Alice L Banks 106 Piedmont Ave Apt A Adairsville, GA 30103

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

internal Revenue Sei	vice		GO to WWW.iis	.gov/i oili	110930 101 111	structions ar	iu tile latest ili	iorination.								
Part I Emp	loyee						Ar	pplicable La	plicable Large Employer Member (Employer)							
1 Name of employ	ee (first name, r	middle initial, last	name)	2 Social	security number	(SSN)	7 Name of emp	loyer			8	Employer identifica	tion number (EIN)			
Alice		L Banks			XXX-XX-53	340	Premier Yarn Dyers, Inc.					580831676				
3 Street address (in	ncluding apartm	nent no.)					9 Street addres	s (including roon	n or suite no.)		10	10 Contact telephone number				
106 Piedmont	Ave Apt A						128 East G	eorge Stree	t			770773	3695			
4 City or town		5 State or province	се	6 Country	and ZIP or forei	n postal code	11 City or town		12 State or pro	ovince	13	Country and ZIP or t	oreign postal code			
Adairsville		GA		US 30 ²	103		Adairsville		GA		U:	S 30103				
Part II Emp	loyee Offe	er of Covera	age		Employee'	s Age on .	January 1		Plan Star	t Month (ei	nter 2-digi	it number):	01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1E	1E	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H			
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33\$		\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A			
17 ZIP Code																

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

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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 about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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Lines 7-13. Part I, lines 7 through 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 or to report errors in the information on the form and ask that they be corrected.

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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.

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	i rt III C	overed Employe	Indiv r prov	/iduals vided self-insu	red coverage, check th	e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) N First n	lame of cove	ered in	dividual(s) . last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Alice		L	Banks	XXX-XX-5340			X	X				June		Aug	С			Dec
19																			
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Part III. Covered Individuals, Lines 18–30

Greg C Brock 1714 Westchester Drive Dalton, GA 30720

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OMB No. 1545-2251

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2023

Internal Revenue Ser	vice		Go to www.irs	s.gov/Form	1095C for ins	tructions and	a the latest into	ormation.							
Part I Emp	loyee						Ap	plicable La	rge Emplo	yer Membe	r (Employe	r)			
1 Name of employe	ee (first name, mi	iddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Greg	C	Brock			XXX-XX-168	30	Premier Yarn Dyers, Inc.					580831676			
3 Street address (in	ncluding apartme	ent no.)					9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	mber		
1714 Westche	ester Drive						128 East Ge	orge Street				77077336	95		
4 City or town 5 State or province 6 Country and ZIP or foreign postal of							-				13 Countr	y and ZIP or fore	eign postal code		
Dalton GA US 30720							Adairsville		GA		US 30	103			
Part II Emp	loyee Offer	of Covera	ige	E	Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see nstructions)	\$	\$ 108.33	\$ 108.33\$	108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33		
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Cat. No. 60705M

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times |X||X| \times X |X| $|\times|$ |X|С 18 **Brock** XXX-XX-1680 Greg \times \times \times \times \times \times |X| $|\times|$ X $|\times|$ \times **Brock** XXX-XX-1993 19 Angela \times \times \times \times \times \times \times |X||X||X||X||X|Sydney XXX-XX-2356 **Brock** 21 22 23 24 25 26 27 28 29 30

Instructions for Recipient (continued)

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Jesus N Castillo 107 Summit Street Cartersville, GA 30120

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OMB No. 1545-2251

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Internal Revenue Se	rvice		Go to www.ir	s.gov/Form1	1095C for ins	tructions ar	ia the latest ir	normation.							
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	vee (first name, r	niddle initial, last	name)	2 Social se	ecurity number	(SSN)	7 Name of emp	oloyer			8 Er	nployer identifica	tion number (EIN)		
Jesus		N Castillo)	X	XX-XX-44	71	Premier Yarn Dyers, Inc.					580831676			
3 Street address (i	including apartm	ent no.)		•			9 Street addres	ss (including roo	m or suite no.)		10 Co	ontact telephone	number		
107 Summit S	Street						128 East G	eorge Stree	et			770773	3695		
4 City or town						n postal code	11 City or town 12 State or province				13 Co	untry and ZIP or	oreign postal code		
						Adairsville		GA		US	30103				
Part II Employee Offer of Coverage Employee's Age of						Age on	January 1		Plan Star	t Month (er	nter 2-digit	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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- **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%, visit 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).
- 11. Reserved for future use.
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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	(a) Name	e of covered ir e, middle initia	ndividual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other	(d) Covered all 12 months) Months						
	First name	e, middie initia	ii, iast name		TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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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, visit IRS.gov.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Deanie D Coker 1935 Moores Ferry Road SW Plainville, GA 30733

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Go to www.irs.gov/Form1095C for instructions and the latest information.

