

## Explanation of Form 1095-C (2023), Employer-Provided Health Insurance Offer and Coverage

### Instructions for Recipient

You are receiving this Form 1095-C because the University of Wisconsin System is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act (ACA). Form 1095-C includes information about the health insurance coverage offered to you by the University. Form 1095-C, Part II, includes information about the coverage, if any, the University offered to you and your spouse and dependent(s).

**Premium Tax Credit.** If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see [Publication 974, Premium Tax Credit \(PTC\)](#).

**Multiple Forms 1095-C.** You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer, it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

**Part III Covered Individuals.** In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

**Form 1095-B, Health Coverage.** If the University provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B.

**Form 1095-A, Health Insurance Marketplace Statement.** If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.

**TIP:** Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

**Additional information.** For additional information about the tax provisions of the Affordable Care Act (ACA), the premium tax credit, and the employer shared responsibility provisions, visit [www.irs.gov/ACA](http://www.irs.gov/ACA) or call the IRS Healthcare Hotline for ACA questions (800-919-0452).

### Part I. Employee

**Lines 1–6.** Part I, Lines 1 through 6, reports information about you, the employee.

**Line 2.** This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the University is required to report your complete SSN to the IRS.

### Part I. Applicable Large Employer Member (Employer)

**Lines 7–13.** Part I, Lines 7 through 13, reports information about your employer.

**Line 10.** This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

<b>Part I</b> APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no.	
▶ <b>Do not attach to your tax return. Keep for your records.</b> Go to <a href="http://www.irs.gov/Form1095C">www.irs.gov/Form1095C</a> for instructions and the latest information.	
EMPLOYEE'S (first name, middle initial, last name) address, ZIP/postal code & country	
APPLICABLE LARGE EMPLOYER'S identification number (EIN)	EMPLOYEE'S social security number (SSN)

**Part II. Employer Offer of Coverage, Lines 14–17**

**Line 14.** The codes listed below for Line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on Line 14.)

The information on Line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s).

For more information about the premium tax credit, see [Publication 974, Premium Tax Credit \(PTC\)](#).

- 1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer).

This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.

For information on the adjustment of the 9.5%, see [IRS.gov](#).

- 1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage **NOT** offered to your spouse or dependent(s).
- 1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but **NOT** your spouse.
- 1D.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but **NOT** your dependent(s).
- 1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- 1F.** Minimum essential coverage **NOT** providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- 1G.** You were **NOT** a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on Line 14.
- 1H.** No offer of coverage (you were **NOT** offered any health coverage or you were offered coverage that is **NOT** minimum essential coverage).
- 1I.** Reserved for future use.
- 1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage **NOT** offered to your dependent(s).
- 1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).

**Line 15.** This line reports the employee required contribution, which is the monthly cost to you for the lowest-cost self-only minimum essential coverage providing minimum value that your employer offered you.

The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report “0.00” for the amount.

For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on Line 15, visit [IRS.gov](#).

**Line 16.** This code provides the IRS information to administer the employer shared responsibility provisions.

Other than a code 2C which reflects your enrollment in your employer’s coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit [IRS.gov](#).

**Line 17.** This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit [IRS.gov](#).

<b>Part II Employee Offer of Coverage</b>			
<b>Plan Start Mo.</b> (enter 2-digit no.):	<b>14 Offer of Coverage</b> (enter required code)	<b>15 Employee Required Contribution</b> (see instructions)	<b>16 Section 4980H Safe Harbor and Other Relief</b> (enter code, if applicable)
All 12 Months		\$	
Jan		\$	
Feb		\$	
Mar		\$	
Apr		\$	
May		\$	
June		\$	
July		\$	
Aug		\$	
Sept		\$	
Oct		\$	
Nov		\$	
Dec		\$	

