



Covered California  
 PO BOX 989725  
 West Sacramento, CA 95798-9725



**COVERED  
 CALIFORNIA**

*Your destination for affordable  
 healthcare, including Medi-Cal*

{FIRST\_NAME} {LAST\_NAME}  
 {ADDRESS\_LINE2}  
 {ADDRESS\_LINE1}  
 {CITY}, {STATE\_CD (FK)} {ZIPCODE}

**Your updated federal tax form for {Tax Year}**

{CURRENT\_DATE}

Case Number: {AHBX\_CASE\_ID}

Dear {FIRST\_NAME} {LAST\_NAME},

**Your updated federal tax Form 1095-A is included with this letter.**

Covered California updated your Internal Revenue Service (IRS) Form 1095-A. This is because we got new information about your case. The last IRS Form 1095-A we sent you for this plan is no longer correct.

**If the "CORRECTED" box is checked at the top of the form**

This means the information changed from your last IRS Form 1095-A. Here are some things that could have changed:

- Personal information like your address
- Health plan information like who was enrolled or the date coverage began or ended
- Your monthly premium or premium tax credit amount

**If the "VOID" box is checked at the top of the form**

This means changes were made to show that you were never enrolled in this plan.

**What to do next**

Use the information on your **updated** IRS Form 1095-A to fill out IRS Form 8962. Do **not** use the information on the last IRS Form 1095-A we sent you for this plan. If you already filed your federal tax return for {Tax Year}, you may need to file an amended (updated) **federal** tax return.

**If you need a digital copy of your Form 1095-A**

Log in to your account at [CoveredCA.com](http://CoveredCA.com). On the homepage, click "View {Tax Year} Federal Tax Form 1095-A." To create an online account, follow the instructions at [CoveredCA.com/create-account](http://CoveredCA.com/create-account).

**If you think we made a mistake**

If you think we made a mistake or your **updated** IRS Form 1095-A is still incorrect, call Covered California at **{SERVICE\_CENTER\_PHONE}** (TTY: 1-888-889-4500). You can also file an IRS Form 1095-A dispute with Covered California online at [CoveredCA.com/1095](https://CoveredCA.com/1095). Click “Errors on your forms?” Then fill out the Request to Correct or Dispute Tax Forms.

### **Need help with your taxes?**

Covered California can answer questions about your IRS Form 1095-A but **cannot** give tax advice. For help with your taxes:

- Talk to a tax adviser or tax preparer
- Go to the IRS website. You can learn more about:
  - Filing your federal tax return at [irs.gov/Filing](https://irs.gov/Filing)
  - The Affordable Care Act, premium tax credits, and taxes at [irs.gov/aca](https://irs.gov/aca)
  - How to correct or amend a return at [irs.gov/help](https://irs.gov/help)
- You may also be able to get free tax help at a local Volunteer Income Tax Assistance (VITA) site or with the Tax Counseling for the Elderly (TCE). VITA generally helps people who make up to \$64,000 a year, people with disabilities, older adults, and taxpayers who speak limited English. TCE helps people 60 years of age or older. To find free help near you:
  - Go online to [irs.treasury.gov/freetaxprep](https://irs.treasury.gov/freetaxprep)
  - Call 1-800-906-9887

### **Questions?**

- Go online to [CoveredCA.com/1095](https://CoveredCA.com/1095)
- Call Covered California, Monday – Friday, 8 a.m. to 6 p.m. at **{SERVICE\_CENTER\_PHONE}** (TTY: 1-888-889-4500)

Thank you,

Covered California

This notice was sent to you in compliance with the Affordable Care Act implementing regulations: 26 Code of Federal Regulations, §1.36B-5.

