USPS User Group Meeting
December 14, 2015
2:00 PM
Room 1-100 Travis Bldg.

Agenda

2:00 p.m.	**Welcome and Introductions, Sona Holmstrom, CPA**
2:10 p.m.	**Commuter Spending Account, Lisa Haralson, CPA**
2:45 p.m.	**Changes to 401k/457, Lisa Haralson, CPA**
3:00 p.m.	**Information about 1095-C Reporting by CPA, Vicki Smith, CPA**
3:30 p.m.	**Other Announcements, Lisa Haralson and Vicki Smith**
3:45 p.m.	**Questions**
4:00 p.m.	**Adjourn**

ACR#60076 Commuter Spending Account

New Screen

```
> GD    XXX,XXXXXXXXX                                                    ON HODCS

                 ---------COMMUTER SPENDING ACCOUNT DEDUCTION---------

   AGENCY---> 00XXX          EMPLOYEE SSN-------> 00XXXXXXXXX
   NAME-> EMPLOYEE A

   DED   SEQ   DED        DED BEGIN   DED END
   NO    NUM   NAME       DATE        DATE         AMOUNT  FREQ     IND

__ 071   000   CSA TRN    03/01/2016  03/31/2016     15.00  01        _
__ 072   000   CSA PRK    03/01/2016  03/31/2016     10.00  01        P
__ 072   001   CSA PRK    02/01/2016  02/29/2016      5.00  00        +
__ 000                    00/00/0000  00/00/0000       .00  __        _
__ 000                    00/00/0000  00/00/0000       .00  __        _
__ 000                    00/00/0000  00/00/0000       .00  __        _
```

Help behind the IND Field:

```
DISPLAYS THE TYPE OF DEDUCTION TRANSACTION PROCESSED FROM ERS. (KEY)

BLANK – REGULAR DEDUCTION TRANSACTION HAS NOT BEEN APPLIED TO H0Z
P – REGULAR DEDUCTION TRANSCATION THAT HAS BEEN APPLIED TO H0Z
+ – POSITIVE ADJUSTMENT TRANSACTION (AGENCY MUST DO MANUALLY USING HUDU1/HUEU1)
- - NEGATIVE ADJUSTMENT TRANSACTION (AGENCY MUST DO MANUALLY USING HUDU1/HUEU1)
```

Notes:

Deduction #71 CSA Transit (TRN)
Deduction #72 CSA Parking (PRK)
All or nothing for deduction.
$130 Max deduction for Transit
$250 Max deduction for Parking
Vendor number is 33273273277-038
New file each month even if no changes are made.

UPDATED REPORT

```
REPORT:   572                          UNIFORM STATEWIDE PAYROLL/PERSONNEL SYSTEM                          PAGE:     1
AGENCY:   XXX                               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          RUN DATE: XX/XX/XXXX
                                          DAILY INSURANCE ADJUSTMENTS REPORTS                          RUN TIME: 19:15:59
                                                   AS OF XX/XX/XXXX

                                              TRAN      ADJUST   ADJUST   COVERAGE     STATE    EMPLOYEE
 SSN          NAME                            DATE      MONTH     YEAR      CODE     CONTRIB    COST
 -----------  ---------------------------     ----      ------    ----    --------   -------    --------

 XXXXXXXXX    XXXXXXX, XXXXXXX X            XX/XX/XXXX     09      20XX       DT         0.00       6.72
                                            XX/XX/XXXX     01      20XX       HL       313.33       0.00
                                            XX/XX/XXXX     02      20XX       HL       313.33       0.00

                                                     AS OF XX/XX/XXXX

                                            PAY PERIOD                        DED       ADJUST
 SSN          NAME                          END DATE                          NUM       AMOUNT
 -----------  -----------------------------  ----------                        ----     --------
 XXXXXXXXX    XXXXXXX, XXXXXXXXXXXXXX X      XX/XX/XXXX                        071        50.00+
 XXXXXXXXX    XXXXX, XXXXXXXXXXX X           XX/XX/XXXX                        072        25.00-
 XXXXXXXXX    XXXXXXX, XXXX X                XX/XX/XXXX                        071        75.00+
```

