HEALTH & WELFARE PLAN LUNCH GROUP

October 2, 2014

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This is an early release draft of an IRS tax form, instructions, or publication, which the IRS is providing for your information as a courtesy. **Do not file draft forms.** Also, do not rely on draft instructions and publications for filing. We generally do not release drafts of forms until we believe we have incorporated all changes. However, unexpected issues sometimes arise, or legislation is passed, necessitating a change to a draft form. In addition, forms generally are subject to OMB approval before they can be officially released. Drafts of instructions and publications usually have at least some changes before being officially released.

Early releases of draft forms and instructions are at IRS.gov/draftforms. Please note that drafts may remain on IRS.gov even after the final release is posted at IRS.gov/downloadforms, and thus may not be removed until there is a new draft for the subsequent revision. All information about all revisions of all forms, instructions, and publications is at IRS.gov/formspubs.

Almost every form and publication also has its own easily accessible information page on IRS.gov. For example, the Form 1040 page is at IRS.gov/form1040; the Form W-2 page is at IRS.gov/w2; the Publication 17 page is at IRS.gov/pub17; the Form W-4 page is at IRS.gov/w4; the Form 8863 page is at IRS.gov/form8863; and the Schedule A (Form 1040) page is at IRS.gov/schedulea. If typing in the links above instead of clicking on them: type the link into the address bar of your browser, not in a Search box; the text after the slash must be lowercase; and your browser may require the link to begin with “www.”. Note that these are shortcut links that will automatically go to the actual link for the page.

If you wish, you can submit comments about draft or final forms, instructions, or publications on the Comment on Tax Forms and Publications page on IRS.gov. We cannot respond to all comments due to the high volume we receive, but we will carefully consider each one. Please note that we may not be able to consider many suggestions until the subsequent revision of the product.

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/f1095c.***

☐ VOID
☐ CORRECTED

600115

OMB No. 1545-2251

2014

Part I Employee

1 Name of employee	2 Social security number (SSN)
3 Street address (including apartment no.)	
4 City or town	5 State or province / 6 Country and ZIP or foreign postal code

Applicable Large Employer Member (Employer)

7 Name of employer	8 Employer identification number (EIN)
9 Street address (including room or suite no.)	10 Contact telephone number
11 City or town	12 State or province / 13 Country and ZIP or foreign postal code

Part II Employee Offer and Coverage

	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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)													

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				☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Instructions for Recipient

This Form 1095-C includes information about the health 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).

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 needed to report on your income tax return that 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. 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.

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. Employee

Lines 1–6. Part I, lines 1–6, reports information about you, the employee.

Line 2. This is 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.

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.

Part I. Applicable Large Employer Member (Employer)

Lines 7–13. Part I, lines 7–13, reports information about your employer.

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form.

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. This information relates to your or your spouse's and dependents' eligibility for coverage subsidized by the premium tax credit. 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 $1,108.65 (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. Line 15 will show an amount only if the minimum essential coverage your employer offered provided minimum value. Also, line 15 will be blank if code 1A or code 1I is reported on line 14.

Line 16. This line provides the IRS information to administer the employer shared responsibility provisions. 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, social security number, 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 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, you will receive one or more additional Forms 1095-C that continue Part III.

MEMORANDUM

TO: Health & Welfare Lunch Group

FROM: Alston & Bird

DATE: October 2, 2014

RE: **1095-C (Combined Reporting)**

A. ***How triggered?*** An employee of an applicable large employer member ("ALE Member") qualifies as a full-time employee for at least 1 month during the calendar year. This includes months during which the employee had the requisite hours of service to qualify as a full-time employee but who was in a limited non-assessment period. NOTE: Part III of the form is also used to identify employees (and family members) covered by the ALE Member under a self-insured plan that qualifies as minimum essential coverage, even if the employee never qualifies as a full-time employee (see the "1G" indicator code associated with Line 14).

Practice Pointer: It is still not clear whether an ALE Member would use 1095-C to report actual coverage for former employees, such as retirees and qualified beneficiaries receiving COBRA. The instructions do clarify that an ALE Member would NOT use 1095-C to report coverage for independent contractors and other self-employed individuals covered under the plan (e.g. non-employee Board of Directors); the employer would use 1095-B to report coverage for such individuals and their covered family members.

B. ***Who files?*** Each ALE Member. A third party may file the form on behalf of the ALE Member but the ALE Member remains responsible.

C. ***When due?*** Provided to affected employees by January 31 of the year following the year being reported. Furnished to the IRS no later than February 28 (if filing in paper) or March 31 (if filing electronically) following the reporting year.

