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Return Service Requested



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T119 P3 155806-1-1-2 - 46454
Bharat Guda
2044 NW Steelrake PI APT N 311
ISSAQUAH WA 98027

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). 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 Pub. 974, Premium Tax Credit (PTC). 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.

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 or MEC") 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.

If your employer 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. 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.

Part I. Employee

Line 1. Part I, lines 1, 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 employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7-13, 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.

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 multi-employer plan due to your membership in a union 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).

1A. Minimum essential coverage (MEC) providing minimum value (MV) 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 MEC 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.

1B. MEC providing MV offered to you and MEC NOT offered to your spouse or dependent(s).

1C. MEC providing MV offered to you and MEC offered to your dependent(s) but NOT your spouse.

1D. MEC providing MV offered to you and MEC offered to your spouse but NOT your dependent(s).

1E. MEC providing MV offered to you and MEC offered to your dependent(s) and spouse.

1F. MEC NOT providing MV 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 coverage or you were offered coverage that is NOT MEC).

1J. MEC providing MV offered to you; MEC conditionally offered to your spouse; and MEC NOT offered to your dependent(s).

1K. MEC providing MV offered to you; MEC conditionally offered to your spouse; and MEC offered to your dependent(s).

1L. Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence location ZIP code.

1M. Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.

1N. Individual coverage HRA offered to you, spouse and dependent(s) with affordability determined by using employee's primary residence location ZIP code.

1O. Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.

1P. Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.

1Q. Individual coverage HRA offered to you, spouse and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.

1R. Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.

1S. Individual coverage HRA offered to an individual who was not a full-time employee.

1T. Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.

1U. Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest-cost self-only MEC providing MV that your employer offered you. This amount 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 a "\$0" for the amount.

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.

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 HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18-23

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not 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 6 covered individuals, see the additional covered individuals on Part III, Continuation Sheet(s).

1095-C
Form
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Go to www.irs.gov/Form1095C for instructions and the latest information.

VOID

OMB No. 1545-2251

2022

CORRECTED

Part I Employee

1 Name of employee (first name, middle initial, last name) Bharat Guda		2 Social security number (SSN) ***-**-2140	7 Name of employer The Math Company Inc		8 Employer identification number (EIN) 352618445
3 Street address (including apartment no.) 2044 NW Steelrake PL APT N 311		4 City or town ISSAQUAH	5 State or province WA	9 Street address (including room or suite no.) 1165 N Clark St Suite 700	10 Contact telephone number (647) 868-5516
		6 Country and ZIP or foreign postal code 98027	11 City or town Chicago	12 State or province IL	13 Country and ZIP or foreign postal code 60610

Applicable Large Employer Member (Employer)

Part II Employee Offer of Coverage

All 12 Months	Employee's Age on January 1												Plan Start Month (Enter 2-digit number):				
	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec					
14 Offer of Coverage (enter required code) 1E																	
15 Employee Contribution (see instructions) \$ 0.00	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 2C																	
17 ZIP Code																	

Part III Covered Individuals

If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.

17 18 19 20 21 22	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	(e) Months of Coverage												
					Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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				<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60605M

Form **1095-C** (2022)