UnitedHealthcare, Inc.
CDB 6055 Operations
P.O. Box 30979
Salt Lake City, UT 84130-0979

12/14/2022

DPS$$$PKG
VENKATA RAVI K DUDDULA
13050 DAHLIA CIR APT 219
EDEN PRAIRIE MN 55344-7639

12/14/2022

**Important Tax Information**
Under the federal health reform law and under certain state laws UnitedHealthcare must report which individuals had a plan with minimum essential coverage. UnitedHealthcare must report this information about your minimum essential coverage on Form 1095-B to the IRS and certain state tax agencies. Certain states may use this information to administer their health care laws.

**What is minimum essential coverage?**
Minimum essential coverage may include health insurance through a government-sponsored program, eligible employer-sponsored plan, individual market plan or other coverage designated by the Department of Health and Human Services. Your UnitedHealthcare plan is minimum essential coverage.

**What is Form 1095-B?**
This is an IRS form that shows the health care information that is shared with the IRS and certain state tax agencies. Certain states may use this information to administer their health care laws.

The form shows this information about your health insurance:

- Type of coverage you had
- Period of coverage
- Who was covered (including dependents)

**Why did you get more than one Form 1095-B?**
You may have been covered under more than one policy during the year. You will get a separate Form 1095-B for each policy.

**Will dependents over age 18 covered under your plan get a separate copy of this form?**
Dependents over age 18 covered under your plan will **not** get a separate copy of Form 1095-B. You should give a copy to individuals covered under your plan, if they need it for their records.

**What if you had minimum essential coverage with another company?**
You should receive a form 1095 from any other company that provided you minimum essential coverage.

**What if you didn't have minimum essential coverage for the entire year?**
Beginning with the 2019 tax year, the IRS penalties have been reduced to zero. Certain states, however, have enacted their own health care laws that require minimum essential coverage and may impose a penalty. For more information, contact your tax advisor or state tax agency.

**Can you get this form electronically?**
We encourage you to choose to get this form electronically. For more information about electronic delivery, please visit myuhc.com.

**Will this form be sent again next year?**
You will get a form 1095 every year from any company that provided you minimum essential coverage.

**Questions?**
If you have any questions, please call us toll-free at the phone number on your health plan ID card. TTY users can dial **711**.

Sincerely,
UnitedHealthcare

Enclosure: Form 1095-B

Form **1095-B**

Department of the Treasury
Internal Revenue Service

# Health Coverage

▶ Do not attach to your tax return. Keep for your records.
▶ Go to *www.irs.gov/Form1095B* for instructions and the latest information.

☐ VOID

☐ CORRECTED

560118

OMB No. 1545-2252

**2022**

## Part I Responsible Individual

| 1 Name of responsible individual–First name, middle name, last name | | | 2 Social security number (SSN) or other TIN | 3 Date of birth (if SSN or other TIN is not available) |
|---|---|---|---|---|
| VENKATA RAVI | K | DUDDULA | ***-**-1715 | |

| 4 Street address (including apartment no.) | 5 City or town | 6 State or province | 7 Country and ZIP or foreign postal code |
|---|---|---|---|
| 13050 DAHLIA CIRCLE APT 219 | EDEN PRAIRIE | MN | UNITED STATES 55344 |

8 Enter letter identifying Origin of the Health Coverage (see instructions for codes): . . . ▶ B

9 Reserved

## Part II Information about Certain Employer-Sponsored Coverage (see instructions)

| 10 Employer name | 11 Employer identification number (EIN) |
|---|---|
| KOLLASOFT INC | 20-8532918 |

| 12 Street address (including room or suite no.) | 13 City or town | 14 State or province | 15 Country and ZIP or foreign postal code |
|---|---|---|---|
| 14301 N 87TH STREET SUITE 317 | SCOTTSDALE | AZ | 85260 |

## Part III Issuer or Other Coverage Provider (see instructions)

| 16 Name | 17 Employer identification number (EIN) | 18 Contact telephone number |
|---|---|---|
| UnitedHealthcare, Inc. | 41-1922511 | 866-633-2446 |

| 19 Street address (including room or suite no.) | 20 City or town | 21 State or province | 22 Country and ZIP or foreign postal code |
|---|---|---|---|
| 601 Brooker Creek Blvd | Oldsmar | FL | UNITED STATES 34677 |

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

| (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 | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
| 23 VENKATA RAVI | K | DUDDULA | ***-**-1715 | | ☐ | X | X | X | X | X | X | X | X | X | ☐ | ☐ | ☐ |
| 24 LAKSHMI | N | DUDDULA | ***-**-2118 | | ☐ | X | X | X | X | X | X | X | X | X | ☐ | ☐ | ☐ |
| 25 SRI RITHVIK | R | DUDDULA | ***-**-9177 | | ☐ | X | X | X | X | X | X | X | X | X | ☐ | ☐ | ☐ |
| 26 SRI SHRAINIK | R | DUDDULA | ***-**-9157 | | ☐ | X | X | X | X | X | X | X | X | X | ☐ | ☐ | ☐ |

# Instructions for Recipient

This Form 1095-B provides information about the individuals in your tax family (yourself, spouse, and dependents) who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. 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.

If individuals in your tax family are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit. For more information on the premium tax credit, see Pub. 974, Premium Tax Credit (PTC).

**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 other individuals covered under the policy if they request it for their records.*

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

**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.

**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
- **G.** Individual coverage health reimbursement arrangement (HRA)

**TIP** *If you or another family member received health insurance coverage through a Health Insurance Marketplace (also known as an Exchange), that coverage will generally be reported on a Form 1095-A rather than a Form 1095-B. If you or another family member received employer-sponsored coverage, that coverage may be reported on a Form 1095-C (Part III) rather than a Form 1095-B. For more information, see* www.irs.gov/Affordable-Care-Act/Questions-and-Answers-About-Health-Care-Information-Forms-for-Individuals.

**Line 9.** Reserved.

**Part II. Information About Certain Employer-Sponsored Coverage, lines 10–15.** If you had employer-sponsored health coverage, this part may provide information about the employer sponsoring the coverage. This part may show only the last four digits of the employer's EIN. This part may also be left blank, even if you had employer-sponsored health coverage. If this part is blank, you do not need to fill in the information or return it to your employer or other coverage provider.

**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 the SSN or other TIN is not entered in column (b). Column (d) will be checked if the individual was covered for at least 1 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.