only be treated as an employee during the break in service for purposes of reporting if the individual remained an employee during that period (and had not terminated employment with the ALE Member). For example, an employee on unpaid leave during the break in service would be treated as an employee for reporting purposes during the break in service, while a former

employee whose employment had been terminated during the break in service would not be treated as an employee for reporting purposes.

Employee Required Contribution. The Employee Required Contribution is the employee's share of the monthly cost for the lowest-cost self-only minimum essential coverage providing minimum value that is offered to the employee by the ALE Member. The employee share is the portion of the monthly cost that would be paid by the employee for self-only coverage, whether paid through salary reduction or otherwise.

For purposes of determining the amount of the employee's share of the monthly cost, an ALE Member may divide the total cost to the employee for the plan year by the number of months in the plan year. This monthly amount of the employee's share of the cost would then be reported for any months of that plan year that fall within the 2017 calendar year. For example, if the plan year begins January 1, the ALE Member may determine the amount to report for each month by taking the total annual employee cost for all 12 months and dividing by 12. If the plan year begins April 1, the ALE Member may determine the amount to report for January through March, 2017, by taking the total annual employee cost for the plan year ending March 31, 2017, and dividing by 12 (and reporting that amount for January, February, and March 2017). Then the ALE Member may determine the monthly amount for April through December, 2017 by taking the total annual employee cost for the plan year ending March 31, 2018, and dividing by 12 (and reporting that amount for April through December 2017).

The Employee Required Contribution may not be the amount the employee paid for coverage. For additional rules on determining the amount of the Employee Required Contribution, including for cases in which an ALE Member makes available certain HRA contributions, cafeteria plan contributions, wellness program incentives, and opt-out payments, see Regulations sections1.5000A-3(e)(3)(ii) and 1.36B-2(c)(3)(v)(A). Also see Notice 2015-87.

Employer. For purposes of these instructions, an employer is the person that is the employer of an employee under the common-law standard for determining employer-employee relationships and that is subject to the employer shared responsibility provisions of section 4980H (these employers are referred to as ALE Members). For more information on which employers are ALE Members, see the definitions of Applicable Large Employer (ALE) and Applicable Large Employer Member (ALE Member).

Full-time employee. For purposes of Forms 1094-C and 1095-C, the term "full-time employee" means a full-time employee as defined under section 4980H and the related regulations, rather than any other definition of that term that the ALE Member may use for other purposes. Accordingly, a full-time employee is an employee who, for a calendar month, is determined to be a full-time employee under either the monthly measurement method or the look-back measurement method (as applicable to that employee). The monthly measurement method and the look-back measurement method are the two methods provided under the section 4980H regulations for determining whether an employee has sufficient hours of service to be a full-time employee. Under the monthly measurement method, a full-time employee is an employee who was employed an average of at least 30 hours of service per week with the ALE Member during a calendar month. Under the look-back measurement method, an employee is a full-time employee for each month of the stability period selected by the ALE Member if the employee was employed an average of least 30 hours of service per week with the ALE Member during the measurement period preceding that stability period. (The look-back measurement method for identifying full-time employees is available only for purposes of determining and computing liability under section 4980H, and not for purposes of determining if the employer is an Applicable Large Employer.) For purposes of both methods, 130 hours of service in a calendar month is treated as the monthly equivalent of at least 30 hours of service per week.

An ALE Member must report complete information for all 12 months of the calendar year for any of its employees who were full-time employees for one or more months of the calendar year. For more information on the identification of full-time employees, including discussion of the monthly measurement method and the look-back measurement method, and the rules for when an ALE Member may use one or both methods, see Regulations sections 54.4980H-1(a)(21) and 54.4980H-3 and Notice 2014-49, 2014-41 I.R.B. 66 (describing a proposed approach to the application of the look-back measurement method in situations in which the measurement period applicable to an employee changes).

Note. A former employee (for example, a retiree) is not a full-time employee for any month after termination of employment with the ALE Member. However, if the former employee was a full-time employee for any month of the calendar year (for example, before retiring mid-year), the ALE Member must complete information in Part II of Form 1095-C for all 12 months of the calendar year, using the appropriate codes.

An ALE Member need not file a Form 1095-C for an individual who for each month of a calendar year is either not an employee of the ALE Member or is an employee in a Limited Non-Assessment Period with respect to section 4980H(b). However, for the months in which the employee was an employee of the ALE Member, such an employee would be included in the total employee count reported on Form 1094-C, Part III, column (c). Also, if during the Limited Non-Assessment Period the employee enrolled in coverage under a self-insured employer-sponsored plan, the ALE Member must file a Form 1095-C for the employee to report coverage information for the year.

Full-time equivalent employees. A combination of employees, each of whom individually is not treated as a full-time employee because he or she is not employed on average at least 30 hours of service per week with an employer, but who, in combination, are counted as the equivalent of a full-time employee solely for purposes of determining whether the employer is an ALE. For rules on how to determine full-time equivalent employees, see Regulations section 54.4980H-2(c).