**Part I Recipient Information**

1 Marketplace Identifier	2 Marketplace-assigned policy number	3 Policy issuer's name		
4 Recipient's name		5 Recipient's SSN	6 Recipient's date of birth	
7 Recipient's spouse's name		8 Recipient's spouse's SSN	9 Recipient's spouse's date of birth	
10 Policy start date	11 Policy termination date	12 Street address (including apartment no.)		
13 City or town	14 State or province	15 Country and ZIP or foreign postal code		

**Part II Covered Individuals**

	A. Covered individual name	B. Covered individual SSN	C. Covered individual date of birth	D. Coverage start date	E. Coverage termination date
16					
17					
18					
19					
20					

**Part III Coverage Information**

Month	A. Monthly enrollment premiums	B. Monthly second lowest cost silver plan (SLCSP) premium	C. Monthly advance payment of premium tax credit
21 January			
22 February			
23 March			
24 April			
25 May			
26 June			
27 July			
28 August			
29 September			
30 October			
31 November			
32 December			
33 Annual Totals			

## Instructions for Recipient

You received this Form 1095-A because you or a family member enrolled in health insurance coverage through the Health Insurance Marketplace. This Form 1095-A provides information you need to complete Form 8962, Premium Tax Credit (PTC). **You must complete Form 8962 and file it with your tax return (Form 1040, Form 1040-SR, or Form 1040-NR) if any amount other than zero is shown in Part III, column C, of this Form 1095-A (meaning that you received premium assistance through advance payments of the premium tax credit (also called advance credit payments)) or if you want to take the premium tax credit.** The filing requirement applies whether or not you're otherwise required to file a tax return. If you are filing Form 8962, you cannot file Form 1040-NR-EZ, Form 1040-SS, or Form 1040-PR. The Marketplace has also reported the information on this form to the IRS. If you or your family members enrolled at the Marketplace in more than one qualified health plan policy, you will receive a Form 1095-A for each policy. Check the information on this form carefully. If you think the information is incorrect, or if you think you should not have received a Form 1095-A because neither you nor anyone else in your family was enrolled in Marketplace health insurance, please contact your Marketplace Call Center. If you purchased insurance through the Federally-facilitated Marketplace, you can find your Call Center information at [www.healthcare.gov/contact-us/](http://www.healthcare.gov/contact-us/). If you purchased insurance through a State-based Marketplace, you can find your Call Center information on your State-based Marketplace website. You can find a list of State-based Marketplace websites at [www.healthcare.gov/marketplace-in-your-state/](http://www.healthcare.gov/marketplace-in-your-state/). If you or your family members were enrolled in a Marketplace catastrophic health plan or separate dental policy, you aren't entitled to take a premium tax credit for this coverage when you file your return, even if you received a Form 1095-A for this coverage. For additional information related to Form 1095-A, go to [www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Health-Insurance-Marketplace-Statements](http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Health-Insurance-Marketplace-Statements).

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

**VOID box.** If the "VOID" box is checked at the top of the form, you previously received a Form 1095-A for the policy described in Part I. That Form 1095-A was sent in error. You shouldn't have received a Form 1095-A for this policy. Don't use the information on this or the previously received Form 1095-A to figure your premium tax credit on Form 8962.

**CORRECTED box.** If the "CORRECTED" box is checked at the top of the form, use the information on this Form 1095-A to figure the premium tax credit and reconcile any advance credit payments on Form 8962. Don't use the information on the original Form 1095-A you received for this policy.

**Part I. Recipient Information, lines 1–15.** Part I reports information about you, the insurance company that issued your policy, and the Marketplace where you enrolled in the coverage.

**Line 1.** This line identifies the state where you enrolled in coverage through the Marketplace.

**Line 2.** This line is the policy number assigned by the Marketplace to identify the policy in which you enrolled. If you are completing Part IV of Form 8962, enter this number on line 30, 31, 32, or 33, box a.

**Line 3.** This is the name of the insurance company that issued your policy.

**Line 4.** You are the recipient because you are the person the Marketplace identified at enrollment who is expected to file a tax return and who, if qualified, would take the premium tax credit for the year of coverage.

**Line 5.** This is your social security number (SSN). For your protection, this form may show only the last four digits. However, the Marketplace has reported your complete SSN to the IRS.

**Line 6.** A date of birth will be entered if there is no SSN on line 5.

**Lines 7, 8, and 9.** Information about your spouse will be entered only if advance credit payments were made for your coverage. The date of birth will be entered on line 9 only if line 8 is blank.