D. ***Assessment of form:***

Item	***Comment***
<u>Code Section 6056 reporting</u>	
Part II: Line 14 — offer of coverage code for the following: • Any employee who qualified as a 4980H full-time employee during any month of the year; and • Any employee who was enrolled at least 1 day of any month during the year in a self-insured plan providing minimum essential coverage.	Designed to indicate whether coverage was offered and the scope of any coverage that was offered (e.g. the scope of individuals eligible for such coverage and whether it provided minimum value). Generally, if the same Code applies for all 12 months during the year, then ALE Members may insert the applicable Code in the "All 12 Months" box and forgo completing the box for each individual month. NOTE: If reporting for an employee who was not a full-time employee during any month of the year but was enrolled in coverage at least one day of 1 month during the year, simply insert "1G" in the "All 12 months" box and then proceed to Section III of the Form. NOTE: Do NOT enter a Code for coverage that the ALE member is treated as having offered under the following transition relief: • Failure to offer dependent coverage • Non-calendar year transition relief • Multi-employer transition relief (e.g. for months that the employer made contributions to the plan but no coverage was offered). Thus, if coverage was NOT actually offered for a month but the employer is treated as offering coverage under one of the transition relief identified above, then report as though the ALE Member was NOT treated as having offered coverage. See below for a more detailed discussion regarding applicable codes.

Part II, Line 15 — employee share of lowest cost monthly premium for self-only coverage that provides minimum value. ONLY complete Line 15 if the covered offered provided minimum value AND the following Codes were included for any month on Line 14: • 1B • 1C • 1D • 1E	This is the lowest cost premium for employee only coverage providing minimum value that was *offered* to the employee without regard to the option actually elected by the employee (if any). If the employee was eligible to be covered under the same option *the entire year*, and the employee premium for employee only coverage did not change during the year, then the ALE Member will only need to provide the applicable indicator code in the "All 12 months" column. Otherwise, the ALE Member will have to complete all 12 months of the form. NOTE: This is not related to the affordability safe harbor (that will be identified on Line 16, if at all). The IRS still needs to know the actual premium amount so that the IRS can properly administer the Code Section 36B premium (even if the ALE Member satisfies the affordability safe harbor (e.g. the W-2) the coverage may not be affordable for purposes of Code Section 36B). Presumably, no premium amount is required for any month in which a Qualifying Offer code was inserted on Line 14 ("1A"). See below for a more detailed discussion regarding the applicable codes.
Part II, Line 16 — applicable section 4980H safe harbor	This Line is intended to identify for the IRS whether you may owe an excise tax or not with respect to an employee. Multiple indicator codes may actually apply to the situation; however, you will use ONLY one code. The instructions clarify when a Code should be used over other potentially applicable codes. For example, if the employer is eligible for the multi-employer plan relief in a month because the employer made contributions for that month to the plan even though coverage wasn't offered by the plan, and the employee is also in a limited non-assessment period, the ALE Member will use the Code applicable to the multi-employer plan relief. NOTE: Affordability safe harbors associated with Codes 2F-H apply only in months in which the employee qualified as a full-time employee and

	was offered coverage that provided minimum value. NOTE: Only use Code 2B — employee not a full-time employee — if the employee also did not enroll in minimum essential coverage (without regard to whether such coverage was self-insured or fully-insured). If the employee was not a full-time employee for a month but was enrolled in minimum essential coverage (without regard to whether fully insured or self-insured), use Code 2C.
Code Section 6055 Reporting	
Part III — Lines 17-22	This section identifies months during which the employee for whom a Code 2C was used on Line 16 AND the coverage was provided through a self-insured plan in which the ALE Member participates. NOTE: Since the form is limited to "employees", it is unclear whether the ALE Member would also use this form to satisfy its 6055 obligation with respect to former employees (such as retirees and COBRA qualified beneficiaries). **IRS clarification is needed.**
Indicator Codes Applicable to Line 14	
1G — Offer of coverage to employee who was not a full-time employee for ANY month of the calendar year AND who enrolled in self-insured coverage for one or more months of the calendar year	This appears to be the code that enables the ALE Member to satisfy its Section 6055 reporting obligation on this combined form with respect to an employee who is covered under the plan at any time during the year but is never a full-time employee (i.e. employee for whom you have no 6056 reporting obligation but for whom you have a 6055 reporting obligation). NOTE: As noted above, this indicator code is inserted into the "All 12 months" column associated with Line 14, even if not covered for all 12 months. This Code will indicate to the IRS that there is a 6055 reporting obligation with respect to this employee but no 6056 reporting obligation. If this Code is used,

