HPHC Insurance Company P.O. Box 809026 Dallas, TX 75380-9026



12/14/2023

DPS\$\$\$PKG SANJAY MOORJANI 161 LAKE SHORE RD APT 2 BRIGHTON MA 02135-6345

### 12/14/2023

# 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 uhcsr.com/myaccount.

# 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.

Sincerely, UnitedHealthcare

# Enclosure: Form 1095-B

This communication is not intended, nor should it be construed, as legal or tax advice. Please contact a legal or tax professional for legal advice, tax treatment and restrictions. Federal and state laws and regulations are subject to change. You may also visit IRS.gov or your state tax agency.

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			Health Co	lith Coverage					I	ō	OMB No. 1545-2252	<b>45-2252</b>	
Department of the Treasury Internal Revenue Service		<ul> <li>Do</li> <li>Go to www.i</li> </ul>	<ul> <li>Do not attach to your tax return. Keep for your records.</li> <li>Go to www.irs.gov/Form1095B for instructions and the latest information.</li> </ul>	your tax return. Keep for your records. <i>095B</i> for instructions and the latest infe	r your records. d the latest inf	ormation.		CORRECTED	CTED	$\mathbb{N}$	620		
Part   Respons	Responsible Individual	al											
1 Name of responsible individual-First name, middle name, last name	ridual–First name, mi	iddle name, last nan	ne		2 Social s	ecurity number (	2 Social security number (SSN) or other TIN		3 Date of birth (if SSN or other TIN is not available)	th (if SSN or	other TIN	is not avail	lable)
SANJAY			MOORJANI		*** <u>-</u> **-8120	-							
4 Street address (including apartment no.) 161 LAKE SHORE RD APT 2	apartment no.) 2	ъ ВД	5 City or town BRIGHTON		<b>6</b> State o MA	State or province			7 Country and ZIP or foreign postal code 02135	nd ZIP or fo	reign posta	Il code	
					9 Reserved	9							
8 Enter letter identifying Origin of the Health Coverage (see instructions for	Origin of the Healt	th Coverage (see	instructions for codes):										
Part II Informati	ion about Cer	tain Employe	Information about Certain Employer-Sponsored Coverage (see instructions)	erage (see in	structions)								
10 Employer name								-	11 Employe	Employer identification number (EIN)	on number	(EIN)	
12 Street address (including room or suite no.)	room or suite no.)	3	City or town		14 State	State or province			15 Country	Country and ZIP or foreign postal code	foreign post	tal code	
Part III Issuer or	Other Covera	age Provider	issuer or Other Coverage Provider (see instructions)					-					
<b>16</b> Name HPHC Insurance Company					17 Emplo 04-314969	17 Employer identification number (EIN) 04-3149694	n number (EIN)	~ ∞	18 Contact te 800-767-0700	Contact telephone number 767-0700	umber		
19 Street address (including room or suite no.) PO Box 809026	room or suite no.)	<b>2</b>	<b>20</b> City or town Dallas		21 State	State or province			22 Country and ZIP or foreign postal code UNITED STATES 75380-9026	and ZIP or f TES 75380	foreign post -9026	tal code	
Part IV Covered	Covered Individuals (E	Enter the infor	(Enter the information for each covered individual.)	ered individu	al.)			_					
(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	erage					
			(		Jan Feb	Mar Apr	May	lut nut	I Aug	Sep	Oct	Nov	Dec
23 SANJAY	MOORJANI	***_**-8120		×									
For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.	berwork Reductio	on Act Notice, se	se separate instruction		-	Cat. No	Cat. No. 60704B		-		Form <b>1095-B</b> (2023)	<b>35-B</b> (2	(023)

(2023)
1095-B
Form

# 560220

Page 2

# Instructions for Recipient

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

reported on that form. As the recipient of this Form 1095-B, you Providers of minimum essential coverage are required to furnish should provide a copy to other individuals covered under the policy if they only one Form 1095-B for all individuals whose coverage is equest it for their records. ЧР

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

Part I. Responsible Individual, lines 1–9. Part I reports information about you and the coverage.

required to report your complete SSN or other TIN, if applicable, to the IRS. 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 Your date of birth will be entered on line 3 only if line 2 is blank.

covered individuals were enrolled. Only one letter will be entered on this line. Line 8. This is the code for the type of coverage in which you or other

- Small Business Health Options Program (SHOP) Ż
  - Employer-sponsored coverage ы
    - Government-sponsored program
    - Individual market insurance C. Government-sponsol D. Individual market inst E. Multiemployer plan
- Other designated minimum essential coverage
- G. Individual coverage health reimbursement arrangement (HRA)

coverage through a Health Insurance Marketplace (also known as <sup>c</sup>orm 1095-A rather than a Form 1095-B. If you or another family member an Exchange), that coverage will generally be reported on a If you or another family member received health insurance d F

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 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 10-15. If you had employer-sponsored health coverage, this part may employer or other coverage provider.

coverage sponsor). Line 18 reports a telephone number for the coverage Part III. Issuer or Other Coverage Provider, lines 16–22. This part reports providing self-insured coverage, government agency sponsoring coverage provider that you can call if you have questions about the information information about the coverage provider (insurance company, employer under a government program such as Medicaid or Medicare, or other reported on the form.

or other TIN, and coverage information for each covered individual. A date of Part IV. Covered Individuals, lines 23–28. This part reports the name, SSN 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 birth will be entered in column (c) only if the SSN or other TIN is not entered 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.