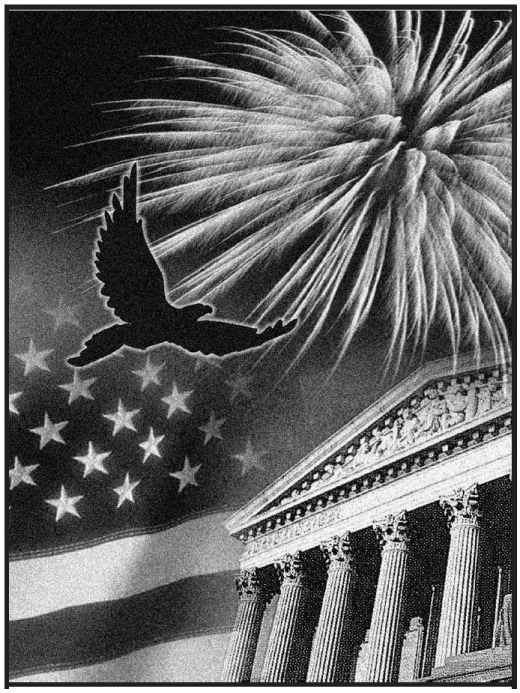
Publication 974

Premium Tax Credit (PTC)

Four use in preparing 2022 Returns

Volume 1 of 5



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Contents

Future Developments

For the latest information about developments related to Pub. 974, such as legislation enacted after it was published, go to *IRS.gov/Pub974.*

What's New

Health Coverage Tax Credit (HCTC). HCTC expired on December 31, 2021. Beginning tax year 2022, Form 8885 and its instructions have been discontinued by the IRS.

Reminders

Applicable federal poverty line percentages. For tax year 2022, the PTC is available to taxpayers with household incomes that exceed 400% of the federal poverty line.

Health reimbursement arrangements (HRAs). Beginning in 2020, employers can offer individual coverage health

reimbursement arrangements (individual coverage HRAs) to help employees and their families with their medical expenses. If you are offered an individual coverage HRA, see *Individual Coverage HRAs*, later, for more information on whether you can claim a PTC for you or a member of your family for Marketplace coverage.

Qualified small employer health reimbursement arrangement (QSEHRA). Under a QSEHRA, an eligible employer can reimburse eligible employees for medical expenses, including premiums for Marketplace health insurance. If you were provided a QSEHRA, your employer should have reported the annual permitted benefit in box 12 of your Form W-2 with code FF. If the QSEHRA is considered affordable coverage for a month, no premium tax credit (PTC) is allowed for the month. If the QSEHRA is not considered affordable coverage for a month, you may still be eligible for the PTC but you

must reduce the monthly PTC (but not below -0-) by the monthly permitted benefit amount. For more information, see *Qualified Small Employer Health Reimbursement Arrangement*, later.

Requirement to reconcile advance payments of the premium tax credit. If you, your spouse with whom you are filing a joint return, or a dependent was enrolled in coverage through the Marketplace for 2022 and advance payments of the premium tax credit (APTC) were made for this coverage, you must file a 2022 return and attach Form 8962 to claim a net PTC. You (or whoever enrolled you) should have received Form 1095-A, Health Insurance Marketplace Statement, from the Marketplace with information about your coverage and any APTC. You must attach Form 8962 even if someone else enrolled you, your spouse, or your dependent. If you are a dependent who

is claimed on someone else's 2022 return, you do not have to attach Form 8962.

Report changes in circumstances when you re-enroll in coverage and during the year. If APTC is being paid for an individual in your tax family (defined later) and you have had certain changes in circumstances (see the examples below), it is important that you report them to the Marketplace where you enrolled in coverage. Reporting changes in circumstances promptly will allow the Marketplace to adjust your APTC to reflect the PTC you are estimated to be able to take on your tax return. Adjusting your APTC when you re-enroll in coverage and during the year can help you avoid owing tax when you file your tax return. Changes that you should report to the Marketplace include the following.

- Changes in household income.

- Moving to a different address. • Gaining or losing eligibility for other health care coverage.
- Gaining, losing, or other changes to employment.
- Birth or adoption.
- Marriage or divorce.
- Other changes affecting the composition of your tax family.

For more information on how to report a change in circumstances to the Marketplace, visit *HealthCare.gov* or your State Marketplace website.

Health insurance options. If you need health coverage, go to *HealthCare.gov* to learn about health insurance options that are available for you and your family, how to purchase health insurance, and how you might qualify to get financial assistance with the cost of insurance.

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

Photographs of missing children. The Internal Revenue Service is a proud partner with the *National Center for Missing & Exploited Children® (NCMEC).* Photographs of missing children selected by the Center may appear in this publication on pages that would otherwise be blank. You can help bring these children home by looking at the photographs and calling 1-800-THE-LOST (1-800-843-5678) if you recognize a child.

Introduction

This publication covers the following general topics, relating to the PTC, which are also covered in the Form 8962 instructions.

- What is the PTC?
- Who must file Form 8962.
- Who can take the PTC. (See Figure A—Can You Take the PTC, later.)

This publication also provides additional instructions for taxpayers in the following special situations.

- Taxpayers who take the PTC and who are filing a separate return from their spouses because of domestic abuse or spousal abandonment.
- Taxpayers who take the PTC and who are also provided a QSEHRA.
- Taxpayers who need to calculate the PTC and APTC for a policy that covered

an individual not lawfully present in the United States.

- Taxpayers who need to determine the applicable second lowest cost silver plan (SLCSP) premium.
- Taxpayers who need to allocate policy amounts for individuals not included in any tax family.
- Taxpayers who need to allocate policy amounts because one qualified health plan covers individuals from three or more tax families in the same month.
- Taxpayers who married during the tax year and want to use an alternative PTC calculation that may lower their taxes.
- Self-employed taxpayers who wish to take the PTC and the self-employed health insurance deduction.

This publication also provides additional information to help you determine if your health care coverage is minimum essential coverage (MEC).

Comments and suggestions. We welcome your comments about this publication and suggestions for future editions.

You can send us comments through *IRS.gov/FormComments*. Or, you can write to the Internal Revenue Service, Tax Forms and Publications, 1111 Constitution Ave. NW, IR-6526, Washington, DC 20224.

Although we can't respond individually to each comment received, we do appreciate your feedback and will consider your comments and suggestions as we revise our tax forms, instructions, and publications. **Don't** send tax questions, tax returns, or payments to the above address.

Getting answers to your tax questions. If you have a tax question not answered by this

publication or the *How To Get Tax Help* section at the end of this publication, go to the IRS Interactive Tax Assistant page at *IRS.gov/ Help/ITA* where you can find topics by using the search feature or viewing the categories listed.

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Questions about Form 1095-A, Health Insurance Marketplace Statement. If you or a member of your tax family was enrolled

in a qualified health plan through a Marketplace in 2022, you should have received a Form 1095-A by early February 2023. Contact your Marketplace if you do not receive a Form 1095-A or if you have questions about the accuracy of your Form 1095-A.

Useful Items

You may want to see:

Publication

☐ **535** 535 Business Expenses (Self-employed individuals may need to see chapter 6.)

Form (and Instructions)

☐ **1095-A** Health Insurance Marketplace Statement

☐ **1095-B** Health Coverage

☐ **1095-C** Employer-Provided Health Insurance Offer and Coverage

☐ **8962** Premium Tax Credit (PTC)

See *How To Get Tax Help*, at the end of this publication, for information about getting publications and forms.

What Is the Premium Tax Credit (PTC)?