	the ALE Member would skip line 15 and then, on line 16, identify the actual months the employee was covered under the plan during the year by inserting Code 2C in each covered month (or in the "All 12 months" box if covered at least day in all 12 months). Covered dependents would be identified in Part III.
1L—Qualified Offer Transition Relief for 2015	If the employer is eligible for the relief because the employer made a qualifying offer to at least 95% of the employer's full-time employees for one or more months during the year, the employer would use this Code on line 14 with respect to such months in which the relief is applicable.
Indicator Codes Applicable to Line 16	
2A-employee not employed during the month	It is clear from this code that ALE Members must report for months in the year that precedes the hire date of an employee for whom the ALE Member has a Section 6056 obligation (i.e. an employee who qualifies as a full-time employee during at least one month).
2C-employee enrolled in coverage	This includes any coverage that qualifies as minimum essential coverage without regard to whether it is affordable and/or provides minimum value and without regard to whether it is self-insured or fully insured
2D-employee in a section 4980H(b) limited non-assessment period	These limited non-assessment periods include the following: • Partial month of employment, • For non-variable or employees of employers who use the monthly measurement period, the first three full calendar months, beginning with the first full-month that the employee is full-time provided that the employee is (i) eligible for the plan but is in a waiting period and (ii) offered MEC coverage that provides minimum value by no later than the 1st day of the 4th full calendar month.

	• Months in an initial measurement period during which the employee averages the requisite hours of service to qualify as full-time. • The 3 full months following a change in status from variable/part-time/seasonal to non-variable provided that (i) the employee is eligible for the plan but is in a waiting period and (ii) the employee is offered coverage by the 1st day of the fourth full calendar month following the change (or if earlier, the first day of the stability period during which the employee would have qualified as full-time).
2E-Multi-employer plan relief rule	For employers eligible for the multi-employer plan relief[1] this would appear to be the code used for every month that the employer makes a contribution to the MET to the extent the employee is also a full-time employee. NOTE: If coverage offered by the MET is waived by the employee, it is unclear whether contributions have to be made for months following the waiver of coverage in order to qualify for the relief. Additional guidance from the IRS would be helpful.

[1]As a threshold matter, employers are eligible for the relief if they are required by a collective bargaining agreement to make contributions with respect to some or all employees to an MET who offers affordable minimum value coverage to employees who satisfy the MET's eligible requirements.

2l-employee subject to fiscal year transition relief	This underscores the point that this transition relief is applied on an employee by employee basis. Whether it applies to the employee depends on which of the 3 potential "buckets" of fiscal year relief prescribed by the IRS. If applicable, this code would be used for each month prior to the start of the employer's plan year in 2015 (or 2016, if a small ALE). NOTE: The preamble to the regulations clearly indicate that transition relief is available with respect an employee ONLY if affordable coverage providing minimum value is offered. The instructions suggest that employers could at least avoid 4980H(a) excise tax with respect to such employees who are offered coverage that is not affordable or doesn't provide minimum value. IRS has informally indicated that instructions reflect intent of IRS and would "trump" preamble to the regulations.

A Quick Reference Guide to Obtaining a Controlling Health Plan HPID

Register in the CMS Enterprise Portal → Register for a HIOS Account and gain access to HIOS → Register the Organization in HIOS → HIOS User Role Management → HPOES - Submitter completes CHP HPID Application → HPOES - Authorizing Official Approves the Application → HPID Number is Assigned

Users that need to obtain a Controlling Health Plan (CHP) Health Plan Identifier (HPID) will go through the CMS Enterprise Portal, access the Health Insurance Oversight System (HIOS), and apply for an HPID from the Health Plan and Other Entity System (HPOES). Detailed steps are provided below:

1 Accessing CMS Enterprise Portal and HIOS

Step 1: Navigate to the CMS Enterprise Portal (https://portal.cms.gov) and click “New User Registration.”

Step 2: Complete the New User Registration process and receive email confirmation of user registration.

Step 3: Navigate back to the CMS portal and login using the new credentials.

Step 4: To establish access to HIOS through the CMS Enterprise portal, click “Request Access Now” and then “Request New System Access,” selecting “HIOS” and “HIOS User” from the dropdown.