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Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form	1095C for ins	tructions ar	id the latest ir	ntormation.								
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)				
1 Name of employ	ree (first name, i	middle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emp	oloyer			8 Ei	mployer identific	ation number (EIN)			
Deanie		D Coker) ×	(XX-XX-62 ⁻	73	Premier Ya	ırn Dyers, Ir	IC.			58083	1676			
3 Street address (i	ncluding apartn	nent no.)					9 Street addres	ss (including roo	m or suite no.)		10 C	10 Contact telephone number				
1935 Moores	Ferry Road	l SW		128 East G	Seorge Stree		7707733695									
4 City or town		5 State or province	се	6 Country a	6 Country and ZIP or foreign postal code				12 State or pr	ovince	13 Co	13 Country and ZIP or foreign posta				
Plainville		GA		US 307	33		Adairsville		GA		US	30103				
Part II Emp	oloyee Offe	er of Covera	age	E	mployee's	Age on C	lanuary 1		Plan Star	t Month (e	nter 2-digit	number):	01			
	All 12 Months	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec					
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1H	1H	1H	1H	1H	1H	1H	1H			
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33\$	108.33	\$ 108.33	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2A	2A	2A	2A	2A	2A	2A	2A			
17 ZIP Code													1005 0			

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions 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 about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive 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, you may receive 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.



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.

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

Part I. Employee

Lines 1-6. Part I, lines 1 through 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 employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7–13. Part I, lines 7 through 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 or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14–17

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.

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- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	rt III Covere			ıred coverage, check th	e box and enter th		on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of o			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. 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, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Allen T Dover 45 Manning Mill Way Adairsville, GA 30103

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2023

Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form	1095C for insi	tructions an	a tne latest int	ormation.						
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	er (Employe	r)		
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emple	oyer			8 Emplo	yer identificatio	n number (EIN)	
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3 Street address (i	ncluding apartm	nent no.)		•			9 Street address	(including room	10 Conta	10 Contact telephone number				
45 Manning M	45 Manning Mill Way							eorge Street		7707733695				
4 City or town	5	State or province	се	6 Country a	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal		
Adairsville	(GA		US 3010	US 30103				GA		US 30	103		
Part II Emp	loyee Offe	r of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	-digit number):		
					Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33\$	108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code													205.0	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Instructions for Recipient

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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	(a) Nam	ne of covered in ne, middle initia	ndividual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months						Months						
_	First nam	ie, middle milia	ii, iast name		Tilv is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Jessy R Guadalupe 114 Cherry Street Rome, GA 30165

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Form	1	JJ	J	U
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VOID OMB No. 1545-2251

Do not attach to your tax return. Keep for your records. Go to www ire gov/Form1005C for instructions and the latest information

Internal Revenue Ser	vice		Go to www.i	rs.gov/Form	1095C for inst	tructions an	d the latest inf	ormation.						
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emple	oyer			8 Emplo	yer identificatio	n number (EIN)	
Jessy		R Guadalı	upe	>	(XX-XX-022	21	Premier Yar	n Dyers, Ind	C.			5808316	76	
3 Street address (in	ncluding apartm	ent no.)	•	'			9 Street address	(including room	10 Conta	10 Contact telephone number				
114 Cherry Street							128 East George Street					7707733695		
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreigr	11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign postal			
Rome		GΑ		US 301	65		Adairsville		GA		US 30	103		
Part II Emp	loyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	digit number): 0		
All 12 Months Jan Feb Mar					Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33\$	5 108.33°	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	
17 ZIP Code			A Nation										005 0 (2000)	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions 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 about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive 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, you may receive 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.



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.

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

Part I. Employee

Lines 1-6. Part I, lines 1 through 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 employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7–13. Part I, lines 7 through 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 or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14–17

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%, visit 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).
- 11. Reserved for future use.
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insured				on for e	ach ind	ividual	enrolle					employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Ronnie W Harris 23 Mill Creek SE Cartersville, GA 30120

Form	109:	5-C
Departi	ment of the	Treasury
Intorna	I Dovonuo	Sorvico

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records. Go to www.irs.gov/Form1095C for instructions and the latest information.