**Lines 10 and 11.** These are the starting and ending dates of the policy.

**Lines 12 through 15.** Your address is entered on these lines.

**Part II. Covered Individuals, lines 16–20.** Part II reports information about each individual who is covered under your policy. This information includes the name, SSN, date of birth, and the starting and ending dates of coverage for each covered individual. For each line, a date of birth is reported in column C only if an SSN isn't entered in column B.

If advance credit payments are made, the only individuals listed on Form 1095-A will be those whom you certified to the Marketplace would be in your tax family for the year of coverage (yourself, spouse, and dependents). If you certified to the Marketplace at enrollment that one or more of the individuals who enrolled in the plan aren't individuals who would be in your tax family for the year of coverage, those individuals won't be listed on your Form 1095-A. For example, if you indicated to the Marketplace at enrollment that an individual enrolling in the policy is your adult child who will not be your dependent for the year of coverage, that child will receive a separate Form 1095-A and won't be listed in Part II on your Form 1095-A.

If advance credit payments are made and you certify that one or more enrolled individuals aren't individuals who would be in your tax family for the year of coverage, your Form 1095-A will include coverage information in Part III that is applicable solely to the individuals listed on your Form 1095-A, and separately issued Forms 1095-A will include coverage information, including dollar amounts, applicable to those individuals not in your tax family.

If advance credit payments weren't made and you didn't identify at enrollment the individuals who would be in your tax family for the year of coverage, Form 1095-A will list all enrolled individuals in Part II on your Form 1095-A.

If there are more than five individuals covered by a policy, you will receive one or more additional Forms 1095-A that continue Part II.

**Part III. Coverage Information, lines 21–33.** Part III reports information about your insurance coverage that you will need to complete Form 8962 to reconcile advance credit payments or to take the premium tax credit when you file your return.

**Column A.** This column is the monthly premiums for the plan in which you or family members were enrolled, including premiums that you paid and premiums that were paid through advance payments of the premium tax credit. If you or a family member enrolled in a separate dental plan with pediatric benefits, this column includes the portion of the dental plan premiums for the pediatric benefits. If your plan covered benefits that aren't essential health benefits, such as adult dental or vision benefits, the amount in this column will be reduced by the premiums for the nonessential benefits. If the policy was terminated by your insurance company due to nonpayment of premiums for 1 or more months, then a -0- may appear in this column for these months regardless of whether advance credit payments were made for these months. See the instructions for Form 8962, Part II, on how to complete Form 8962 if -0- is reported for 1 or more months.

**Column B.** This column is the monthly premium for the second lowest cost silver plan (SLCSP) that the Marketplace has determined applies to members of your family enrolled in the coverage. The applicable SLCSP premium is used to compute your monthly advance credit payments and the premium tax credit you take on your return. See the instructions for Form 8962, Part II, on how to use the information in this column or how to complete Form 8962 if there is no information entered, the information is incorrect, or the information is reported as -0-. If the policy was terminated by your insurance company due to nonpayment of premiums for 1 or more months, then a -0- may appear in this column for the months, regardless of whether advance credit payments were made for these months.

**Column C.** This column is the monthly amount of advance credit payments that were made to your insurance company on your behalf to pay for all or part of the premiums for your coverage. If this is the only column in Part III that is filled in with an amount other than zero for a month, it means your policy was terminated by your insurance company due to nonpayment of premiums, and you aren't entitled to take the premium tax credit for that month when you file your tax return. You must still reconcile the entire advance payment that was paid on your behalf for that month using Form 8962. No information will be entered in this column if no advance credit payments were made.

**Lines 21–33.** The Marketplace will report the amounts in columns A, B, and C on lines 21–32 for each month and enter the totals on line 33. Use this information to complete Form 8962, line 11 or lines 12–23.

## **Section 1557 of the Patient Protection and Affordable Care Act (ACA)**

Covered California complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation. Covered California does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity or sexual orientation.

Covered California provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats and other formats). Covered California also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact the Civil Rights Coordinator at 916-228-8764 or by email at [CivilRights@covered.ca.gov](mailto:CivilRights@covered.ca.gov).

If you believe that Covered California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity or sexual orientation, you can file a grievance with the Civil Rights Coordinator.