Governmental Unit and Agency or Instrumentality of a Governmental Unit. A Governmental Unit is the government of the United States, any State or political subdivision thereof, or any Indian tribal government (as defined in section 7701(a)(40)) or subdivision of an Indian tribal government (as defined in section 7871(d)). For purposes of these instructions, references to a Governmental Unit include an Agency or Instrumentality of a Governmental Unit. Until guidance is issued that defines the term Agency or Instrumentality of a Governmental Unit for purposes of section 6056, an entity may determine whether it is an Agency or Instrumentality of a Governmental Unit based on a reasonable and good faith interpretation of existing rules relating to agency or instrumentality determinations for other federal tax purposes.

Health coverage. As used in these instructions, health coverage refers to minimum essential coverage, unless otherwise indicated.

Hours of service. An hour of service is each hour for which an employee is paid, or entitled to payment, for the performance of duties for the employer, and each hour for which an employee is paid, or entitled to payment, for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity

(including disability), layoff, jury duty, military duty, or leave of absence. An hour of service does not include any hour of service performed as a bona fide volunteer of a government entity or tax-exempt entity, as part of a Federal Work-Study Program (or a substantially similar program of a State or political subdivision thereof) or to the extent the compensation for services performed constitutes income from sources outside the United States. For additional rules for determining hours of service, see Regulations sections 54.4980H-1(a)(24), 54.4980H-3(b) and Notice 2015–87, Q&A 14, at www.irs.gov/irb/2015–52_IRB/ar11.html. See section VI of the preamble to the section 4980H regulations for a discussion of determination of hours of service for categories of employees for whom the general rules for determining hours of service may present special difficulties (including adjunct faculty and commissioned salespeople) and certain categories of work hours associated with some positions of employment, including layover hours (for example, for certain airline employees), on-call hours, and work performed by an individual who is subject to a vow of poverty as a member of a religious order.

Limited Non-Assessment Period. A Limited Non-Assessment Period generally refers to a period during which an ALE Member will not be subject to an assessable payment under section 4980H(a), and in certain cases section 4980H(b), for a full-time employee, regardless of whether that employee is offered health coverage during that period.

The first five periods described below are Limited Non-Assessment Periods with respect to sections 4980H(a) and 4980H(b) only if the employee is offered health coverage by the first day of the first month following the end of the period. Also, the first five periods described below are Limited Non-Assessment Periods for section 4980H(b) only if the health coverage that is offered at the end of the period provides minimum value. For more information on Limited Non-Assessment Periods and the application of section 4980H, see Regulations section 54.4980H-1(a)(26).

- First Year as ALE Period. January through March of the first calendar year in which an employer is an ALE, but only for an employee who was not offered health coverage by the employer at any point during the prior calendar year.
- Waiting Period under the Monthly Measurement Method. If an ALE Member is using the monthly measurement method to determine whether an employee is a full-time employee, the period beginning with the first full calendar month in which the employee is first otherwise (but for completion of the waiting period) eligible for an offer of health coverage and ending no later than two full calendar months after the end of that first calendar month.
- Waiting Period under the Look-Back Measurement Method. If an ALE Member is using the look-back measurement method to determine whether an employee is a full-time employee and the employee is reasonably expected to be a full-time employee at his or her start date, the period beginning on the employee's start date and ending not later than the end of the employee's third full calendar month of employment.
- Initial Measurement Period and Associated Administrative Period under the Look-Back Measurement Method. If an ALE Member is using the look-back measurement method to determine whether a new employee is a full-time employee, and the employee is a variable hour employee, seasonal employee or part-time employee, the initial measurement period for that employee and the administrative period immediately following the end of that initial measurement period.
- Period Following Change in Status that Occurs During Initial Measurement Period Under the Look-Back Measurement Method. If an ALE Member is using the look-back measurement method to determine whether a new employee is a full-time employee, and, as of the employee's start date, the employee is a variable hour employee, seasonal employee or part-time employee, but, during the initial measurement period, the employee has a change in employment status such that, if the employee had begun employment in the new position or status, the employee would have reasonably been expected to be a full-time employee, the period beginning on the date of the employee's change in employment status and ending not later than the end of the third full calendar month following the change in employment status. If the employee is a full-time employee based on the initial measurement period and the associated stability period starts sooner than the end of the third full calendar month following the change in employment status, this Limited Non-Assessment Period ends on the day before the first day of that associated stability period.
- First Calendar Month of Employment. If the employee's first day of employment is a day other than the first day of the calendar month, then the employee's first calendar month of employment is a Limited Non-Assessment Period.

Minimum essential coverage (MEC). Although various types of health coverage may qualify as minimum essential coverage, for purposes of these instructions, minimum essential coverage refers to health coverage under an eligible employer-sponsored plan. For more details on minimum essential coverage, see *Minimum essential coverage* in Pub. 974.

