Infosys Limited 2400 N. Glenville Drive, STE C150 Richardson, TX 75082

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Form1095-C	Employer-Provided Health Insurance Offer and Coverage										☐ VOID					********							
Department of the														☐ CORRECTED				20	124				
Treasury Do no						o not attach to your tax return. Keep for your records									- CONNECTED				2022				
Internal Revenue Service ► Go to www.irs.gov/Form1095C for instructions and the latest information																							
Part Employee 1 Name of employee (first name, middle initial, last name) 2 Social security number (SSN)									Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification number (EIN)														
Sandeep Omprakash	2 Social sec xxx-xx-102	١)	Infosy						58-17602														
3 Street address (in 800 W Queen Cre					ss (incl ville Drive	_		ent no.	10 Contact telephone number 469-269-9314														
4 City or town 5 State or province				6 Country a	postal	11 City					12 Sta		13 Country and ZIP or foreign postal										
Chandler AZ				code USA 8524					Richardson						province TX		code USA 75082						
Part II Em	ie	ee's Age	e on January 1						Plan Start Month: 04														
14 Offer of	All 12 Mon			Feb	Mar		Apr	May	Jun		Jul		Aug		Sept		Oct		Nov		Dec		
Coverage (enter required code)	1E	Τ.																					
15 Employ ee Required Contribution (see	\$	\$124.38		\$124.38	\$124.38		\$132.47	\$132.47	\$132.4	132.47 \$1		7	\$ 132.47		\$132.47		§ 132.47		132.47	\$ 132	\$ 132.47		
instructions) 16 Section 4980H		-							-				-		ļ			+		+			
Safe Harbor and Other Relief (enter code, if applicable)	nd enter 2C																						
17 ZIP Code																							
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(a) Name of covered individual(s) First						(c)	DOB (If SSN	(d) Covered	t					(e) I	Months o	f cover	rage						
name, middle initial, last name			(b) SSN or other TIN			or other TIN is not av ailable)		all 12 months	Jan	Jan Fet									Oct	Nov	Nov Dec		
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Form 1095-C (2022)							60	102

Form 1095-C(2022)

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") 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 governmentsponsored 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



Employers are required to furnish Form 1095-C only to the employee. As the recipient of this Form 1095-C, you should provide a copy to any family members covered under a self-insured employer-sponsored plan listed in Part III if they request it for their records.

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

Part I. Employee

Lines 1-6. Part I, lines 1-6, 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 and Coverage, Lines 14-16

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 multiemployer plan due to your membership in a union, that 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). For more information about the premium tax credit, see Pub. 974.

Part II. Employer Offer and Coverage, Lines 14-16

1A. Minimum essential coverage providing minimum value 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 minimum essential coverage 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. For information on the adjustment of the 9.5%, see IRS.gov.

1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s). 1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse. 1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).

1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.

1F. Minimum essential coverage NOT providing minimum value 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 montl 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 health coverage or you were offered coverage that is NOT minimum essential coverage).

1J. Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).

IK. Minimum essential coverage providing minimum value offered to you; minimu essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).

AL. Individual coverage 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 location ZIP Code.

1N. Individual coverage HRA offered to you, spouse and dependent(s) with the transfer of the property of the providence location. affordability determined by using employee's primary residence location ZIP Code 10. Individual coverage HRA offered to you only using the employee's primary employment site ZIP Code affordability safe harbor.

P. 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

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

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 minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA the employee required contribution is the excess of the monthly premium based the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the instructions for Forms 1094-C and 1095-C f more details. The amount reported on line 15 may not be the amount you paid for more details. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such at family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, 1E, 1J, 1K 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U 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 "0.00" the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, see IRS.gc

Line 16. This code provides the IRS information to administer the employer share 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. For more information about the employer shared responsibilit provisions, see IRS.gov

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 1M, 1N or 1T was used on line 14, this will be your primary residence location. If code 10, 1P, 1Q, or 1U was used on line 14, this will be your primary work location For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18-30

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 (includi 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." adate of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employer 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 13 covered individuals, additional copies of page 3 may be used.