Premium tax credit (PTC). The PTC is a tax credit for certain people who enroll, or whose family member enrolls, in a qualified health plan offered through a Marketplace. The credit provides financial assistance to pay the premiums for the qualified health plan by reducing the amount of tax you owe, giving you a refund, or increasing your refund amount. You must file Form 8962 to compute and take the PTC on your tax return.

Advance payments of the premium tax credit (APTC).

The APTC is a payment made during the year to your insurance provider that pays for part or all of the premiums for a qualified health

plan covering you or an individual in your tax family. Your APTC eligibility is based on the Marketplace's estimate of the PTC you will be able to take on your tax return. If APTC was paid for you or an individual in your tax family, you must file Form 8962 to reconcile (compare) this APTC with your PTC. If the APTC is *more* than your PTC, you have excess APTC and you must repay the excess, subject to certain limitations. If the APTC is *less* than the PTC, you can get a credit for the difference, which reduces your tax payment or increases your refund.

Changes in circumstances. The Marketplace determined your eligibility for, and the amount of, your 2022 APTC using projections of your income and the number of individuals you certified to the Marketplace would be in your tax family (yourself, spouse, and dependents) when you enrolled in a qualified health plan. If this information changed during 2022 and you did not

promptly report it to the Marketplace, the amount of APTC paid may be substantially different from the amount of PTC you can take on your tax return. See *Report changes in circumstances when you re-enroll in coverage and during the year*, earlier, for changes that can affect the amount of your PTC.

Who Must File Form 8962

You must file Form 8962 with your income tax return (Form 1040, 1040-SR, or 1040-NR) if any of the following apply to you.

- You are taking the PTC.
- APTC was paid for you or another individual in your tax family.
- APTC was paid for an individual you told the Marketplace would be in your tax family and neither you nor anyone else included that individual in a tax family. See *Individual you enrolled who is not included in a tax family* under *Lines 12 Through 23—Monthly Calculation* in the Form 8962 instructions.

If any of the circumstances above apply to you, you must file an income tax return and attach Form 8962 even if you are not otherwise required to file. You must use Form

1040, 1040-SR, or 1040-NR. For help in determining which of these forms to file, see the Instructions for Form 1040 or the Instructions for Form 1040-NR.

If you are filing Form 8962, you cannot file Form 1040-SS or 1040-PR.

If someone else enrolled an individual in your tax family in coverage, and APTC was paid for that individual's coverage, you must file Form 8962 to reconcile the APTC. You need to obtain a copy of the Form 1095-A from the person who enrolled the individual.

If you are claimed as a dependent, the person who claims you will file Form 8962 to take the PTC and, if necessary, repay excess APTC for your coverage. You do not need to file Form 8962.

Who Can Take the PTC

You can take the PTC for 2022 if you meet the conditions under (1), (2), **and** (3) below.

1. For at least 1 month of the year, all of the following were true.
    a. An individual in your tax family was enrolled in a qualified health plan offered through the Marketplace on the first day of the month.
    b. That individual was not eligible for MEC for the month, other than individual market coverage. An individual is generally considered eligible for MEC for the month only if they were eligible for every day of the month (see *Minimum Essential Coverage*, later).
    c. The portion of the enrollment premiums (described later) for the month for which you are

responsible was paid by the due date of your tax return (**not** including extensions). However, if you became eligible for APTC because of a successful eligibility appeal and you retroactively enrolled in the plan, then the portion of the enrollment premium for which you are responsible must be paid on or before the 120th day following the date of the appeals decision.

2. No one can claim you as a dependent for the year.

3. You are an applicable taxpayer for 2022. To be an applicable taxpayer, you must meet all of the following requirements.

    a. Your household income for 2022 is at least 100% of the federal poverty line for your family size (see *Line 4* in the Form 8962

instructions). However, having household income below 100% of the federal poverty line will not disqualify you from taking the PTC if you meet certain requirements described under *Household income below 100% of the federal poverty line* under *Line 5* in the Form 8962 instructions.

b. If you were married at the end of 2022, you must generally file a joint return. However, filing a separate return from your spouse will not disqualify you from being an applicable taxpayer if you meet certain requirements described under *Married taxpayers*, later.

You are not entitled to the PTC for health coverage for an individual for any period during which the individual is not lawfully present in the United States.

For additional requirements and more details, see *Applicable taxpayer*, later.

Terms You May Need To Know

The terms defined below are generally the same as those in the Form 8962 instructions. However, additional information is provided below on what documentation to keep if you are a victim of domestic abuse or spousal abandonment, and on MEC, later.

Tax family. For purposes of the PTC, your tax family consists of the following individuals.

- You, if you file a tax return for the year and you can't be claimed as a dependent on someone else's 2022 tax return.
- Your spouse if filing jointly and they can't be claimed as a dependent on someone else's 2022 tax return.
- • Your dependents whom you claim on your 2022 tax return. If you are filing

Form 1040-NR, you should include your dependents in your tax family only if you are a U.S. national; resident of Canada, Mexico, or South Korea; or a resident of India who was a student or business apprentice.

Your family size equals the number of qualifying individuals in your tax family (including yourself).

Note. Listing your dependents by name and social security number (SSN) or individual taxpayer identification number (ITIN) on your tax return is the same as claiming them as a dependent. If you have more than four dependents, see the Instructions for Form 1040 or the Instructions for Form 1040-NR.

Household income. For purposes of the PTC, household income is the modified adjusted gross income (modified AGI) of you and your spouse (if filing a joint return) (see *Line 2a* in the Form 8962 instructions) plus the modified AGI of each individual whom you

claim as a dependent and who is required to file an income tax return because their income meets the income tax return filing threshold (see *Line 2b* in the Form 8962 instructions). Household income does not include the modified AGI of those individuals whom you claim as dependents and who are filing a 2022 return only to claim a refund of withheld income tax or estimated tax.