NEW REPORT

```
REPORT:   957                          UNIFORM STATEWIDE PAYROLL/PERSONNEL SYSTEM                          PAGE:     1
AGENCY:   XXX                               XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                          RUN DATE: XX/XX/XXXX
                                         COMMUTER SPENDING ACCOUNT UPDATES                             RUN TIME: 19:15:59
                                                      XX/XX/XXXX


                                                                        PAY PERIOD      PARKING      TRANSIT
 SSN              ERS EMP ID         NAME                               END DATE        AMOUNT       AMOUNT
 -----------      -----------        -----------------------------     ----------      --------     -------
 XXXXXXXXX        XXXXXXXXXXX        XXXXXXXXXXX, XXXX X              XX/XX/XXXX                    100.00
 XXXXXXXXX        XXXXXXXXXXX        XXXXXXX, XXXXXXXXXXX X           XX/XX/XXXX       25.00         75.00
 XXXXXXXXX        XXXXXXXXXXX        XXXX, XXXX X                     XX/XX/XXXX      250.00
 XXXXXXXXX        XXXXXXXXXXX        XXXXXXX, XXXXXXX X               XX/XX/XXXX       50.00        130.00
```

UPDATED REPORT

```
 REPORT:   959                              STATEWIDE PAYROLL/PERSONNEL SYSTEM                      PAGE:     1
 AGENCY:   XXX                                XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX                   RUN DATE: XX/XX/XXXX
                                              BENEFIT TOTALS REPORTED TO ERS                   RUN TIME: 22:38:06
                                                  DOCUMENT:   XXXXXXXX

TOTAL RECORDS         :         4,283

PENSIONABLE EARNINGS  : 16,988,693.94   EMPLOYEE INSURANCE    :    674,078.62   401K CONTRIBUTIONS       :  320,188.02
PRETAX EMPLOYEE RET   :  1,084,904.90   DENTAL DISCOUNT PROG  :          0.00   ROTH 401K CONTRIBUTIONS  :   15,200.60
POSTTAX EMPLOYEE RET  :          0.00   TOBACCO USER PREMIUM  :     33,690.00   401K LOAN DEDUCTIONS     :  137,862.00
EMPLOYEE LECOS CONT   :          0.00   OPT OUT CREDIT        :      1,680.00   457 CONTRIBUTIONS        :   82,549.00
EMPLOYER RET CONT     :  1,161,007.77   STATE INS CONTR       :  2,052,832.30   ROTH 457 CONTRIBUTIONS   :   11,502.00
PAYROLL RET CONT      :          0.00   PAYROLL HLTH INS CON  :    144,893.93   457 LOAN DEDUCTIONS      :  125,230.00
EMPLOYER LECOS CONTR  :          0.00   SKIP CONTRIBUTIONS    :          0.00
EMPLOYEE RET FEES     :          0.00   FLEX DEDUCTIONS       :    210,358.00
EMPLOYER RET FEES     :          0.00   FLEX DEDUCTION FEES   :          0.00
```

ACR#60015 Deferred Compensation Changes

BEFORE – HN1U1

```
> GU    ____________________________________________________________ ON HN1U1

            ---------TEXA$AVER (401K) CONTRIBUTION SCREEN----------

__ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
   NAME->
   PLAN ID-->  401                             CURR POS-> 00000000
   VENDOR ID--> 8888    VENDOR NAME-->


   PERCENT-->    .00             START DT-> 00/00/0000  STOP DT-> 00/00/0000

   DED FREQ---> 00
   CHANGE REASON IND-----> __              REVIEW HISTORY--------> _
   TOTAL DEDUCTIONS YTD-->      .00        MAX ANNUAL DEDUCTION-->      .00
```

AFTER – HN1U1

```
> GU    ____________________________________________________________ ON HN1U1

            ---------TEXA$AVER (401K) CONTRIBUTION SCREEN----------

__ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
   NAME->
   PLAN ID-->  401                             CURR POS-> 00000000
   VENDOR ID--> 8888    VENDOR NAME-->


   CHANGE REASON IND-----> __              REVIEW HISTORY--------> _
   TOTAL DEDUCTIONS YTD-->      .00        MAX ANNUAL DEDUCTION-->      .00
```