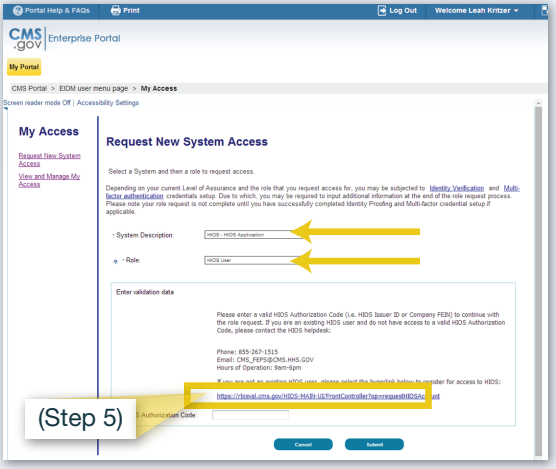
Step 5: Navigate to the HIOS registration page using the URL provided on the page and complete the HIOS user registration process.

Step 6: Once the HIOS user registration request has been reviewed and approved by the HIOS Helpdesk, an email containing the HIOS authorization code will be provided.

Step 7: Repeat steps 3 and 4 in the CMS Enterprise Portal and enter the authorization code on the “Request New System Access” page.

Step 8: Log out of the CMS Enterprise Portal and log back in. Users should see a yellow “HIOS” button on the top left of the dashboard indicating successful access established to HIOS.

Step 9: Click on the yellow HIOS button, followed by the “Access HIOS” link to navigate to the HIOS Homepage.



2 HIOS Organization Registration

Step 1: Click on the “Manage an Organization” button on the HIOS homepage. To determine if the organization already exists in HIOS, users will search by Federal Employer Identification Number (FEIN).

Step 2: If the organization does not exist in HIOS, users will need to register their organization by selecting an organization type, clicking on “Create Organization,” and filling out the information on the page including the domiciliary address.

Step 3: Receive an email notification once the organization request has been reviewed and approved by the HIOS Helpdesk.

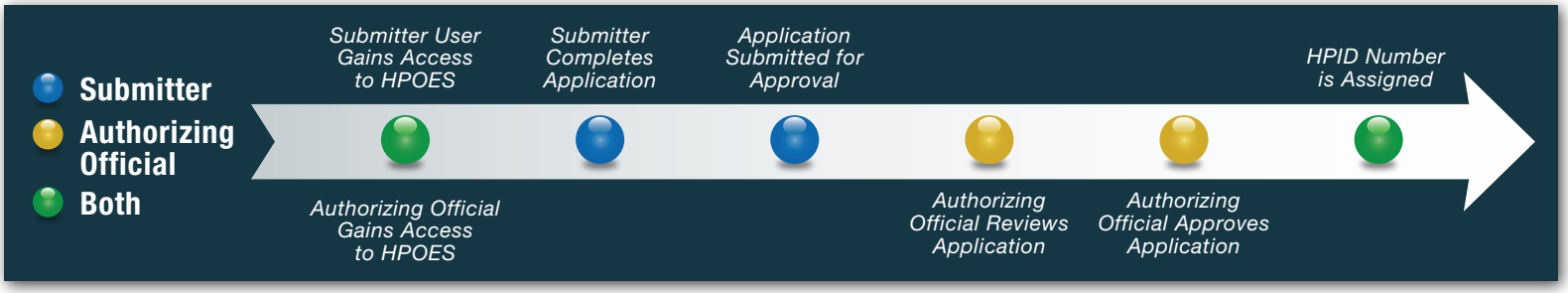
3 HIOS Role Management

Step 1: Once the organization has been successfully registered, click on "Role Management" button on the HIOS home page.

Step 2: Navigate to the "Request Role" tab, select the HPOES module, the requested role (Submitter or Authorizing Official), and identify the company association for the user by entering the FEIN, and submit the role request.

Step 3: Receive an email notification once the role request has been reviewed and approved by the HIOS Helpdesk.

In order to submit the application and obtain an HPID for a Controlling Health Plan, both the Submitter and Authorizing Official users must have approved access to HPOES for their respective organization. The below steps outline the process for each user to complete to obtain an HPID for a Controlling Health Plan:



4 CHP HPID Application (Submitter User)

Step 1: Click on the "HPOES" button on the HIOS homepage.

Step 2: Select the "Create Profile and Apply for HPID" button under the Controlling Health Plan (CHP) Function section of the HPOES homepage to initiate a CHP HPID application for the associated organization.

Step 3: Select the organization from the dropdown and provide either an NAIC number or Payer ID. If the Submitter user does not wish to provide either, they may enter "Not Applicable" in the Payer ID field. The organization must have an approved Authorizing Official in order to proceed forward with the application.