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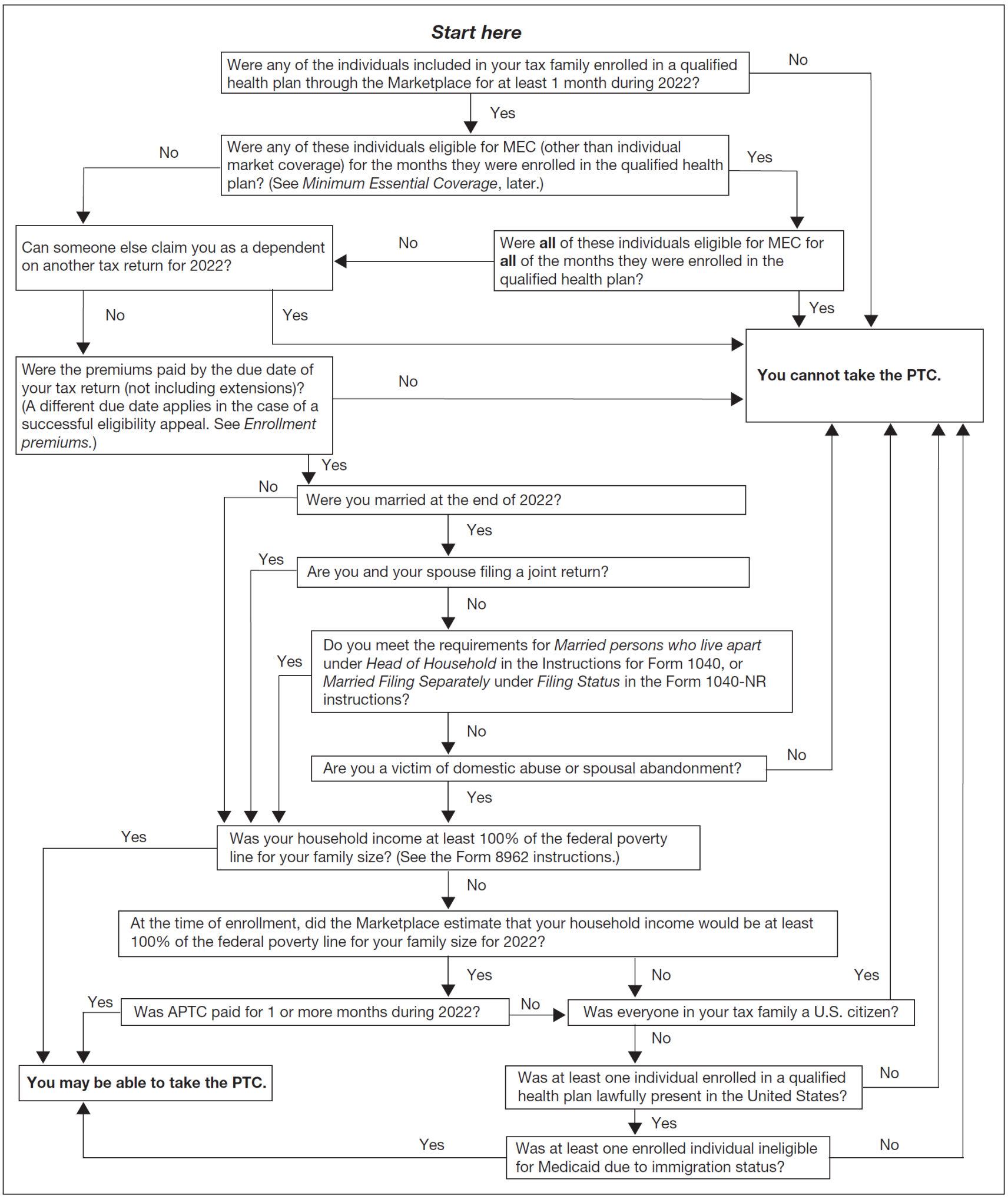
Figure A. **Can You Take the PTC?**

This flowchart can help you determine whether you can take the PTC. But do not rely on this flowchart alone. Be sur you read *Who Can Take the PTC*, discussed earlier, or in the Form 8962 instructions.



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Modified AGI. For purposes of the PTC, modified AGI is the AGI on your tax return plus certain income that is not subject to tax (foreign earned income, tax-exempt interest, and the portion of social security benefits that is not taxable). Use Worksheet 1-1 and Worksheet 1-2 in the Form 8962 instructions to determine your modified AGI.

Taxpayer's tax return including income of a dependent child. A taxpayer who includes the gross income of a dependent child on the taxpayer's tax return must include on Worksheet 1-2 the child's tax-exempt interest and the portion of the child's social security benefits that is not taxable.

Coverage family. Your coverage family includes all individuals in your tax family who are enrolled in a qualified health plan and are not eligible for MEC (other than individual market coverage). The individuals included in your coverage family may change from month to month. If an individual in your tax family is

not enrolled in a qualified health plan, or is enrolled in a qualified health plan but is eligible for MEC (other than individual market coverage), they are not part of your coverage family. Your PTC is available to help you pay only for the coverage of the individuals included in your coverage family.

Monthly credit amount. The monthly credit amount is the amount of your tax credit for a month. Your PTC for the year is the sum of all of your monthly credit amounts. Your credit amount for each month is the lesser of:

- The enrollment premiums (described next) for the month for one or more qualified health plans in which you or any individual in your tax family enrolled, or
- The amount of the monthly applicable SLCSP premium (described later) less your monthly contribution amount (described later).

To qualify for a monthly credit amount, at least one individual in your tax family must be enrolled in a qualified health plan on the first day of that month. Generally, if coverage in a qualified health plan began after the first day of the month, you are not allowed a monthly credit amount for the coverage for that month. However, if an individual in your tax family enrolled in a qualified health plan in 2022 and the enrollment was effective on the date of the individual's birth, adoption, or placement for adoption or in foster care, or on the effective date of a court order placing the individual with your family, the individual is treated as enrolled as of the first day of that month. Therefore, the individual may be a member of your tax family and coverage family for the entire month for purposes of computing your monthly credit amount.

Enrollment premiums. The enrollment premiums are the total amount of the premiums for the month, reduced by any

premium amounts for that month that were refunded, for one or more qualified health plans in which any individual in your tax family enrolled. Form 1095-A, Part III, column A, reports the enrollment premiums.

You are generally not allowed a monthly credit amount for the month if any part of the enrollment premiums for which you are responsible that month has not been paid by the due date of your tax return (not including extensions). However, if you became eligible for APTC because of a successful eligibility appeal and you retroactively enrolled in the plan, the portion of the enrollment premium for which you are responsible must be paid on or before the 120th day following the date of the appeals decision. Premiums another person pays on your behalf are treated as paid by you.

If your share of the enrollment premiums is not paid, the issuer may terminate coverage. The termination is generally effective no

sooner than the second month of nonpayment. For any months you were covered but did not pay your share of the premiums, you are not allowed a monthly credit amount.

Applicable SLCSP premium. The applicable SLCSP premium is the second lowest cost silver plan premium offered through the Marketplace where you reside that applies to your coverage family (described earlier). The SLCSP premium is not the same as your enrollment premium unless you enroll in the applicable SLCSP. Form 1095-A, Part III, column B, generally reports the applicable SLCSP premium. If no APTC was paid for your coverage, Form 1095-A, Part III, column B, may be wrong or blank or may report your applicable SLCSP premium as -0-. Also, if you had a change in circumstances during 2022 that you did not report to the Marketplace, the SLCSP premium reported on Form 1095-A in Part III, column B, may be wrong. In either

case, you must determine your correct applicable SLCSP premium. You do not have to request a corrected Form 1095-A from the Marketplace. See *Missing or incorrect SLCSP premium on Form 1095-A* under *Line 10* in the Form 8962 instructions.

Monthly contribution amount. Your monthly contribution amount is used to calculate your monthly credit amount. It is the amount of your household income you would be responsible for paying as your share of premiums each month if you enrolled in the applicable SLCSP. It is not based on the amount of premiums you paid out of pocket during the year. You will compute your monthly contribution amount in Part I of Form 8962.

Qualified health plan. For purposes of the PTC, a qualified health plan is a health insurance plan or policy purchased through a Marketplace at the bronze, silver, gold, or platinum level. Throughout this publication, a

qualified health plan is also referred to as a "policy." Catastrophic health plans and stand-alone dental plans purchased through the Marketplace, and all plans purchased through the Small Business Health Options Program (SHOP), are not qualified health plans for purposes of the PTC. Therefore, they do not qualify a taxpayer to take the PTC.

Applicable taxpayer. You must be an applicable taxpayer to take the PTC. Generally, you are an applicable taxpayer if your household income for 2022 (described earlier) is at least 100% of the federal poverty line for your family size (provided in Tables 1-1, 1-2, and 1-3 in the Form 8962 instructions) and no one can claim you as a dependent for 2022. In addition, if you were married at the end of 2021, you must file a joint return to be an applicable taxpayer unless you meet one of the exceptions described under *Married taxpayers*, later.

For individuals with household income below 100% of the federal poverty line, see *Household income below 100% of the federal poverty line* under *Line 5* in the Form 8962 instructions. However, the exception described under *Estimated household income at least 100% of the federal poverty line* in the Form 8962 instructions does not apply if, with intentional or reckless disregard for the facts, you provide incorrect information to the Marketplace for the year of coverage. You provide information with intentional disregard for the facts if you know that the information provided is inaccurate. You provide information with a reckless disregard for the facts if you make little or no effort to determine whether the information provided is accurate and your lack of effort to provide accurate information is substantially different from what a reasonable person would do under the circumstances.