BEFORE – HN1R1

```
> GU    ____________________________________________________________ ON HN1R1

            ------TEXA$AVER (ROTH 401K) CONTRIBUTION SCREEN--------

 __ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
    NAME->
    PLAN ID-->  401                             CURR POS-> 00000000
    VENDOR ID--> 8888    VENDOR NAME--> WELLS FARGO BANK


    PERCENT-->    .00             START DT-> 00/00/0000  STOP DT-> 00/00/0000

    DED FREQ---> 00                        REVIEW HISTORY--------> _
    CHANGE REASON IND-----> __             TOTAL DEDUCTIONS YTD-->      .00

    MAXIMUM ANNUAL 401K/ROTH 401K/403B DEDUCT AMOUNT-------------->      .00
```

AFTER – HN1R1

```
> GU    ____________________________________________________________ ON HN1R1

            ------TEXA$AVER (ROTH 401K) CONTRIBUTION SCREEN--------

__ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
   NAME->
   PLAN ID-->  401                             CURR POS-> 00000000
   VENDOR ID--> 8888    VENDOR NAME--> WELLS FARGO BANK

   [redacted]

   [redacted]

   CHANGE REASON IND-----> __             REVIEW HISTORY--------> _
   TOTAL DEDUCTIONS YTD-->      .00       [redacted]      .00
```

BEFORE – HN1UA

```
> GU    ____________________________________________________________ ON HN1UA

           ------------403B/457 CONTRIBUTION SCREEN--------------

__ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
   NAME->
   PLAN ID--> ___                              CURR POS-> 00000000
   VENDOR ID--> ____    VENDOR NAME-->

   START DATE-> 00/00/0000   STOP DATE-> 00/00/0000   DED FREQ--> 00

   PROD   AMOUNT             PROD    AMOUNT            PROD     AMOUNT
   FA        .00             MF         .00            SC          .00
   SA        .00             CD         .00            GFA         .00
   VA        .00             MM         .00            WL          .00
   GVA       .00             TL         .00


   CHANGE REASON IND-----> __              REVIEW HISTORY--------> _
   TOTAL DEDUCTIONS YTD-->      .00        MAX ANNUAL DEDUCTION-->      .00
   CATCH-UP YEAR---------> _______________ ANNUAL CATCH-UP AMOUNT>      .00
```

AFTER – HN1UA

```
> GU    ____________________________________________________________ ON HN1UA

           ------------403B/457 CONTRIBUTION SCREEN--------------

__ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
   NAME->
   PLAN ID--> ___                              CURR POS-> 00000000
   VENDOR ID--> ____    VENDOR NAME-->

   START DATE--> 00/00/0000  STOP DATE-> 00/00/0000   DED FREQ--> 00


   PROD   AMOUNT             PROD    AMOUNT            PROD     AMOUNT
   FA        .00             MF         .00            SC          .00
   SA        .00             CD         .00            GFA         .00
   VA        .00             MM         .00            WL          .00
   GVA       .00             TL         .00

   CHANGE REASON IND-----> __              REVIEW HISTORY--------> _
   TOTAL DEDUCTIONS YTD-->      .00        MAX ANNUAL DEDUCTION-->      .00
   CATCH-UP YEAR---------> _______________ ANNUAL CATCH-UP AMOUNT>      .00
```

BEFORE – HN1R7

```
> GU    ____________________________________________________________ ON HN1R7

           ------------ROTH 457 CONTRIBUTION SCREEN--------------

__ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
   NAME->
   PLAN ID--> 457                              CURR POS-> 00000000
   VENDOR ID--> 9999    VENDOR NAME--> WELLS FARGO BANK

   DED AMOUNT-->      .00  START DATE-> 00/00/0000  STOP DATE-> 00/00/0000
   DED FREQ--> 00

   CHANGE REASON IND-----> __
   REVIEW HISTORY--------> _               TOTAL DEDUCTIONS YTD-->      .00

   MAXIMUM ANNUAL 457/ROTH 457 DEDUCT AMOUNT--------------------->      .00

   CATCH-UP YEAR---------> ______________  ANNUAL CATCH-UP AMOUNT>      .00
```

AFTER – HN1R7

```
> GU    ____________________________________________________________ ON HN1R7
                                                     LEVEL 01 LINK FROM TERBR
           ------------ROTH 457 CONTRIBUTION SCREEN--------------

__ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
   NAME->
   PLAN ID--> 457                              CURR POS-> 00000000
   VENDOR ID--> 9999    VENDOR NAME--> WELLS FARGO BANK

   CHANGE REASON IND-----> __

   CATCH-UP YEAR---------> ______________ ANNUAL CATCH-UP AMOUNT>      .00
```