Minimum value. A plan provides minimum value if the plan pays at least 60% of the costs of benefits for a standard population and provides substantial coverage of inpatient hospitalization services and physician services.

Offer of health coverage. An ALE Member makes an offer of coverage to an employee if it provides the employee an effective opportunity to enroll in the health coverage (or to decline that coverage) at least once for each plan year. For this purpose, the plan year must be 12 consecutive months unless a short plan year of less than 12 consecutive months is permitted for a valid business purpose. An ALE Member makes an offer of health coverage to an employee for the plan year if it continues the employee's election of coverage from a prior year but provides the employee an effective opportunity to opt out of the health coverage. If an ALE Member provides health coverage to an employee but does not provide the employee an effective opportunity to decline the coverage, the ALE Member is treated as having made an offer of health coverage to the employee only if that health coverage provides minimum value and does not have an Employee Required Contribution for the coverage for any calendar month of more than 9.5% (as adjusted) of a monthly amount determined as the mainland federal poverty line for a single individual for the applicable calendar year, divided by 12.

For purposes of reporting, an offer to a spouse includes an offer to a spouse that is subject to one or more reasonable, objective conditions, regardless of whether the reasonable, objective conditions are satisfied. For example, an offer of coverage that is available to a spouse only if the spouse certifies that the spouse does not have access to health coverage from another employer is treated as an offer of coverage to the spouse for reporting purposes. Note that this treatment is for reporting purposes only, and generally will not affect the spouse's eligibility for the premium tax credit if the spouse did not meet the condition and therefore did not have an actual offer of coverage. A conditional offer to a spouse is reported by entering code 1J or 1K (as applicable) on line 14 of Form 1095-C. See the instructions for line 14 for more information. An offer to a dependent does not include an offer to a dependent that is subject to one or more reasonable, objective conditions unless the dependent satisfies the conditions and the dependent actually had an offer of coverage. In addition, an offer of coverage is treated as made to an employee's dependents only if the offer of coverage is made to an unlimited number of

dependents regardless of the actual number of dependents, if any, an employee has during any particular calendar month.

An ALE Member offers health coverage for a month only if it offers health coverage that would provide coverage for every day of that calendar month. For reporting purposes, this means that an offer of coverage does not occur for a month if an employee's employment terminates before the last day of a calendar month and the health coverage also ends before the last day of that calendar month (or for an employee who did not enroll in coverage, the coverage would have ended if the employee had enrolled in coverage). However, see the description of Code Series 2—Section 4980H Safe Harbor Codes and Other Relief for Employers, code 2B which may be applicable in these circumstances to indicate that the ALE Member is treated as having offered coverage for the entire month for purposes of section 4980H.

An ALE Member offers health coverage to an employee if it, or another employer in the Aggregated ALE Group, or a third party such as a multiemployer or single employer Taft-Hartley plan, a multiple employer welfare arrangement (MEWA), or, in certain cases, a staffing firm, offers health coverage on behalf of the employer. See Regulations sections 54.4980H-4(b)(2) and 54.4980H-5(b).

Interim Guidance Regarding Multiemployer Arrangements. An ALE Member is treated as offering health coverage to an employee if the ALE Member is required by a collective bargaining agreement or related participation agreement to make contributions for that employee to a multiemployer plan that offers, to individuals who satisfy the plan's eligibility conditions, health coverage that is affordable and provides minimum value, and that also offers health coverage to those individuals' dependents. For more information, see section XV.E of the preamble to the final regulations under section 4980H. This relief is referred to as the multiemployer arrangement interim guidance and the multiemployer interim rule relief in these instructions.

Qualifying Offer. A Qualifying Offer is an offer of MEC providing minimum value to one or more full-time employees for all calendar months during the calendar year for which the employee was a full-time employee for whom a section 4980H assessable payment could apply, with an Employee Required Contribution for each month not exceeding 9.5 % (as adjusted) of the mainland single federal poverty line divided by 12, provided that the offer includes an offer of MEC to the employee's spouse and dependents (if any).

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on these forms to carry out the Internal Revenue laws of the United States and the Patient Protection and Affordable Care Act. Our legal right to ask for the information on this form is Internal Revenue Code sections 6055, 6056, 4980H and their regulations. We request it to confirm that you are providing your employees offers of, and enrollment in, health coverage and to determine the employer shared responsibility payments and eligibility of your employees for premium tax credits. If you do not provide this information, we may be unable to determine whether your employees are entitled to premium tax credits. Providing false or fraudulent information may subject you to penalties. We may disclose this information to the Department of Justice for civil or criminal litigation and to cities, states, and the District of Columbia for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to Federal and state agencies to enforce Federal nontax criminal laws, or to Federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file this form will vary depending on individual circumstances. The estimated average time is:

Form 1094–C	4 hrs.
Form 1095–C	12 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making this form simpler, we would be happy to hear from you. You can send us comments from *IRS.gov/FormComments*. Or you can write to the Internal Revenue Service, Tax Forms and Publications Division, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224. Don't send the form to this office.