Internal Revenue Sei	rvice		Go to www.i	rs.gov/Form	1095C for ins	tructions an	a the latest int	ormation.						
Part I Emp	oloyee						Ар	plicable La	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 En	nployer identifica	tion number (EIN)	
Ronnie	\	W Harris		\ \ \ \	(XX-XX-74!	55	Premier Yar	n Dyers, In	C.			580831	676	
3 Street address (in	ncluding apartm	nent no.)					9 Street address	(including roon	10 Cd	10 Contact telephone number				
23 Mill Creek	SE						128 East Ge	eorge Stree	t			770773	3695	
4 City or town	5	5 State or province	ce	6 Country a	6 Country and ZIP or foreign postal code				12 State or pro	ovince	13 Co	untry and ZIP or	oreign postal code	
Cartersville	(GA		US 301:	US 30120				GA		US	30103		
Part II Emp	loyee Offe	er of Covera	nge	E	mployee's	Age on J	anuary 1		Plan Star	t Month (er	nter 2-digit r	2-digit number):		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1H	1H	1H	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33\$	5 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2D	2D	2D	2D	2D	
17 ZIP Code													1095-С (2022)	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	I rt III Cove If Emp	red Indi	viduals vided self-ins	ured coverage, check th	ne box and enter th	e information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of First name,	of covered in	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Ronnie	W	Harris	XXX-XX-7455	,		X	×	X	X	×	X	×	Aug	П			
19	Sandra		Harris	XXX-XX-2510			\times	\boxtimes	\times	\times	\times	\times	\times					
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Maria E Perez-Soto 6 Dellwood Dr NW Rome, GA 30165

Form	095	5-C
Departm	ent of the	Treasury
Intornal	Davanua C	onvioo

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2023

Internal Revenue Sei	vice		Go to www.ii	rs.gov/Form	1095C for insi	tructions an	a the latest int	ormation.							
Part I Emp	loyee						Ар	plicable La	arge Emplo	yer Membe	r (Employe	r)			
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Maria		E Perez-S	Soto) ×	(XX-XX-81 ²	10	Premier Yar	n Dyers, Ind	3.			5808316	76		
3 Street address (i	ncluding apartm	ent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
6 Dellwood Dr	NW						128 East George Street					7707733695			
4 City or town	5	State or provinc	ce	6 Country a			11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code		
Rome		GA		US 301	US 30165				GA		US 30	103			
Part II Emp	loyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nun	nber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June				Oct	Oct Nov			
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33\$	108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													205.0		

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Instructions for Recipient

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If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive 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, you may receive 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.



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.

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

Part I. Employee

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Part I. Applicable Large Employer Member (Employer)

Lines 7-13. Part I, lines 7 through 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 or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14–17

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%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insured				on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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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, visit IRS.gov.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Jessica H Pinion 38 Bishop Road NW Cartersville, GA 30121

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CORRECTED

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2023

internal Revenue Se	rvice		GO to www.irs	s.gov/roiiii	1095C IOI IIIS	tructions and	u the latest line	ormation.								
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)				
1 Name of employ	ee (first name, m	iddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)			
Jessica	+	H Pinion			XXX-XX-540	00	Premier Yarı	n Dyers, Ind	C.			5808316	76			
3 Street address (i	ncluding apartme	ent no.)		<u>'</u>			9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number				
38 Bishop Ro	ad NW						128 East George Street					7707733695				
4 City or town	5	State or province	ce	6 Country and ZIP or foreign postal code			11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code			
Cartersville		SA .		US 301	21		Adairsville		GA		US 30	103				
Part II Emp	loyee Offe	r of Covera	age	E	Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E			
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33\$	108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H			
17 ZIP Code																

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions 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.

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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 employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insured				on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Terry W Pruitt 26 Dana Way NW Cartersville, GA 30121

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Internal	Rovenue Sen	/ica

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OMB No. 1545-2251

Do not attach to your tax return. Keep for your records. Go to www.irs.gov/Form1095C for instructions and the latest information.

Internal Revenue Se	rvice		Go to www.ii	rs.gov/Form	1095C for insi	tructions and	a tne latest int	ormation.						
Part I Emp	oloyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, r	middle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emple	oyer			8 Emplo	yer identification	n number (EIN)	
Terry	'	W Pruitt)	(XX-XX-354	40	Premier Yarn Dyers, Inc.					580831676		
3 Street address (i	ncluding apartm	nent no.)		•			9 Street address (including room or suite no.)					10 Contact telephone number		
26 Dana Way	NW						128 East Ge	eorge Street	t			77077336	95	
4 City or town	į	5 State or province	се	6 Country a	and ZIP or foreigr		11 City or town		12 State or pro	vince	13 Countr	y and ZIP or for	eign postal code	
Cartersville		GA		US 3012	21		Adairsville		GA		US 30	103		
Part II Emp	oloyee Offe	er of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33\$	108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code													205.0	

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Irt III Covere			ed coverage, check th	e box and enter th	e informatio	on for e	ach inc	dividual	enrolle	d in cov	/erage,	includir	ng the e	employe	ee. 🗵]	
	(a) Name of c	overed in	idividual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months							of covera		0 1			_
	r irst marile, mid		i, iast flame		The is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. 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, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Aletae B Quarles 168 Nathan Dr SE Calhoun, GA 30701

Form	1	U;	y;) –	U
Depar					
Intern:	al R	aven	LIE S	ervic	2

Part I Employee

168 Nathan Dr SE

Aletae

4 City or town

1 Name of employee (first name, middle initial, last name)

3 Street address (including apartment no.)

В

Quarles

5 State or province

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

XXX-XX-5172

2 Social security number (SSN)

Go to www.irs.gov/Form1095C for instructions and the latest information.

