



## **Employer-Provided Health Insurance Offer and Coverage (1095-C) and Health Coverage (1095-B) Statements for Tax Year 2016**

### **Frequently Asked Questions**

This notice is to tell you about statements you may soon receive from the San Diego Unified School District and/or your medical plan carrier (Kaiser or UnitedHealthcare). These information statements are required to be delivered between January and March 2017 under the Affordable Care Act (ACA) and the Internal Revenue Service (IRS). The deadline for employers and medical plan carriers to issue these statements is March 2, 2017.

#### **Who will receive a Form 1095-C from the San Diego Unified School District?**

Employees who meet the ACA definition of a full-time employee will receive a Form 1095-C. Even some part-time employees who are not covered under the District sponsored health plan may receive a Form 1095-C. Dependents are not required to be reported on the 1095-C for medical plans like the District's plans. Covered dependents will be reported on the 1095-B by medical carriers (see description of 1095-B below). Retirees will not receive a 1095-C from the District (see 1095-B below).

Beginning in 2016, the District is required to report to the IRS about the health coverage, if any, that was offered to our employees who meet the ACA definition of a full-time employee, generally defined as working 30 or more hours per week during the previous plan year. The District is also required to provide an information statement (Form 1095-C) to these employees about the information that will be reported to the IRS.

#### **Who will receive a Form 1095-B from their medical plan carrier?**

All employees (subscribers) enrolled in a District medical plan, regardless of full-time status and retirees enrolled in a District retiree health plan will receive a Form 1095-B from medical carriers (i.e. Kaiser or UnitedHealthcare).

Beginning in 2016, medical plan carriers are required to report to the IRS about the minimum essential coverage provided to subscribers and their dependents during the previous year. District medical plan carriers are also required to provide an information statement (Form 1095-B) to each subscriber about the information the carrier will report to the IRS.

#### **When and how will I receive my statements?**

Employers and medical plan carriers must issue statements to employees and subscribers by March 2, 2017 for the 2016 tax reporting year. Similar to a Form W-2, the Form 1095-C will be mailed to the home address on file with the District and the carrier. The District is also required to send to the IRS copies of all forms issued.

**Do I need the Form(s) to prepare my income tax returns?** For the 2016 tax year it is **not** a requirement to have Form 1095-C or 1095-B in order to file the U.S. Individual Income Tax Return in 2017. The government has provided an opportunity for individuals to self-report coverage for the 2016 tax year, attesting that the individual (and any dependents, if applicable) had “minimum essential coverage” throughout the year. Keep these forms with your 2016 tax records as proof that you had health coverage in 2016 if audited by the IRS in the future.

**What information is included on the form?**

A sample screen shot of Form 1095-C is shown below. It is divided into three parts:

- Part I, Employee and Employer Information
- Part II, Employee Offer of Coverage, if any
- Part III, Covered Individuals (if applicable)

**1095-C** Employer-Provided Health Insurance Offer and Coverage  
 Form 1095-C  
 Department of the Treasury  
 Internal Revenue Service  
 OMB No. 1545-2251  
 2016  
 Do not attach to your tax return. Keep for your records.  
 Information about Form 1095-C and its separate instructions is at [www.irs.gov/form1095c](http://www.irs.gov/form1095c)

**Part I Employee** **Applicable Large Employer Member (Employer)**

1 Name of employee 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN)  
 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number  
 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code

**Part II Employee Offer of Coverage** **Plan Start Month (Enter 2-digit number):**

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Coverage (enter required code)													
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$

**Part III Covered Individuals**  
 If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

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

**Who do I call for questions?**

See a tax advisor or contact the IRS with questions specific to your situation. Visit any of the following web sites:

- [www.healthcare.gov](http://www.healthcare.gov)
- [www.irs.gov](http://www.irs.gov)
- [ACA Questions and Answers about Health Care Forms-IRS](#)

If you have questions about your District health coverage, please contact Employee Benefits at (619) 725-8130, email them at [employeebenefits@sandi.net](mailto:employeebenefits@sandi.net) or visit the Benefits Department web page from <https://www.sandiegounified.org/>.