Why did I get this 1095B form?

The Affordable Care Act (ACA)'s individual shared responsibility provision requires individuals and their household members to have one of the following when filing for their federal Tax return.

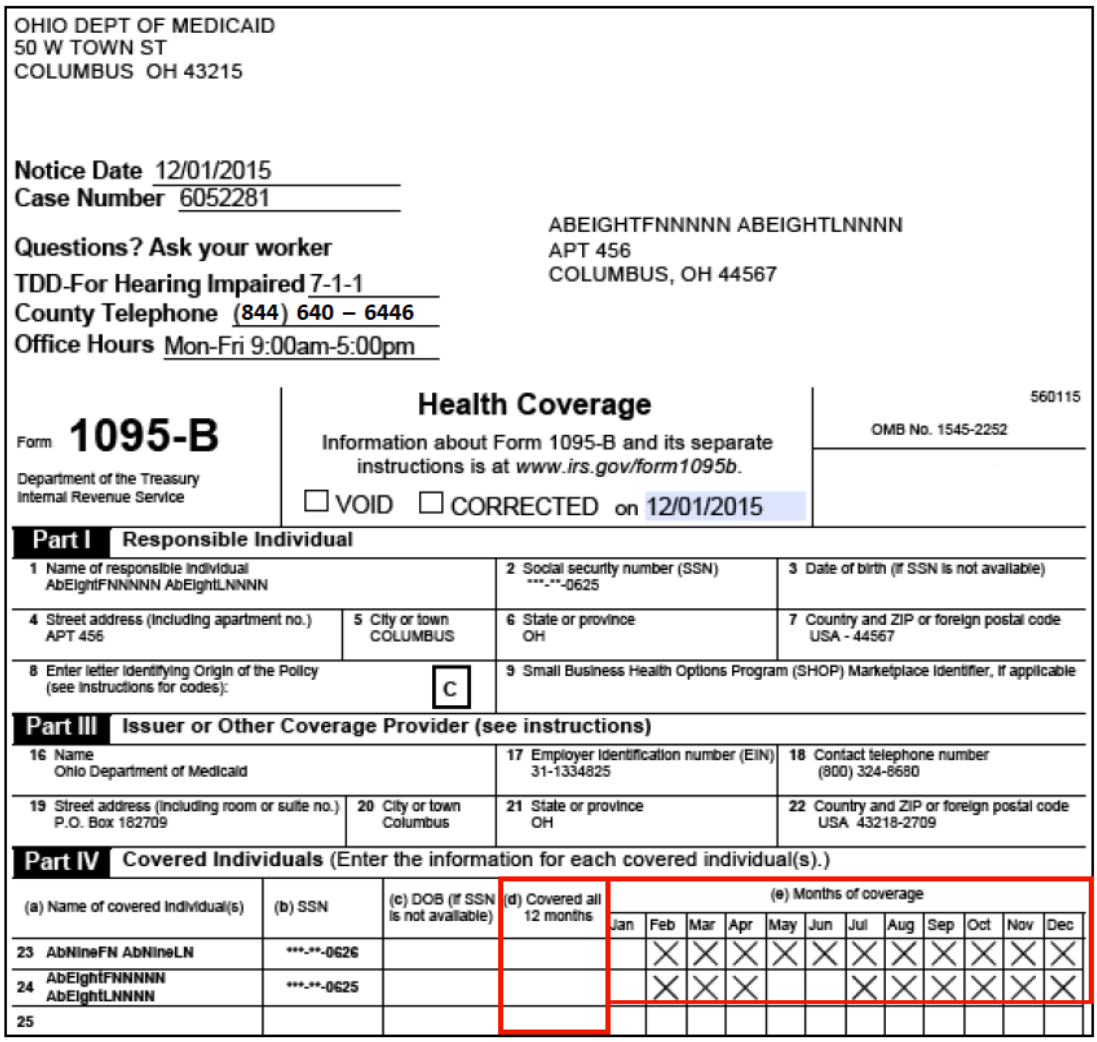
- Have qualifying health care coverage (known as minimum essential coverage (MEC)),
- Qualify for health coverage exemption, or
- Make an individual shared responsibility payment

The Internal Revenue Service (IRS) requires employers and other providers of MEC to document the months that an individual was covered for the prior tax year on the 1095-B Health Coverage form. Individuals can use the 1095-B form to substantiate their claim of MEC.

A 1095-B table in the Ohio Benefits system serves as a repository for data extracts from the Ohio Benefits, CRIS-E, and SACWIS systems. This data includes individuals who were covered through a Medicaid MEC plan for at least one day in the applicable tax year, and is used to create the 1095-B form.

What is the 1095-B Form?

The IRS 1095-B form documents the months from the previous calendar year that a resident had MEC for tax reporting purposes. All residents who had qualifying health coverage through the Ohio Benefits, CRIS-E, and SACWIS eligibility systems will receive this form.



OHIO DEPT OF MEDICAID
50 W TOWN ST
COLUMBUS OH 43215

Notice Date 12/01/2015
Case Number 6052281

Questions? Ask your worker
TDD-For Hearing Impaired 7-1-1
County Telephone (844) 640 – 6446
Office Hours Mon-Fri 9:00am-5:00pm

ABEIGHTFNNNNN ABEIGHTLNNNN
APT 456
COLUMBUS, OH 44567

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 on 12/01/2015

560115
OMB No. 1545-2252

Part I Responsible Individual

1 Name of responsible individual	2 Social security number (SSN)	3 Date of birth (if SSN is not available)
AbEightFNNNNN AbEightLNNNN	***-**-0625	

4 Street address (including apartment no.)	5 City or town	6 State or province	7 Country and ZIP or foreign postal code
APT 456	COLUMBUS	OH	USA - 44567

8 Enter letter identifying Origin of the Policy (see instructions for codes):	9 Small Business Health Options Program (SHOP) Marketplace Identifier, if applicable
C	

Part III Issuer or Other Coverage Provider (see instructions)

16 Name	17 Employer identification number (EIN)	18 Contact telephone number
Ohio Department of Medicaid	31-1334825	(800) 324-8680

19 Street address (including room or suite no.)	20 City or town	21 State or province	22 Country and ZIP or foreign postal code
P.O. Box 182709	Columbus	OH	USA 43218-2709

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 AbNineFN AbNineLN	***-**-0626				X	X	X	X	X	X	X	X	X	X	X
24 AbEightFNNNNN AbEightLNNNN	***-**-0625				X	X	X			X	X	X	X	X	X
25															

Please keep this form for your records.
You may need it when you file your taxes.