You can file a grievance in the following ways:

**Mail:** Civil Rights Coordinator  
P.O. Box 989725  
West Sacramento, CA 95798-9725

**Phone:** 916-228-8764

**Fax:** 916-228-8909

**Email:** [CivilRights@covered.ca.gov](mailto:CivilRights@covered.ca.gov)

You can also file a civil rights complaint with the Office for Civil Rights at the U.S. Department of Health and Human Services.

**Mail:** U.S. Department of Health and Human Services  
200 Independence Ave. SW, Room 509F, HHH Building  
Washington, DC 20201

**Phone:** 1-800-368-1019 or TTY: 1-800-537-7697

**Online:** Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>. Complaint forms are available on the U.S. Department of Health and Human Services Office for Civil Rights website.



## Getting Help in a Language Other than English

**IMPORTANT:** Can you read this letter? You can call 1-800-300-1506 and ask for this letter translated to your language or in another format such as large print. For TTY call 1-888-889-4500 where you can also request this letter in alternate format.

**Español IMPORTANTE:** ¿Puede leer esta carta? Usted puede llamar al 1-800-300-0213 y pedir esta carta traducida en su idioma o en otro formato como en letras grandes. Para TTY, llame al 1-888-889-4500, donde también puede pedir esta carta en algún formato diferente. (Spanish)

**中文/繁體字 重要事項:** 您能讀懂這封信嗎? 您可以致電 1-800-300-1533 並要求將這封信翻譯成您的語言或者索要其他格式如大字版本的信件。對於 TTY, 請致電

1-888-889-4500, 您也可以在那里索取其他格式的信件。(Chinese)

**Tiếng Việt QUAN TRỌNG:** Quý vị có thể đọc được bức thư này không? Quý vị có thể gọi điện đến số 1-800-652-9528 và yêu cầu được dịch bức thư này sang ngôn ngữ của quý vị hoặc chuyển sang định dạng khác như bản in khổ lớn. Người dùng TTY, hãy gọi số 1-888-889-4500 quý vị cũng có thể yêu cầu định dạng thay thế khác cho bức thư này. (Vietnamese)

**한국어 중요:** 이 편지를 읽을 수 있습니까? 1-800-738-9116 으로 연락하여 귀하의 언어로 번역되거나 큰 활자와 같은 다른 형식으로 요청하십시오. TTY 1-888-889-4500 에서도 이 편지의 다른 포맷을 요청할 수도 있습니다. (Korean)

**Tagalog MAHALAGA:** Maaari ba ninyong basahin ang sulat na ito? Maaari kang tumawag sa 1-800-983-8816 at humiling na isalin ang sulat na ito sa iyong wika o sa iba pang format katulad ng malalaking titik. Para sa TTY, tumawag sa 1-888-889-4500 kung saan maaari kang humiling ng alternatibong format ng sulat na ito. (Tagalog)

**العربية هام:** هل يمكنك قراءة هذا الخطاب؟ يمكنك الاتصال بـ 1-800-826-6317 وطلب هذا الخطاب مترجماً إلى لغتك أو بصيغة أخرى، بخط كبير مثلاً، للصم والبكم، اتصل بـ 1-888-889-4500 حيث يمكنك أيضاً أن تطلب هذا الخطاب بصيغة مختلفة. (Arabic)

**հայերէն ԿԱՐԵՎՈՐ Է:** Դուք կարո՞ղ էք կարդալ այս նամակը: Դուք կարո՞ղ էք զանգահարել 1-800-996-1009 և խնդրել, որ այս նամակը թարգմանվի Ձեր լեզվով կամ Ձեզ տրվի մեկ այլ ձևաչափով. օրինակ՝ խոշորատառ: TTY-ի համար զանգահարել 1-888-889-4500, որտեղ կարո՞ղ էք նաև այդ նամակը թարգմանի ձեր լեզվով այս նամակը: (Armenian)

**ភាសាខ្មែរ សំខាន់:** តើលោកអ្នកអាចអានលិខិតនេះបានដែរឬទេ? លោកអ្នកអាចទូរស័ព្ទមកលេខ 1-800-906-8528 ដើម្បីសុំឱ្យគេបកប្រែលិខិតនេះជាភាសាសំលោកអ្នក ឬជាទម្រង់មួយផ្សេងទៀតដូចជាអក្សរពុម្ពធំៗ។ សម្រាប់ TTY ទូរស័ព្ទមកលេខ 1-888-889-4500