BEFORE – HN1LN (Revised layout only)

```
> GU    ____________________________________________________________ ON HN1LN

            ---------LOAN REPAY (401K) CONTRIBUTION SCREEN----------

__ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
   NAME->
   PLAN ID-->  401                             CURR POS-> 00000000
   VENDOR ID--> 8888    VENDOR NAME-->


   MTHLY LOAN REPAY-->      .00  START DT-> 00/00/0000  STOP DT-> 00/00/0000
   DED FREQ----> 00


   TOTAL DEDUCTIONS YTD-->       .00       REVIEW HISTORY--------> _
```

AFTER – HN1LN (Revised layout only)

```
> GU    ____________________________________________________________ ON HN1LN

            ---------LOAN REPAY (401K) CONTRIBUTION SCREEN----------

__ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
   NAME->
   PLAN ID-->  401                             CURR POS-> 00000000
   VENDOR ID--> 8888    VENDOR NAME-->

   START DATE-> 00/00/0000   STOP DATE-> 00/00/0000   DED FREQ--> 00

   MTHLY LOAN REPAY-->      .00

                                          REVIEW HISTORY--------> _
   TOTAL DEDUCTIONS YTD-->       .00
```

BEFORE – HN1LO (Revised layout only)

```
> GU    ____________________________________________________________ ON HN1LO

            ---------LOAN REPAY (457) CONTRIBUTION  SCREEN----------

__ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
   NAME->
   PLAN ID-->  457                             CURR POS-> 00000000
   VENDOR ID--> 9999    VENDOR NAME-->


   MTHLY LOAN REPAY-->      .00  START DT-> 00/00/0000  STOP DT-> 00/00/0000
   DED FREQ----> 00


   TOTAL DEDUCTIONS YTD-->       .00       REVIEW HISTORY--------> _
```

AFTER – HN1LO (Revised layout only)

```
> GU    ____________________________________________________________ ON HN1LO

            ---------LOAN REPAY (457) CONTRIBUTION  SCREEN----------

__ AGENCY ----> 00000   EMP SSN-> 00000000000  CURR ORG-> 00000000000
   NAME->
   PLAN ID-->  457                             CURR POS-> 00000000
   VENDOR ID--> 9999    VENDOR NAME-->

   START DATE-> 00/00/0000   STOP DATE-> 00/00/0000   DED FREQ--> 00

   MTHLY LOAN REPAY-->      .00

                                          REVIEW HISTORY--------> _
   TOTAL DEDUCTIONS YTD-->       .00
```

REPORT: 978 UNIFORM STATEWIDE PAYROLL/PERSONNEL SYSTEM PAGE: 1
AGENCY: XXX XXXXXXXXXXXXXXXXXXXXXXXXXXXXX RUN DATE: XX/XX/2016
ERS TRANSMITTED DCP ELECTION CHANGES--SUCCESSFUL UPDATES RUN TIME: 12:26:42
FOR THE MONTH OF FEBURARY 2016

ORG CODE	EMPLOYEE NAME	FRQ	SSN	TYPE	ACTION	SCREEN	AMOUNT	PERCENT	C/U IND	START DT	END DT
00000000001	EMPLOYEE A	M	XXXXXXXXX	401	INSERTED	HN1U1	3096.55			02/01/2016	
00000000001	EMPLOYEE B	M	XXXXXXXXX	401	INSERTED	HN1U1		1.00		02/01/2016	
00000000001	EMPLOYEE C	M	XXXXXXXXX	401R	INSERTED	HN1R1	500.00			02/01/2016	
00000000001	EMPLOYEE D	M	XXXXXXXXX	401R	INSERTED	HN1R1		2.00		02/01/2016	
00000000001	EMPLOYEE E	M	XXXXXXXXX	457	INSERTED	HN1UA		80.00	N	02/01/2016	
00000000001	EMPLOYEE F	M	XXXXXXXXX	457	INSERTED	HN1UA	400.00		N	02/01/2016	
00000000001	EMPLOYEE G	M	XXXXXXXXX	457R	INSERTED	HN1R7		3.00	N	02/01/2016	
00000000001	EMPLOYEE H	M	XXXXXXXXX	457R	REPLACED	HN1R7	0.00		N		01/31/2016

TOTAL RECORDS UPDATED FOR AGENCY: 8
TOTAL RECORDS FOR AGENCY: 8

ONE FINE AGENCY
RM 222
123 SESAME STREET
AUSTIN TX 78787

21400000000
MARE E. CHRISTMAS

111 ELF STREET
AUSTIN TX 78732

123-00001

Form **1095-C** Department of the Treasury Internal Revenue Service

Employer Provided Health Insurance Offer and Coverage

Information about Form 1095-C and its separate instructions is at www.irs.gov/form/1095c

☐ VOID ☐ CORRECTED

OMB No. 1545-2251

2015

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and contact telephone no.