Individuals who are incarcerated. Individuals who are incarcerated (other than pending disposition of charges, for example, awaiting trial) are not eligible for coverage in a qualified health plan through a Marketplace. However, these individuals may be applicable taxpayers and take the PTC for the coverage of individuals in their tax families who are eligible for coverage in a qualified health plan.

Individuals who are not lawfully present. Individuals who are not lawfully present in the United States are not eligible for coverage in a qualified health plan through a Marketplace. They cannot take the PTC for their own coverage and are not eligible for the repayment limitations in Table 5 (in the Form 8962 instructions) for APTC paid for their own coverage. However, these individuals may be applicable taxpayers and take the PTC for the coverage of individuals in their tax families, such as their children, who are lawfully present and eligible for coverage in a qualified

health plan. For more information about who is treated as lawfully present for this purpose, visit *HealthCare.gov*. See *Individuals Not Lawfully Present in the United States Enrolled in a Qualified Health Plan*, later, for more information on reconciling APTC when an unlawfully present person is enrolled individually or with lawfully present family members.

Married taxpayers. If you are considered married for federal income tax purposes, you must file a joint return with your spouse to take the PTC unless one of the two exceptions below applies to you.

You are not considered married for federal income tax purposes if you are divorced or legally separated according to your state law under a decree of divorce or separate maintenance. In that case, you cannot file a joint return but may be able to take the PTC on your separate return. See Pub. 501,

Dependents, Standard Deduction, and Filing Information.

If you are considered married for federal income tax purposes, you may be eligible to take the PTC without filing a joint return if one of the two exceptions below applies to you. If Exception 1 applies, you can file a return using head of household or single filing status and take the PTC. If Exception 2 applies, you are treated as married but can take the PTC with the filing status of married filing separately.

Exception 1—Certain married persons living apart. You may file your return as if you are unmarried and take the PTC if one of the following applies to you.

- You file a separate return from your spouse on Form 1040 or 1040-SR because you meet the requirements for *Married persons who live apart* under *Head of Household* in the Instructions for Form 1040.

- You file as single on your Form 1040-NR because you meet the requirements for *Exception* under *Filing Status* in the Instructions for Form 1040-NR.

Exception 2—Victim of domestic abuse or spousal abandonment. If you are a victim of domestic abuse or spousal abandonment, you can file a return as married filing separately and take the PTC for 2022 if all of the following apply to you.

- You are living apart from your spouse at the time you file your 2022 tax return.
- You are unable to file a joint return because you are a victim of domestic abuse (described next) or spousal abandonment (described below).
- You check the box on your Form 8962 to certify that you are a victim of

domestic abuse or spousal abandonment.

- You have not used this exception to take the PTC in each of 2019, 2020, and 2021.

Domestic abuse. Domestic abuse includes physical, psychological, sexual, or emotional abuse, including efforts to control, isolate, humiliate, and intimidate, or to undermine the victim's ability to reason independently. All the facts and circumstances are considered in determining whether an individual is abused, including the effects of alcohol or drug abuse by the victim’s spouse. Depending on the facts and circumstances, abuse of an individual’s child or other family member living in the household may constitute abuse of the individual. If you have concerns about your safety, please consider contacting the confidential 24-hour National Domestic Violence Hotline at 1-800-799-SAFE (7233), or 1-800-787-3224 (TTY), or 1-855-812-1001

(video phone, only for deaf callers). For additional information and resources, see Pub. 3865, Tax Information for Survivors of Domestic Abuse, available at *IRS.gov/Pub3865* and Part V of Form 8857, Request for Innocent Spouse Relief, available at *IRS.gov/Form8857*.

Spousal abandonment. A taxpayer is a victim of spousal abandonment for a tax year if, taking into account all facts and circumstances, the taxpayer is unable to locate their spouse after reasonable diligence.

Records of domestic abuse and spousal abandonment. If you checked the box in the upper right corner of Form 8962 indicating that you are eligible for the PTC despite having a filing status of married filing separately, you should keep records relating to your situation, like with all aspects of your tax return. What you have available may depend on your circumstances. However, the following list provides some examples of

records that may be useful. (Do not attach these records to your tax return.)

- Protective and/or restraining order.
- Police report.
- Doctor's report or letter.
- A statement from someone who was aware of, or who witnessed, the abuse or the results of the abuse. The statement should be notarized if possible.
- A statement from someone who knows of the abandonment. The statement should be notarized if possible.

Married filing separately. If you file as married filing separately and are not a victim of domestic abuse or spousal abandonment (see *Exception 2—Victim of domestic abuse or spousal abandonment* under *Married taxpayers*, earlier), then you are not an applicable taxpayer and you cannot take the

PTC. You must generally repay all of the APTC paid for a qualified health plan that covered only individuals in your tax family. If the policy also covered at least one individual in your spouse's tax family, you must generally repay half of the APTC paid for the policy. See *Line 9* in the Form 8962 instructions. However, the amount of APTC you have to repay may be limited. See *Line 28* in the Form 8962 instructions.

Minimum Essential Coverage (MEC)

Under the health care law, certain health coverage is called MEC. You generally cannot take the PTC for an individual in your tax family for any month that the individual is eligible for MEC, except for individual market coverage (defined below). MEC includes the following.

- Individual market coverage (including qualified health plans).
- Most coverage through government-sponsored programs (including Medicaid coverage, Medicare Part A or C, the Children's Health Insurance Program (CHIP), certain benefits for veterans and their families, TRICARE, and health coverage for Peace Corps volunteers).

- Most types of employer-sponsored coverage.
- Grandfathered health plans.
- Other health coverage designated by the Department of Health and Human Services (HHS) as MEC.

MEC does not include coverage consisting solely of excepted benefits. Excepted benefits include vision and dental coverage not part of a comprehensive health insurance plan, workers' compensation coverage, and coverage limited to a specified disease or illness.

For more information on what is MEC, see *IRS.gov/ Affordable-Care-Act/Individuals-and-Families/Individual- Shared-Responsibility-Provision*.

Note. Your MEC may be reported to you on Form 1095-A, Form 1095-B, or Form 1095-C.

MEC eligibility when Marketplace does not discontinue APTC. If an individual in your tax family is enrolled in a qualified health plan for which APTC was made and the individual is or will soon become eligible for other MEC, you must notify the Marketplace about the other MEC and that the APTC for the individual's coverage should be discontinued. If the Marketplace does not discontinue APTC for the first calendar month beginning after the month you notify the Marketplace, the individual is treated as eligible for the other MEC no earlier than the first day of the second calendar month beginning after the first month the individual may enroll in the other MEC. A different rule applies to Medicaid and CHIP eligibility, discussed later under *Government-Sponsored Programs*.

Expatriate Health Plans

In general, an expatriate health plan is certain health insurance coverage that is

offered to foreign nationals who are temporarily assigned for work in the United States, U.S. residents who are temporarily working outside of the United States, and certain nonemployees (such as students and missionaries) who are traveling internationally. To qualify, the health insurance coverage must generally offer a minimum level of benefits in the region in which the covered individual is temporarily located and be offered by a qualifying expatriate health insurance issuer. An expatriate health plan is considered employer-sponsored coverage for a primary insured who receives it through their employer (and for that employee's covered dependents). It is considered individual market coverage for any other primary insured.