**ខ្មែរសំលោកអ្នកអាចអានលិខិតនេះបានដែរឬទេ? លោកអ្នកអាចទូរស័ព្ទមកលេខ 1-800-921-8879 (Khmer)**

**Русский ВАЖНАЯ ИНФОРМАЦИЯ:** Вы можете прочитать это письмо? Вы можете позвонить по телефону 1-800-778-7695 и запросить получение этого письма, переведенного на Ваш родной язык, или распечатанного крупным шрифтом. Лица со сниженным слухом могут позвонить по телефону 1-888-889-4500, чтобы запросить это письмо в ином формате. (Russian)

**فارسی مهم:** آیا می توانید این نامه را بخوانید؟ می توانید با شماره 1-800-921-8879 تماس بگیرید و تقاضا کنید که این نامه به زبان شما ترجمه شود یا به فرمت دیگری مانند حروف درشت به شما ارسال شود. برای TTY با شماره 1-888-889-4500 تماس بگیرید و از طریق همان شماره همچنین می توانید درخواست کنید که این نامه به فرمت دیگری به شما ارسال شود. (Farsi)

**Hmoob TSEEM CEEB:** Koj nyeem puas tau tsab ntawv no? Koj hu tau rau 1-800-771-2156 thiab nug kom daim ntawv txais ua yog koj cov lus los sis yog lwm hom xws lis luam tus ntawv loj. Hu tau TTY ntawm 1-888-889-4500 ua koj thov hloov tau lwm hom. (Hmong)

**महत्वपूर्ण:** क्या आप यह पत्र पढ़ सकते हैं? इस पत्र को अपनी भाषा में अनुवाद करने के लिए या बड़े प्रिंट की तरह किसी अन्य प्रारूप में प्राप्त करने के लिए 1-800-300-1506 पर कॉल करके अनुरोध कर सकते हैं। TTY के लिए 1-888-889-4500 पर कॉल करें जहाँ आप इस पत्र को किसी अन्य प्रारूप में प्राप्त करने का अनुरोध कर सकते हैं। (Hindi)

**重要:** この文書を読むことができますか? 希望の言語に翻訳された文書、または大きな文字など別の形式の文書をご希望の場合、1-800-300-1506までお電話ください。TTYの場合、1-888-889-4500にお電話いただければ、その他の形式の文書をリクエストすることもできます。(Japanese)

**ਮਹੱਤਵਪੂਰਨ:** ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ ਸਕਦੇ ਹੋ? ਤੁਸੀਂ 1-800-300-1506 'ਤੇ ਕਾਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਇਸ ਪੱਤਰ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਜਾਂ ਕਿਸੇ ਹੋਰ ਸਰੂਪ ਵਿਚ, ਜਿਵੇਂ ਕਿ ਵੱਡੇ ਪਿਰੰਟ ਲਈ ਪੁੱਛ ਸਕਦੇ ਹੋ। ਟੀਟੀਟਾਈ ਲਈ 1-888-889-4500 'ਤੇ ਕਾਲ ਕਰੋ ਜਿੱਥੇ ਕਿ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਦੇ ਵਿਕਲਪਕ ਰੂਪ ਵਿਚ ਸਰੂਪ ਲਈ ਬੇਨਤੀ ਵੀ ਕਰ ਸਕਦੇ ਹੋ। (Punjabi)

**สำคัญ:** คุณสามารถอ่านจดหมายฉบับนี้ได้หรือไม่ คุณสามารถติดต่อได้ที่เบอร์ 1-800-300-1506 เพื่อขอให้แปลจดหมายฉบับนี้เป็นภาษาของคุณ หรือขอเปลี่ยนแปลงรูปแบบตัวอักษรให้เป็นรูปแบบอื่น เช่นตัวอักษรขนาดใหญ่ สำหรับระบบ TTY คุณสามารถติดต่อได้ที่เบอร์ 1-888-889-4500 ซึ่งคุณสามารถขอจดหมายฉบับนี้ในรูปแบบอื่น ๆ ได้ (Thai)