ONE FINE AGENCY
RM 222
123 SESAME STREET
AUSTIN TX 78787
512-555-1212 123

Part I Employee

EMPLOYEE'S name, address, ZIP/postal code & country

21400000000
MARE E. CHRISTMAS

111 ELF STREET
AUSTIN TX 78732

APPLICABLE LARGE EMPLOYER'S identification number (EIN)	EMPLOYEE'S social security number (SSN)
74-6000144	XXX-XX-4705

Part II Employee Offer and Coverage

Plan Start Month (enter 2-digit number)	14 Offer of coverage (enter required code)	15 Employee Share of Lowest Cost Monthly Premium, for Self-Only Minimum Value Coverage	16 Applicable Section 4980H Safe Harbor (enter code, if applicable)
09			
All 12 Months		$	
January	1H	$	2D
February	1H	$	2D
March	1H	$	2D
April	1E	$ 0.00	2C
May	1E	$ 0.00	2C
June	1E	$ 0.00	2C
July	1E	$ 0.00	2C
August	1H	$	2A
September	1H	$	2A
October	1H	$	2A
Novenber	1H	$	2A
December	1H	$	2A

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each covered individual. ☐

	(a) Name of covered individual(s)	(b) SSN	(c) DOB (if SSN is not available)	(d) Covered all 12 months	(e) Months of Coverage Jan.	Feb.	Mar.	Apr.	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
17				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
18				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
19				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
20				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
21				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
22				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
23				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
24				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
25				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
26				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
27				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
28				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
29				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
30				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
31				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
32				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
33				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
34				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

For Privacy Act and Paperwork Reduction Act Notice, see instructions on back.

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provision in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. For more information about the premium tax credit, see Pub. 974, Premium Tax Credit (PTC). You may receive multiple Forms 1095-C if you had multiple employers during the year that were Applicable Large Employers (for example, you left employment with one Applicable Large Employer and began a new position of employment with another Applicable Large Employer). In that situation, each Form 1095-C would have information only about the health insurance coverage offered to you by the employer identified on the form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing information about the health coverage it offered.

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III provides information to assist you in completing your income tax return by showing you or those family members had qualifying health coverage (referred to as "minimum essential coverage") for some or all months during the year.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, the issuer of the insurance or the sponsor of the plan providing the coverage will furnish you information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, the provider of that coverage will furnish you information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.

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

Part I.
Applicable Large Employer Member (Employer)
Reports information about your employer and includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.
Employee
Reports information about you, the employee, and includes your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the issuer is required to report your complete SSN to the IRS.

Caution: *If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN.*

Part II. Employer Offer and Coverage, Lines 14-16
Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
1A. Minimum essential coverage providing minimum value offered to you with an employee contribution for self-only coverage equal to or less than 9.5% of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year.
1B. Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
1C. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
1D. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
1E. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
1F. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
1G. You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box on line 14.
1H. No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
1I. Your employer claimed "Qualifying Offer Transition Relief" for 2015 and for at least one month of the year you (and your spouse or dependent(s)) did not receive a Qualifying Offer. Note that your employer has also provided a contact number at which you may request further information about the health coverage, if any, you were offered (see line 10).
Line 15. This line reports the employee share of the lowest-cost monthly premium for self-only minimum essential coverage providing minimum value that your employer offered you. The amount reported on line 15 may not be the amount you paid for coverage if, for example, you chose to enroll in more expensive coverage such as family coverage. Line 15 will show an amount only if code 1B, 1C, 1D, or 1E is entered on line 14. If you were offered coverage but not required to contribute any amount towards the premium, this line will report a 0.00 for the amount.
Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, see IRS.gov.

Part III. Covered Individuals, Lines 17-22
Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, see the additional covered individuals on Part III, Continuation Sheet(s).