Individual Market Coverage

A health plan offered in the individual market is health insurance coverage provided to an

individual by a health insurance issuer licensed by a state, including a qualified health plan offered through the Marketplace. Even though these plans are MEC, eligibility for individual market coverage does not prevent an individual from qualifying for the PTC for coverage in a qualified health plan purchased through the Marketplace.

Individual market coverage also includes coverage under certain expatriate health plans offered to students and religious missionaries traveling internationally. See *Expatriate Health Plans*, earlier.

Government-Sponsored Programs

The following government-sponsored programs are MEC.

1. Medicare Part A coverage.
2. Medicare Advantage plans.
3. Medicaid, except for the following programs.

a. Optional coverage of family planning services.

b. Optional coverage of tuberculosis-related services.

c. Coverage of pregnancy-related services in states that do not provide full Medicaid benefits on the basis of pregnancy.

d. Coverage limited to the treatment of emergency medical conditions.

e. Coverage of medically needy individuals (except for coverage for medically needy individuals that HHS has designated as MEC—see *Other Coverage Designated by the Department of Health and Human Services*, later).

f. Coverage under a section 1115 demonstration waiver program (except for coverage under a section 1115 demonstration

program that HHS has designated as MEC—see *Other Coverage Designated by the Department of Health and Human Services*, later).

Call your state Medicaid office if you have any questions about the coverage you have.

4. The Children's Health Insurance Program (CHIP), except certain CHIP coverage for pregnancy services. (Certain coverage often called a CHIP buy-in program is not considered a government-sponsored program and is discussed later under *Other Coverage Designated by the Department of Health and Human Services*.)

5. Coverage under the TRICARE program, except for the following programs.

   a. Coverage on a space-available basis in a military treatment facility for individuals who are not eligible

for TRICARE coverage for private sector care.

b. Coverage for a line-of-duty-related injury, illness, or disease for individuals who have left active duty.

6. The following coverage administered by the Department of Veterans Affairs.

a. Coverage consisting of the medical benefits package for eligible veterans.

b. Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

c. Comprehensive health care for children suffering from spina bifida who are the children of Vietnam veterans and veterans of covered service in Korea.

7. Health coverage provided to Peace Corps volunteers.
8. Refugee Medical Assistance.
9. Coverage through a Basic Health Program (BHP) standard health plan.

In general, you cannot get the PTC for your coverage in a qualified health plan if you are eligible for government-sponsored MEC. You are generally considered eligible for a government-sponsored program if you meet the criteria for coverage under the program. But see *Exceptions*, later. However, you will not lose the PTC for your coverage until the first day of the first full month you can receive benefits under the government program. If you can be covered under a government-sponsored program, you must complete the requirements necessary to receive benefits (for example, submitting an application or providing required information) by the last day of the third full calendar month following the event that establishes

eligibility (for example, becoming eligible for Medicare when you turn 65). If you do not complete the necessary requirements in this time, you will lose the PTC for your coverage in a qualified health plan beginning with the first day of the fourth calendar month following the event that makes you eligible for the government coverage.

Example 1. Ellen was enrolled in a qualified health plan with APTC. She turned 65 on June 3 and became eligible for Medicare. Ellen must apply to Medicare to receive benefits. She applied to Medicare in September and was eligible to receive Medicare benefits beginning on December 1. Ellen completed the requirements necessary to receive Medicare benefits by September 30 (the last day of the third full calendar month after the event that established her eligibility, turning 65). She was eligible for Medicare coverage on December 1, the first day of the first full month that she could receive benefits. Thus,

Ellen can get the PTC for her coverage in the qualified health plan for January through November. Beginning in December, Ellen cannot get the PTC for her coverage in the qualified health plan because she is eligible for Medicare.

Example 2. The facts are the same as in *Example 1*, except that Ellen did not apply for the Medicare coverage by September 30. Ellen is considered eligible for government-sponsored coverage beginning on October 1. She can get the PTC for her coverage for January through September. She cannot get the PTC for her coverage in a qualified health plan as of October 1, the first day of the fourth month after she turned 65.

Exceptions. While you are generally considered eligible for government-sponsored MEC (and are ineligible for the PTC) if you are able to enroll in that coverage, you are considered eligible for government-sponsored

coverage under the following programs only if you are **enrolled** in the program.

1. A veteran's health care program listed in (6), earlier.
2. The following TRICARE programs.
    a. The Continued Health Care Benefit Program.
    b. Retired Reserve.
    c. Young Adult.
    d. Reserve Select.
3. Medicaid coverage for comprehensive pregnancy-related services and CHIP coverage based on pregnancy, if the individual is enrolled in a qualified health plan at the time the individual becomes eligible for Medicaid or CHIP.
4. Coverage under Medicare Part A for which the individual must pay a premium.

In addition, an individual is considered eligible for MEC under a Medicaid or Medicare program for which eligibility requires a determination of disability, blindness, or illness only when the responsible agency makes a favorable eligibility determination.

Retroactive coverage. If APTC is being paid for coverage in a qualified health plan and you become eligible for government coverage that is effective retroactively (such as Medicaid or CHIP), you will not retroactively lose the PTC for your coverage. You can get the PTC for your coverage until the first day of the first calendar month after you are approved for the government coverage.

Example. In November, Freda enrolled in a qualified health plan for the following year and got APTC for her coverage. Freda lost her part-time job and on April 10 applied for coverage under the Medicaid program. Freda's application was approved on May 15, with Medicaid coverage retroactively effective

April 1. For purposes of the PTC, Freda is considered eligible for government-sponsored coverage on June 1, the first day of the first calendar month after her application was approved. Freda may be eligible for the PTC for January through May.

Termination for nonpayment of premiums. If Medicaid or CHIP coverage for you or a family member is terminated due to nonpayment of premiums, you cannot get the PTC for the coverage of that individual (for the remainder of the year of the termination).

Determining eligibility for Medicaid or CHIP at enrollment. An individual is treated as ineligible for Medicaid, CHIP, and similar programs (such as a BHP) for the period of coverage under a qualified health plan if, when the individual enrolled in the qualified health plan, the Marketplace determined that the individual was ineligible for Medicaid or CHIP based on the applicable Medicaid and CHIP income standards. However, this

exception does not apply if you, or the individual you are including in your tax family, with intentional or reckless disregard for the facts, provided incorrect information to the Marketplace for the year of coverage. You provide information with intentional disregard for the facts if you know that the information provided is inaccurate. You provide information with a reckless disregard for the facts if you make little or no effort to determine whether the information provided is accurate and your lack of effort to provide accurate information is substantially different from what a reasonable person would do under the circumstances.

Example. In November, Catelyn enrolled in a qualified health plan for the following year and got APTC for her coverage. The Marketplace determined that Catelyn was ineligible for Medicaid and estimated that her household income will be 140% of the federal poverty line for her family size for purposes of

determining APTC. During the year, Catelyn lost her job and her household income for 2022 is 130% of the federal poverty line (within the Medicaid income threshold). For purposes of the PTC, Catelyn is treated as ineligible for Medicaid for 2022. Catelyn may be eligible for the PTC for the entire year.

Medicaid or CHIP eligibility when Marketplace does not discontinue APTC. If a determination is made that an individual who is enrolled in a qualified health plan for which APTC is made is eligible for Medicaid or CHIP but the Marketplace does not discontinue APTC for the first calendar month beginning after the eligibility determination, the individual is treated as eligible for Medicaid or CHIP no earlier than the first day of the second calendar month beginning after the eligibility determination.

Employer-Sponsored Plans

The following employer-sponsored plans are MEC.

