kynect
Kentucky's Healthcare Connection

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Department For Medicaid Services

PO Box 2104, Frankfort, KY 40602
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DATE: November 26, 2015

CASE NUMBER: N/A

IPPFL Z IJNM
JM SES 681
MHYVXF, KY 47852

IMPORTANT TAX INFORMATION

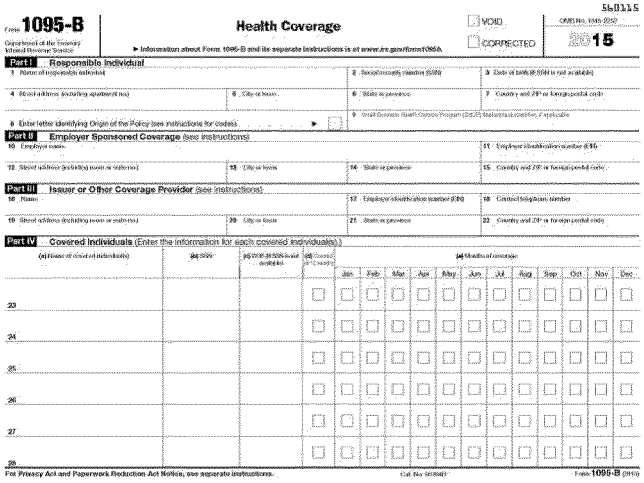
PLEASE DO NOT DISCARD

Please Keep This Notice For Filing Your 2015 Federal Income Tax Return.

This notice is being provided to you because you received medical coverage from Medicaid or KCHIP (Kentucky Children's Health Insurance Program) programs in 2015.

Attached is an important tax document from kynect called **IRS Form 1095-B: Health Coverage.** This document provides information you will need regarding your medical coverage in order to complete your household's Federal Income tax filing for 2015.

*Si prefiere recibir este formulario en español, visite nuestra página web **kynect.ky.gov** o llámenos al 1-844-373-2417.


Form 1095-B Health Coverage VOID CORRECTED 2015

Part I Responsible Individual

Part II Employer Sponsored Coverage (see instructions)

Part III Issuer or Other Coverage Provider (see instructions)

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

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Q: Why do I need Form 1095-B?
A: Form 1095-B is provided to help you indicate whether you had health coverage for year 2015 on your tax form if you plan to file a tax return in 2016. There is a line on Form 1040, 1040A, and 1040EZ where you or a tax preparer indicate if you, your spouse (if filing jointly), and your dependents had health care coverage throughout 2015. You do not need to send this form to IRS only keep it for your personal records in case IRS asks for it. One Form 1095-B will be provided for each individual who received at least one month of Medicaid coverage during 2015.

If you do not file taxes no other action needs to be taken. Keep this form for your records.

If you received assistance under one of the programs listed below, you will not get a 1095-B form;

- Medicare Savings Program
- Emergency Time-limited Medical coverage
- Prenatal Presumptive Eligibility
- BCCTP (Breast Cervical Cancer Treatment Program)
- Spend-Down Medicaid Card

A copy of your Form 1095-B is also sent to the IRS so they can determine whether you were covered by minimum essential health coverage during any of the 12 months in 2015.

Form 1095-B will show the IRS that you had Medicaid or KCHIP health insurance coverage in 2015 as required by the Affordable Care Act;

Q: Who should I contact if I need help?
A: If you have questions about how to file your taxes using Form 1095-B, you can call the IRS Tax Help Line for Individuals at 1-800-829-1040. The Tax Help Line is open Monday - Friday from 7am to 7pm, local time. You may also go to the IRS website at www.irs.gov. You may also want to consider working with your tax preparer.

If you have questions about the information contained on Form 1095-B please call the kynect tax line at 1-844-373-2417.

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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)
IPPFL Z IJNM		*****1530	
4 Street address (including apartment no.)	**5** City or town	**6** State or province	**7** Country and ZIP or foreign postal code
JM SES 681	MHYVXF	KY	47852
8 Enter letter identifying Origin of the Policy (see instructions for codes): . . . . ▶ C		**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
Commonwealth of Kentucky/KY State Treasurer/Dept. for Medicaid Services		61-0600439	(855) 459-6328
19 Street address (including room or suite no.)	**20** City or town	**21** State or province	**22** Country and ZIP or foreign postal code
275 East Main Street 6W-D	Frankfort	KY	40621

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 IPPFL Z IJNM	*****1530		☑	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28			☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse (if you file a joint return), and individuals you claim as dependents had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year. Individuals who don't have minimum essential coverage and don't qualify for an exemption from this requirement may be liable for the individual shared responsibility payment.

Minimum essential coverage includes government-sponsored programs, eligible employer-sponsored plans, individual market plans, and other coverage the Department of Health and Human Services designates as minimum essential coverage. For more information on the requirement to have minimum essential coverage and what is minimum essential coverage, see *www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Individual-Shared-Responsibility-Provision*

Providers of minimum essential coverage are required to furnish only one Form 1095-B for all individuals whose coverage is reported on that form. As the recipient of this Form 1095-B, you should provide a copy to other individuals covered under the policy if they request it for their records.

Part I. Responsible Individual, lines 1–9. Part I reports information about you and the coverage.

Lines 2 and 3. Line 2 reports your social security number (SSN) or other taxpayer identification number (TIN), if applicable. For your protection, this form may show only the last four digits. However, the coverage provider is required to report your complete SSN or other TIN, if applicable to the IRS. Your date of birth will be entered on line 3 only if line 2 is blank

If you don't provide your SSN or other TIN and the SSNs or other TINs of all covered individuals to the sponsor of the coverage, the IRS may not be able to match the Form 1095-B with the individuals to determine that they have complied with the individual shared responsibility provision.

Line 8. This is the code for the type of coverage in which you or other covered individuals were enrolled. Only one letter will be entered on this line.

A. Small Business Health Options Program (SHOP)
B. Employer-sponsored coverage
C. Government-sponsored program
D. Individual market insurance
E. Multiemployer plan
F. Other designated minimum essential coverage

If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will be reported on a Form 1095-A rather than a Form 1095-B.

Line 9. This line will be blank for 2015.

Part II. Employer-Sponsored Coverage, lines 10-15. This part will be completed by the insurance company if an insurance company provides your employer-sponsored health coverage. It provides information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. If your coverage isn't insured employer coverage, this part will be blank.

Part III. Issuer or Other Coverage Provider, lines 16-22. This part reports information about the coverage provider (insurance company, employer providing self-insured coverage, government agency sponsoring coverage under a government program such as Medicaid or Medicare, or other coverage sponsor). Line 18 reports a telephone number for the coverage provider that you can call if you have questions about the information reported on the form

Part IV. Covered Individuals, lines 23-28. This part reports the name, SSN or other TIN, and coverage information for each covered individual. A date of birth will be entered in column (c) only if an SSN or other TIN isn't 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 six covered individuals, see Part IV, Continuation Sheet(s), for information about the additional covered individuals.