

APPLICABLE LARGE EMPLOYER'S name, street address, city or town, state or province, country, ZIP or foreign postal code, and telephone no. <b>AMENSYS INC</b> <b>860 HEBRON PARKWAY, SUITE 604</b> <b>LEWISVILLE, TX 75057</b> <b>(972) 801-9970</b>		<b>Employee Offer of Coverage</b>				<b>Employer Provided Health Insurance Offer and Coverage</b>  <b>For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.</b>  Department of the Treasury -- IRS
03102 MUSP 00022  EMPLOYEE'S name, address, ZIP/postal code & country <b>PRABHU MUSKEM</b> <b>2250 MARSH LN APT 1112</b> <b>CARROLLTON, TX 75006-7500</b>	<b>Plan Start Month</b> (Enter 2-digit no.):	<b>14 Offer of Coverage</b> (enter required code)	<b>15 Employee Required Contribution</b> (see instructions)	<b>16 Section 4980H Safe Harbor and Other Relief</b> (enter code, if applicable)		
	All 12 Months		\$			
	Jan	1H	\$			
	Feb	1H	\$			
	Mar	1H	\$			
	Apr	1H	\$			
	May	1E	\$	347.00	2H	
	Jun	1E	\$	347.00	2H	
	Jul	1E	\$	347.00	2H	
	Aug	1E	\$	347.00	2H	
	Sep	1E	\$	347.00	2H	
	Oct	1E	\$	347.00	2H	
	Nov	1E	\$	347.00	2H	
Dec	1E	\$	347.00	2H		

**Covered Individuals** If Employer provided self-insured coverage, check the box and enter information for each individual enrolled in coverage, including the employee.

(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 mos.	(e) Months of coverage															
				Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec				
17																			
18																			
19																			
20																			
21																			
22																			

CAA 7 B1095CI NTF 2581494 B95CHPREC

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, Employee Offer of Coverage section, 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 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 health insurance coverage offered to you by employer identified on form. If your employer is not an Applicable Large Employer it is not required to furnish you a Form 1095-C providing info. about 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 & that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Covered Individuals section 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, issuer of the insurance or 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 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 the Covered Individuals section if they request it for their records.

**Additional Information.** For additional information about the tax provisions of the Affordable Care Act (ACA), including the individual shared responsibility provisions, the premium tax credit, and the employer shared responsibility provisions, see www.irs.gov/Affordable-Care-Act/Individuals-and-Families or call the IRS Healthcare Hotline for ACA questions (1-800-919-0452).

**Employee** Reports information about you, the employee. Reports your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.

**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 the Employee's section, a Taxpayer Identification Number (TIN) may be provided instead of SSN. See the Covered Individuals section.

**Applicable Large Employer** Reports information about your employer. This 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 Offer of 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 required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.

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

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

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

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

**1F.** Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).

**1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the All 12 Months box or in the separate monthly boxes for all 12 calendar months on line 14.

**1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).

**1I.** Reserved.

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

**1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).

**Line 15.** Reports employee required contribution, which is monthly cost to you for lowest-cost 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 amt. only if code 1B, 1C, 1D, 1E, 1J, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for coverage, this line will report a "0.00" for amt. For more information, including on how your eligibility for other healthcare arrangements might affect amt. reported on line 15, see IRS.gov.

**Line 16.** Provides 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.

**Covered Individuals, Lines 17-22** Reports name, SSN (or TIN for covered individuals other than the listed employee), and coverage info. about each individual (including any full-time employee & non-full-time employee, & any employee's family members) covered under employer's health plan, if plan is "self-insured." A date of birth will be entered in column (c) only if SSN (or TIN for covered individuals other than listed employee) is not entered in column (b). Column (d) will be checked if individual was covered for at least 1 day in every month of the year. For individuals who were covered for some but not all months, info. will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 6 covered individuals, you will receive one or more additional form(s).