1. Group health insurance coverage for employees under:
    a. An insured plan or coverage offered in the small or large group market within a state;
    b. A governmental plan, such as the Federal Employees Health Benefits Program; or
    c. A grandfathered health plan offered in a group market.
2. A self-insured group health plan for employees.
3. Coverage under certain expatriate health plans for employees (discussed earlier).

4. The Nonappropriated Fund Health Benefits Program of the Department of Defense.

In general, these employer-sponsored plans may also include retiree or COBRA coverage.

Employer-sponsored plans that are MEC are also referred to as "eligible employer-sponsored plans."

Exceptions. The following paragraphs discuss when employer-sponsored plans are not considered MEC and the circumstances in which you may be eligible for the PTC even if you have an offer of coverage under an employer-sponsored plan.

Excepted benefits. Employer-sponsored health coverage that is limited to excepted benefits is not MEC. Excepted benefits include stand-alone vision and dental plans, workers' compensation coverage, and coverage limited to a specified disease or illness.

Affordability and minimum value. Even if you had the opportunity to enroll in coverage offered by your employer that qualifies as MEC, you are considered eligible for an employer-sponsored plan (and cannot get the PTC for your coverage in a qualified health plan) only if the employer-sponsored coverage is affordable (defined later) and the coverage provides minimum value (defined later).

Your tax family members may also be unable to get the PTC for coverage in a qualified health plan for months they were eligible to enroll in employer-sponsored coverage offered to them by your employer but only if the coverage qualifies as MEC and was affordable and provided minimum value for you. In addition, if you or your family member enrolls in the employer coverage that qualifies as MEC, the individual enrolled cannot get the PTC for coverage in a qualified health plan, even if the employer coverage is

not affordable or does not provide minimum value.

Waiting periods and other periods without access to benefits. You are not considered eligible for employer coverage, and can get the PTC for your coverage in a qualified health plan if you are otherwise eligible, for a month when you cannot receive benefits under the employer coverage (for example, you are in a waiting period before the employer coverage becomes effective). However, if you could have enrolled in employer coverage that is MEC and is affordable and provides minimum value and you did not enroll during an enrollment period, you cannot get the PTC for your coverage in a qualified health plan for the remainder of the plan year to which the enrollment period related. If the enrollment period related to coverage for more than one plan year, and you do not have another opportunity to enroll in the employer

coverage for plan years following the initial plan year, you can take the PTC for your coverage in a qualified health plan during those later plan years, if you are otherwise eligible.

Coverage after employment ends. If your employment with an employer ends and you are offered employer coverage by your former employer (for example, COBRA or retiree coverage), you are considered eligible for that employer coverage for PTC purposes only for the months that you are enrolled in the employer coverage. This same rule applies to an individual who may enroll in the coverage by reason of a relationship to a former employee.

Individual not in your tax family. An individual who can enroll in your employer coverage who is not a member of your tax family (for example, an adult non-dependent child under age 26) is considered eligible for the employer coverage for PTC purposes only

for the months the individual is enrolled in the employer coverage.

How to determine if the plan is affordable. Your employer coverage is generally considered affordable for you and for a family member if your share of the annual cost for self-only coverage, which is sometimes referred to as the "employee required contribution," is not more than 9.61% of your tax family's household income for 2022. For 2023, this threshold will decrease to 9.12%. Self-only coverage is used for this calculation even if you have a spouse or dependents and therefore would enroll in coverage that is not self-only coverage (for example, family coverage). However, employer-sponsored coverage is not considered affordable if, when you or a family member enrolled in a qualified health plan, you gave accurate information about the availability of employer coverage to the Marketplace, and the Marketplace determined

that you were eligible for APTC for the individual's coverage in the qualified health plan. See *Determining affordability at the time of enrollment*, later, for more information on this rule.

Certain employer arrangements. An employee's required contribution for employer-sponsored coverage may be affected by various arrangements offered by the employer.

Wellness program incentives. If the employer that offered you (or your spouse) employer-sponsored coverage for 2022 also offered a wellness incentive that potentially affected the amount that you had to pay toward coverage, the following rules apply: If the condition for satisfying the wellness incentive (in other words, the condition the employee must meet to pay the smaller amount for coverage) relates exclusively to tobacco use, your required contribution is based on the amount you would have paid for

coverage if you had satisfied the condition for the wellness incentive. Wellness incentives relating exclusively to tobacco use are treated as satisfied in determining your required contribution regardless of whether you would have actually earned the incentive had you enrolled in the coverage. If factors other than tobacco use are part of the condition for satisfying the wellness incentive, your required contribution is based on the amount you would have paid for coverage had you not satisfied the wellness incentive.

Example. George can enroll in employer coverage. George's monthly premiums for self-only coverage are $450. If George, who is a smoker, attends a smoking cessation class, his monthly premiums will be reduced by $100. If George completes a cholesterol screening, his monthly premiums will be reduced by $50. Whether or not George actually completes either of these wellness program incentives, for purposes of

determining whether the coverage is affordable for George, his required contribution will be considered to be the amount reduced by the $100 incentive for attending a smoking cessation class but not reduced by the $50 incentive for completing a cholesterol screening. Therefore, for purposes of determining whether his coverage is considered affordable, George's required contribution is $350.

Health reimbursement arrangements (HRAs). If the employer that offered you employer-sponsored coverage for 2022 also contributed (or offered to contribute) to an HRA that may be used to pay premiums for the employer-sponsored coverage, your required contribution for the employer-sponsored coverage is reduced by the amount the employer contributed (or offered to contribute) to the HRA for 2022, as long as you were informed of the HRA contribution offer by a reasonable time before you had to

decide whether to enroll in the coverage. Employers may offer you alternative or additional HRA coverage. See *Individual coverage HRAs* next.

Individual coverage HRAs. Starting in 2020, employers can offer individual coverage HRAs to help employees and their families with their medical expenses. Under an individual coverage HRA, employers can reimburse eligible employees for medical expenses, including premiums for Marketplace health insurance.

If you were covered under an individual coverage HRA for 2022, you are not allowed a PTC for your 2022 Marketplace health insurance. Also, if another member of your tax family was covered under an individual coverage HRA for 2022, you are not allowed a PTC for the family member's 2022 Marketplace health insurance. If you or a family member could have been covered by an individual coverage HRA for 2022, but you

opted out of receiving reimbursements under the individual coverage HRA, you may be allowed a PTC for your, and your family member's, Marketplace health insurance if the individual coverage HRA is considered unaffordable.

Qualified small employer health reimbursement arrangements (QSEHRAs). If your employer provided you with a QSEHRA, special rules apply. See *Qualified Small Employer Health Reimbursement Arrangement*, later, for more details.

Health flex contributions. If the employer that offered you (or your spouse) employer-sponsored coverage for 2022 also made (or offered to make) a health flex contribution for 2022, your required contribution for the employer-sponsored coverage is reduced by the amount of the health flex contribution (or offer). A health flex contribution is an employer contribution to a cafeteria plan that

may be used only to pay for medical care (and not taken as cash or other taxable benefits) and is available for use toward the purchase of MEC. Cafeteria plan contributions that may be used for expenses other than medical care are not health flex contributions and so do not reduce your required contribution.

Opt-out payments. If the employer that offered you (or your spouse) employer-sponsored coverage for 2022 offered you an additional payment if you declined to enroll in the coverage (an "opt-out payment"), your required contribution for employer-sponsored coverage is increased by amounts that the employer offered to pay you for declining the coverage. In some cases, an employer may make this opt-out payment only if the employee both declines the coverage and also satisfies another condition (such as enrolling in coverage offered by the employee's spouse). If your employer imposed other

conditions on receiving the opt-out payment (in addition to declining the employer's health coverage), you may treat the opt-out payment as increasing the employee's required contribution only if you can demonstrate that you met the conditions (such as enrolling in coverage offered by your spouse's employer).

