New Tax Forms Are Coming Soon!

Why will I receive 1095 form(s)?

The Affordable Care Act (ACA) requires the County to provide a 1095-C form that documents whether you worked full time and received an offer of ACA-compliant[1] medical insurance each month during 2015.

The ACA also requires certain medical plan providers send Form 1095-B to their members indicating the months you and your dependents had medical coverage in 2015.

Depending on your 2015 medical plan, you will receive either:

- Form 1095-B, or
- Form 1095-C, or
- Both

Samples of the forms are on pages 2 and 3 of this newsletter.

If you changed employers in 2015, you may receive similar forms from your former employer and medical plan.

FORM 1095-B

Employees enrolled in the following medical plans in 2015 will receive Form 1095-B directly from their plan:

- CIGNA
- UnitedHealthcare
- Kaiser
- CAPE/Blue Shield
- ALADS/Anthem Blue Cross
- Fire Fighters Local 1014

The form will show each month you and your dependents had coverage in 2015.

FORM 1095-C

The County will mail Form 1095-C to you separately from your W-2 form.

This form will show whether you worked full time in 2015 and were offered medical insurance.

For non-represented employees enrolled in the County's Anthem Blue Cross medical plans, the form will show each month you and your dependents had coverage in 2015.

What Does This Mean to You?

You will receive Form 1095-B and/or Form 1095-C in the mail by March 31, 2016. These forms are for recordkeeping purposes. You do not need the forms to complete your 2015 tax return. Keep the 1095 form(s) with your other tax documents.

[1] *All of the County's medical plans meet the minimum essential coverage required by the ACA.*

FORM 1095-B

You will receive this form in the mail from your medical plan if you were enrolled in CIGNA, Kaiser, UnitedHealthcare, CAPE/Blue Shield, ALADS/Anthem Blue Cross or Fire Fighters Local 1014.

This form provides information on your medical plan and shows the months you and your dependents were enrolled. Employees enrolled in the County's Anthem Blue Cross medical plan will not receive this form.

Parts I and II: Information about you and the County.

Part III: Information about your 2015 medical plan.

Part IV: Will show which months you and your dependents were covered in your medical plan in 2015.

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Form **1095-B**

Department of the Treasury
Internal Revenue Service

Health Coverage

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

☐ VOID
☐ CORRECTED

OMB No. 1545-2252

2015

Part I **Responsible Individual**

1 Name of responsible individual		2 Social security number (SSN)	3 Date of birth (If SSN is not available)
4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
8 Enter letter identifying Origin of the Policy (see instructions for codes): . . . . . ▶ ☐		9 Small Business Health Options Program (SHOP) Marketplace identifier, if applicable	

Part II **Employer Sponsored Coverage** (see instructions)

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

Part III **Issuer or Other Coverage Provider** (see instructions)

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

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

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of coverage											
					Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60704B Form **1095-B** (2015)

If you do not receive this form by March 31, 2016, contact your medical plan.

FORM 1095-C

You will receive this form in the mail from the County by March 31, 2016. This form includes information on the medical coverage the County offered you in 2015.

Part I: Information about you and the County.

Part II: Will show which months the County offered you medical coverage in 2015, the type of coverage and whether you enrolled or waived. It also will show the lowest employee cost available under your benefit program.

Part III: If you were enrolled in the County's Anthem Blue Cross medical plans, this section will show the months you and your dependents had coverage in 2015.

For all other medical plans, this information will be reported on Form 1095-B.

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

Employer-Provided Health Insurance Offer and Coverage

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

☐ VOID
☐ CORRECTED

600116
OMB No. 1545-2251
2015

Part I Employee

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

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	10 Contact telephone number
11 City or town	12 State or province / 13 Country and ZIP or foreign postal code

Part II Employee Offer and Coverage

Plan Start Month (Enter 2-digit number):

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

Part III Covered Individuals

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

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (If SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Cat. No. 60705M Form **1095-C** (2015)

If you do not receive this form by March 31, 2016, you may download it from mylacountybenefits.com, or call the Benefits Hotline at (213) 388-9982 starting April 1, 2016.

The County of Los Angeles
P.O. Box 67128
Los Angeles, CA 90067

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Look Inside to Learn about New Tax Forms for 2015

Important Information Inside!

Do Not Discard!

- You will be sent new tax forms about your medical plan coverage by March 31, 2016
- Read this mailer to find out which forms you will receive
- Keep the new forms with your tax records

DHR
Department of Human Resources
County of Los Angeles