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CRANSTON RI 02920-8409

HealthSourceRI
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF HUMAN SERVICES

johnson jordan
1111 DISNEY BLVD 123456
DISNEY, FL 11111

Communication Notice

Dear johnson jordan :

Here is your Form 1095-B for 2015. This is a federal tax form that shows the months that you, or members of your family, had health coverage through Medicaid during the year. This form will help you show that you have met the federal requirement to have health coverage.

If you or members of your family had other sources of health coverage in 2015, you may receive other 1095 forms. Please see the attached list of frequently asked questions for more information.

The information on this form has been sent to the IRS. You do not need to attach it to your federal tax return, but you should keep it for your records.

Please review the form carefully. If you think any of the information on this form is wrong, please call the Department of Human Services at 855-855-6128. You can find out more by visiting the EOHHS website (www.eohhs.ri.gov) and clicking on "Form 1095-B," or by visiting the IRS website (IRS.gov/aca).

Thank you,
HSRI Team

Frequently Asked Questions about the 1095-B Form

What is this form?

Form 1095-B is a tax document. It includes information about the Medicaid health coverage that you, or members of your family, had during each month in 2015. If you or your family have other kinds of health coverage, you may receive other health care tax documents:

Type of health coverage	Federal tax form that you may receive
Purchased through HealthSource RI	Form 1095-A
Medicaid, Medicare, or through your job	Form 1095-B
Through your job (large employers)	Form 1095-C

For example, if you purchased coverage through HealthSource RI, but you have children who were covered by RIte Care (Medicaid) you will receive both a Form 1095-A *and* a Form 1095-B.

Why am I receiving this form?

You are receiving this form because you, your spouse, or one or more of your dependents were enrolled in Medicaid for at least part of one month in 2015.

What do I need to do with this form?

Check to make sure the information is correct, paying special attention to Part I and Part IV of the form. You should also keep the form for your records.

Do I need to file Form 1095-B with my tax return?

No, but you should save it with your records. You should read the instructions that come with this form and any other tax forms that you receive for more information.

What if my Form 1095-B has incorrect or missing information?

If you believe any of the information on the form is wrong (for example, if you think you were covered for months not shown on the form) call the Department of Human Services at 855-855-6128.

Where can I find more information?
For more information about health care tax documents, visit these websites:

IRS.gov/aca
www.eohhs.ri.gov

The following individuals are listed on 1095-B Tax Form:

Individual	Source System
johnson jordan	HealthSourceRI
yamthung pelling	HealthSourceRI

Form **1095-B**
Department of the Treasury
Internal Revenue Services

Health Coverage

☐ VOID
☐ CORRECTED

56011

OMB No. 1545-225

2015

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

Part I Responsible Individual (Policy Holder)

1 Name of responsible individual johnson jordan		**2** Social security number (SSN) XXX-XX-5496	**3** Date of birth (if SSN is not available) Apr 21 1980
4 Street address (including apartment no.) 1111 DISNEY BLVD 123456	**5** City or town DISNEY	**6** State or province FL	**7** Country and ZIP or foreign postal code 11111
8 Enter letter identifying Origin of Policy (see instructions for codes) ---------> **'C'**		**9** Small Business Health Options Program (SHOP) marketplace Identifier, if applicable	

Part II Employer Sponsored Coverage

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

16 Name State of Rhode Island		**17** Employer Identification number (EIN) 05-6000522	**18** Contact Telephone number (401) 462-3395
19 Street address (including room or suite no.) 50 Service Avenue 1	**20** City or town Warwick	**21** State or province RI	**22** Country and ZIP or foreign postal code 02886

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	johnson jordan	XXX-XX-5496	Apr 21 1980									X	X	X	X	X
24	yamthung pelling	XXX-XX-2789	Jun 23 1980									X	X	X	X	X

Instructions for Recipient

This Form 1095-B provides information needed to report on your income tax return that you, your spouse, 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 do not have minimum essential coverage and do not qualify for an exemption 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*.

TIP *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 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.

CAUTION *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. Miscellaneous minimum essential coverage

TIP *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 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.