More information about employer arrangements. You should contact your employer if you have questions about the effect of the employer arrangements described above on your required contribution.

If your employer or the employer of a family member offered MEC providing minimum value and provided you a Form 1095-C and the employer also offered a non-health flex contribution or an opt-out payment, the amount reported on line 15 of Form 1095-C may not accurately reflect the amount of your

required contribution for purposes of the PTC. If you have questions about the amount reported on line 15, contact your employer using the contact number provided on the Form 1095-C.

Determining affordability at the time of enrollment. Your employer coverage is not considered affordable if, when you enroll in a qualified health plan, the Marketplace determines that your required contribution for employer coverage will be more than 9.61% of what the Marketplace estimates will be your household income and therefore that you are eligible for APTC for coverage in the qualified health plan. Eligibility for employer coverage in this situation does not disqualify you from taking the PTC when you file your tax return, even if your required contribution for coverage was not more than 9.61% of the household income on your return. However, you will be treated as eligible for affordable

employer coverage based on the household income on your tax return if:

- You did not provide current information to the Marketplace relating to your household income and the required contribution for your employer coverage during each annual re-enrollment period, or
- You provided incorrect information to the Marketplace about your required contribution with intentional or reckless disregard for the facts.

You provide information with intentional disregard for the facts if you know that the information provided is inaccurate. You provide information with a reckless disregard for the facts if you make little or no effort to determine whether the information provided is accurate and your lack of effort to provide accurate information is substantially different from what a reasonable person would do under the circumstances.

The employer coverage offered by the various employers in the following examples qualifies as MEC.

Example 1. Celia is single and has no dependents. Her household income for 2022 was $47,000. Celia's employer offered its employees a health insurance plan that provided minimum value and for which the required contribution was $3,450 for self-only coverage for 2022 (7.34% of Celia's household income). Because Celia's required contribution for self-only coverage did not exceed 9.61% of household income, her employer's plan is considered affordable for Celia, and Celia is considered eligible for the employer coverage for all months in 2022. Celia cannot get the PTC for coverage in a qualified health plan.

Example 2. The facts are the same as in *Example 1*, except that Celia is married to Jon and the employer's plan required Celia to contribute $5,300 for coverage for Celia and

Jon for 2022 (11.28% of Celia's household income). Because Celia's required contribution for self-only coverage ($3,450) does not exceed 9.61% of household income, her employer's plan is considered affordable for Celia and Jon. Both Celia and Jon are considered eligible for the employer coverage for all months in 2022 and cannot get the PTC for coverage in a qualified health plan.

Example 3. Don was eligible to enroll in employer coverage in 2022. Don's required contribution for self-only coverage that provided minimum value was $3,700. Don applied for coverage in a qualified health plan through the Marketplace. The Marketplace projected that Don's 2022 household income would be $37,000 and determined that Don's employer coverage was unaffordable because Don's required contribution was more than 9.61% of Don's household income. Don enrolled in a qualified health plan through the Marketplace with APTC and not in the

employer coverage. In December, Don received an unexpected $2,500 bonus, which increased his 2022 household income to $39,500. Although Don's required contribution for the employer coverage was not more than 9.61% of the household income on Don's tax return, Don is considered not eligible for the employer coverage for 2022 because the Marketplace estimated that the employer coverage would cost more than 9.61% of Don's household income. Don can get the PTC if he otherwise qualifies.

Example 4. Hal was eligible for employer coverage for 2022. His required contribution for self-only coverage was $3,400, and Hal enrolled in the coverage. His household income for 2022 was $33,000, which means that his required contribution was more than 9.61% of his household income. Even though the employer coverage was not affordable, Hal cannot get the PTC for coverage in a

qualified health plan because he enrolled in the employer coverage.

Example 5. Elsa is married and has two dependent children. Her household income for 2022 was $39,000. Elsa's employer offered only self-only coverage to employees. No family coverage was offered. The plan had a required contribution of $3,000 for self-only coverage for 2022 (7.69% of Elsa's household income) and provided minimum value. Because Elsa's required contribution for self-only coverage was not more than 9.61% of household income, her employer's plan is considered affordable for Elsa. Thus, Elsa is considered eligible for the employer coverage for 2022 and cannot get the PTC for coverage in a qualified health plan. However, because Elsa's employer did not offer coverage to Elsa's spouse and children, Elsa could take the PTC for her spouse and two children if they enrolled in a qualified health plan and otherwise qualify.

Example 6. The facts are the same as in *Example 5*, except that Elsa's employer also offers coverage to Elsa's spouse and children. The premiums for family coverage cost $6,900 (17.69% of Elsa's household income). Because the required contribution for self-only coverage was not more than 9.61% of Elsa's household income, the employer coverage is considered affordable for Elsa and her family. Elsa cannot take the PTC for anyone in her family.

Determining affordability for part-year period. If you are employed for part of a year or employed by different employers during the year, you determine whether your coverage is affordable by looking separately at each coverage period that is less than a full calendar year. For each period, the coverage is affordable if your required contribution for the entire year would not be more than 9.61% of your household income for the year.

Example. Elvis was enrolled in a qualified health plan without APTC beginning in January 2022. He began working for a new employer in May that offers health insurance coverage with a calendar year plan year. Elvis' required contribution for the employer coverage for the remainder of the year was $200/month, which would be $2,400 for the full plan year. Elvis does not enroll in the employer coverage or inform the Marketplace of the offer of employer coverage. Elvis' household income for the year is $20,000. Elvis' employer coverage is considered unaffordable for the period May through December because his required contribution for the full plan year, $2,400, is more than 9.61% of his household income. As a result, Elvis could take the PTC for May through December if he otherwise qualifies.

Coverage year not a calendar year. If your employer's plan year is not the calendar year and you are a calendar year taxpayer, you

determine whether your coverage is affordable by looking separately at the portion of the calendar year in each plan year. A coverage period in 2022 that falls in a plan year beginning in 2021 is considered affordable if your required contribution for the entire plan year is not more than 9.61% of your household income for 2022. A coverage period in 2022 that falls in a plan year beginning in 2022 is considered affordable if your required contribution for the entire plan year is not more than 9.61% of your household income for 2022.

The employer coverage offered by the various employers in the following examples qualifies as MEC.

Example 1. Tim's employer offers health insurance coverage with a plan year of July 1 through June 30. His required contribution for the plan year that began on July 1, 2021, was $250 per month ($3,000 for the entire plan year). Tim enrolled in a qualified health plan

on January 1, 2022, and did not apply for APTC. Tim’s household income for 2022 is $30,000. Tim’s required contribution for the plan year, $3,000, is 10% of his household income for 2022. Because 10% is more than 9.61% (the required contribution percentage for the plan year beginning in 2021), Tim’s employer coverage for January 1, 2022, through June 30, 2022, is not considered affordable, and Tim can take the PTC for those months if he is otherwise eligible.

For the plan year that began on July 1, 2022, Tim’s required contribution was reduced to $200 per month (or $2,400 for the entire plan year). Tim’s required contribution of $2,400 is 8% of his 2022 household income. Because 8% is not more than 9.61% (the required contribution percentage for the plan year beginning in 2022), Tim’s employer coverage for July 1, 2022, through December 31, 2022, is considered affordable and he is not eligible for the PTC for those months.