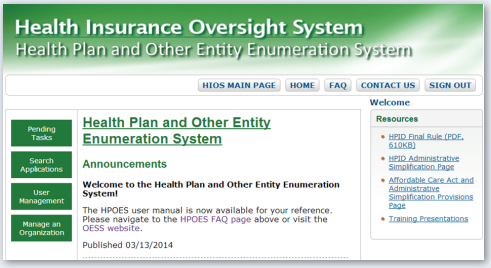
Step 4: Certify to the accuracy of the application and submit it for approval.

Step 5: Receive email confirmation of their CHP application submission.

5 CHP HPID Application (Authorizing Official)

Step 1: Receive an email notification when an application has been submitted and is awaiting their approval.

Step 2: Click on the "HPOES" button on the HIOS homepage.



Step 3: Navigate to the "Pending Tasks" button on the HPOES homepage and select the application to be reviewed.

Step 4: Approve or reject the application.

Step 5: Once the Authorizing Official approves the application, an HPID will be assigned to the CHP.

6 HPID number has been assigned

Note: *The submitter user will receive an email notification once the application has been approved with the assigned HPID number. The HPID number will also be available to view within HPOES.*

Bulletin: IRS Notice 2014-55

On September 18, 2014, the IRS issued several pieces of guidance on pressing Affordable Care Act issues. In this Bulletin, we discuss Notice 2014-55, which provides for two new permissible, mid-year cafeteria plan election changes. The first of these changes is intended to allow employees who were expected to average 30 hours of service per week to revoke their election and elect other minimum essential coverage if they experience a change in employment status after which they are not expected to average 30 hours of service, *even if they do not lose eligibility under the plan.* The second of these changes is designed to allow employees enrolled in a group health plan who are eligible to enroll in the Marketplace to elect such coverage, either during a special enrollment period or during the Marketplace's annual enrollment period (e.g., when the group health plan year is not calendar year). Employers may immediately rely on this guidance. Each of these new election change rules is described below.

Reduction in Hours of Service

The first of the two new election changes applies to an employee originally expected to average at least 30 hours of service per week but who experiences a change in employment status such that the employee is no longer expected to average 30 hours of service per week *AND who does not lose eligibility under the plan as a result of the status change (e.g., if the status change occurs during a month in a stability period during which the employee qualified as full-time).*

Practice Pointer: Generally, losing eligibility under the plan is a cornerstone requirement of the election change rules applicable to change in status events; however, if this event occurs and the additional elements described below are satisfied, this new guidance will allow an election change in this particular situation *even though eligibility under the plan has not been lost*.

If such an event occurs, the employee will be permitted to prospectively revoke his or her election under the plan so long the election change corresponds to the employee's (and related individuals') intended enrollment *in another plan that provides minimum essential coverage* that is effective no later than the first day of the second month following the date the coverage is revoked (i.e., if the coverage is terminated in June, coverage must begin on August 1st).

Practice Pointer: Minimum essential coverage is broadly defined and includes, but is not limited to, coverage in an "eligible employer sponsored plan" (i.e., a group health plan that provides other than excepted benefits) and a qualified heath plan in the Marketplace. That being said, the opportunities to enroll in the Marketplace following a change in employment status that does not cause a loss of coverage under the plan are limited.

Enrollment in a Marketplace QHP

The second new election change applies to an employee who qualifies for either a special or annual enrollment period in the Marketplace. If this occurs, the employee will be permitted to prospectively revoke his or her election under the plan to enroll in the Marketplace, if the election change corresponds to the intended enrollment of the employee (and related individuals) in Marketplace coverage that is effective *no later than* the day following the last day of the original plan coverage.

Under both options, the plan may rely on the "reasonable representation" of the employee that the relevant criteria are met.

Implementing the Guidance

This new guidance is effective immediately, and the IRS intends to amend the cafeteria plan regulations under Treas. Reg. § 1.125-4 to reflect these changes. Like other cafeteria plan election changes under Treas. Reg. § 1.125-4, these changes are permissible, not required. To take advantage of this guidance, the cafeteria plan must be amended on or before the last day of the plan year in which elections are allowed (although it may be amended for a 2014 plan year any time on or before the last day of the 2015 plan year). The amendment can be effective retroactively to the first day of the plan year if the plan operates in accordance with this guidance and the employer informs participants of the change. However, plans may not allow retroactive revocations of coverage elections.

Practice Pointer: While the plan amendment may be made before the end of the 2015 plan year, it is important to communicate this change to employees and record the date in your files if you intend to incorporate these changes into your plan.