Example 2. Maria's employer offers health insurance coverage with a plan year of September 1 through August 31. Maria's required contribution for the employer coverage for the plan year September 1, 2022, through August 31, 2023, is $3,700. Maria's household income for 2022 is $37,000. Maria's employer coverage is considered unaffordable for the period September 1 through December 31, 2022, because her required contribution for the plan year, $3,700, is more than 9.61% of her 2022 household income. If Maria enrolls in a qualified health plan for 2023 and requests APTC, the Marketplace will determine whether the employer coverage is considered affordable for the period January 1, 2023, through August 31, 2023, by comparing Maria's required contribution for the plan year beginning in 2022, $3,700, to her estimated 2023 household income.

How to determine if a plan provides minimum value. An employer-sponsored plan provides minimum value only if the plan pays at least 60% of the total allowed costs of benefits for a standard population and provides substantial coverage of inpatient hospitalization services and physician services. A plan meets the 60% rule only if an employee's expected cost-sharing (deductibles, co-pays, and co-insurance) under the plan is no more than 40% of the cost of the benefits. This percentage is based on actuarial principles using benefits provided to a standard population and is not based on what you actually pay for cost sharing.

Your employer must provide you with a summary of benefits and coverage (SBC) on or before the first day of the open enrollment period for the plan you are enrolled in for the current coverage period. The employer must also provide you with SBCs you request for other plans in which you can enroll. If you are

not enrolled in a plan, the employer must provide you with the SBCs for all plans in which you can enroll. The SBC will tell you whether an employer-sponsored plan provides minimum value. If your employer sent you a Form 1095-C, line 14 of that form will include an indicator code telling you if your employer offered you a health plan in the previous year that provided minimum value.

Qualified Small Employer Health Reimbursement Arrangement (QSEHRA)

Under a QSEHRA, an eligible employer can reimburse eligible employees for medical expenses, including premiums for a qualified health plan purchased through the Marketplace. An eligible employer is one that, in general, employs fewer than 50 full-time employees and does not offer a group health plan.

A QSEHRA is an arrangement that meets all the following requirements.

1. The arrangement is funded solely by the employer, and no salary reduction contributions may be made under the arrangement.
2. The arrangement provides, after the eligible employee provides proof of coverage, for the payment or reimbursement of the medical expenses incurred by the employee or the employee's family members.
3. The amount of payments and reimbursements doesn’t exceed $5,450 ($11,050 for family coverage) for 2022.
4. The arrangement is generally provided on the same terms to all eligible employees. However, the employer's QSEHRA may exclude employees who haven't completed 90 days of service,

employees who haven't attained age 25 before the beginning of the plan year, part-time or seasonal employees, employees covered by a collective bargaining agreement if health benefits were the subject of good-faith bargaining, and employees who are nonresident aliens with no earned income from sources within the United States.

If you are provided a QSEHRA, and it is considered affordable coverage for a month, no PTC is allowed for that month. If the QSEHRA is not considered affordable coverage for 1 or more months, you may still be eligible for the PTC. If you are eligible for the PTC for any month for which you are provided a QSEHRA, you must reduce your PTC (but not below -0-) for that month by the monthly QSEHRA permitted benefit amount. The monthly permitted benefit amount is the maximum QSEHRA benefit amount an eligible

employee is allowed per month. See *Permitted benefit reported on Form W-2*, later, and Worksheet Q for more information.

Written notice of QSEHRA. If you were provided a QSEHRA during 2022, your employer should have provided written notice to you by the later of October 3, 2021, or 90 days before the first day of the plan year of the QSEHRA, or if you're an employee who is not eligible to participate at the beginning of the year, the date on which you're first eligible to participate in the QSEHRA. The information in this notice is necessary to determine how the QSEHRA affects your PTC. The permitted benefit for **self-only** coverage as reported by the employer in the written notice is used to determine whether the QSEHRA is considered affordable coverage, regardless of whether the permitted benefit provided to you is for self-only or family coverage. If the notice provided to you does not include a permitted benefit amount for

self-only coverage, you must contact your employer to get that information. Use Worksheet N to determine whether your QSEHRA is considered affordable coverage for the months of the year that you were provided the QSEHRA. You will need the notice provided by your employer and the permitted benefit for self-only coverage to complete Worksheet N.

Permitted benefit reported on Form W-2. Your employer should have reported your annual permitted benefit (self-only or family amount, as applicable) in box 12 of your Form W-2 with code FF. Your permitted benefit amount, as reported to you by your employer on Form W-2, is used to calculate the amount by which you must reduce your PTC, if you are otherwise eligible for the PTC. Use Worksheet Q to figure your monthly PTC for months in which you were provided a QSEHRA.

APTC for 2022 and 2023. If APTC was paid for your 2022 Marketplace coverage, your QSEHRA permitted benefit for 2022 was not considered by the Marketplace in calculating the amount of your 2022 APTC. Furthermore, if you requested APTC for your 2023 Marketplace coverage, the Marketplace did not consider your 2023 permitted benefit in calculating the amount of your 2023 APTC. If you are provided a QSEHRA for 2023, you

should contact the Marketplace and ask the Marketplace to reduce the amount of APTC to be paid on your behalf for 2023 to limit the risk of having excess APTC for 2023.

Worksheet N. **Worksheet To Determine if the QSEHRA Is Considered Affordable**

Keep for Your Records

Note. See *Special instructions for Worksheet N* if your SLCSP premium was not the same for all months of 2022 or you changed employers during 2022.

1.	Enter the amount from Form 8962, line 3	**1.**
2.	Multiply line 1 by 0.0961	**2.**
3.	Enter the number of months you were provided the QSEHRA in 2022	**3.**
4.	Divide line 2 by 12.0	**4.**
5.	If you enrolled in a qualified health plan, enter the monthly premium you would pay for self-only coverage under the second lowest cost silver plan (SLCSP) offered by the Marketplace where you enrolled in coverage. If you did not enroll in a qualified health plan, enter the monthly premium that the oldest member of your coverage family who is enrolled in a qualified health plan would pay for self-only coverage under the SLCSP offered by the Marketplace where that family member enrolled. See *Applicable SLCSP premium tools*, later, to learn how to retrieve the applicable SLCSP premium	**5.**
6.	Enter the self-only coverage permitted benefit from the written notice provided by your employer. If you were provided the QSEHRA for less than 12 months in 2022, see *Part-year coverage*, later, for what amount to enter on line 6	**6.**
7.	Divide line 6 by line 3	**7.**
8.	Subtract line 7 from line 5	**8.**
9.	Compare lines 4 and 8. • If line 4 is less than line 8, the QSEHRA is not considered affordable. Stop here. Complete Worksheet Q. • If line 4 is greater than or equal to line 8, the QSEHRA is considered affordable. Skip Worksheet Q. Stop here and do not file Form 8962 if you were provided a QSEHRA for every month you were covered by a qualified health plan and no APTC was paid for you or another individual in your tax family. Otherwise, enter "QSEHRA" in the top margin of Form 8962. If you are completing Form 8962, lines 12 through 23, stop here and enter -0- on lines 12 through 23, column (e), for each month you were provided the QSEHRA. If you are completing Form 8962, line 11, and you were provided the QSEHRA for all of 2022, stop here and enter -0- on line 11, column (e). If you were not provided the QSEHRA for all of 2022, complete lines 10 through 13 below.	
10.	Enter the smaller of Form 8962, line 11, column (a) or (d)	**10.**
11.	Divide line 10 by 12.0	**11.**
12.	Multiply line 11 by line 3	**12.**
13.	Subtract line 12 from line 10. Enter the result here and on Form 8962, line 11, column (e)	**13.**

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