6 Country and ZIP or foreign postal code 11 City or town

2023 Applicable Large Employer Member (Employer) 8 Employer identification number (EIN) 580831676 9 Street address (including room or suite no.) 10 Contact telephone number 7707733695 12 State or province 13 Country and ZIP or foreign postal code

Calhoun	(GΑ		US 30	701		Adairsville		GA		US 3	0103	
Part II Emp	oloyee Offe	r of Cover	age		Employee's Age on January 1				Plan Start Month (enter 2-digit number): 0				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G	1G
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code													

7 Name of employer

Premier Yarn Dyers, Inc.

128 East George Street

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Instructions for Recipient

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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 about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive 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, you may receive 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.



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.

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

Part I. Employee

Lines 1-6. Part I, lines 1 through 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 employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7–13. Part I, lines 7 through 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 or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14–17

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%, visit 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).
- 11. Reserved for future use.
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
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- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	art III Cove	red Indi loyer pro	viduals vided self-insu	red coverage, check th			on for e	each inc	lividual	enrolle					employe	e. 🗵		-
	(a) Name o First name, i	of covered in	ndividual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months) Months						
	First name, i		ii, iast name		Tilv is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Kenneth G Quick 12 Bramblewood Drive Cartersville, GA 30120

Form	I 09:	5-C
Departi	ment of the	Treasury
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CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

Go to www.irs.gov/Form1095C for instructions and the latest information.

2023

internal Revenue Sei	rvice		GO to www.ii	s.gov/roiiii	1095C IOI IIIS	tructions and	u the latest line	ormation.			I			
Part I Emp	loyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)	
Kenneth		G Quick		XXX-XX-1307 Pre			Premier Yarn Dyers, Inc.					580831676		
3 Street address (in	ncluding apartme	ent no.)					9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	mber	
12 Bramblewo	ood Drive						128 East Ge	orge Street	t			77077336	95	
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code	
Cartersville		GΑ		US 301	US 30120 Adairsville GA					US 30	103			
Part II Emp	loyee Offe	r of Covera	age	E	Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33 \$	108.33	\$ 108.33	\$ 108.33	\$\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	108.33	\$ 108.33	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code														

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions 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 about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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Part I. Applicable Large Employer Member (Employer)

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (c) DOB (if SSN or other (d) Covered (e) Months of coverage (b) SSN or other TIN (a) Name of covered individual(s) First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times \times \times \times |X| \times \times G XXX-XX-1307 18 Kenneth Quick 19 20 21 22 23 24 25 26 27 28 29 30

Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. 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, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Part III. Covered Individuals, Lines 18–30

Claudia Villanueva 5 Verbena Ave Rome, GA 30165

Form 1095-C
Department of the Treasury
Internal Revenue Service

Claudia

5 Verbena Ave

Part I Employee

1 Name of employee (first name, middle initial, last name)

3 Street address (including apartment no.)

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Do not attach to your tax return. Keep for your records.

2 Social security number (SSN)

XXX-XX-7326

Go to www.irs.gov/Form1095C for instructions and the latest information.

Applicable Large Employer Member (Employer) 8 Employer identification number (EIN) Premier Yarn Dyers, Inc. 580831676 9 Street address (including room or suite no.) 10 Contact telephone number 128 Fast George Street 7707733695

5 Verbena Ave							126 East George Street					1101133093			
4 City or town	Ę	5 State or provin	се	6 Country a	and ZIP or foreig	n postal code	11 City or town		12 State or pro	vince	13 Country	y and ZIP or for	eign postal code		
Rome		GA		US 301	65		Adairsville		GA		US 301	103			
Part II Em	ployee Offe	er of Covera	age	Employee's Age on			anuary 1		Plan Start	Month (ente	r 2-digit num	2-digit number):			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33\$	108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33\$	5 108.33 \$	5 108.33	\$ 108.33		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code															
F D						·						_ 4	00E 0		

7 Name of employer

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Villanueva

Cat. No. 60705M

Instructions for Recipient

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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times |X||X| \times X |X| $|\times|$ |X|18 Claudia Villanueva XXX-XX-7326 \times \times \times |X||X| $|\times|$ \times X $|\times|$ \times \times 19 0 Picon XXX-XX-5558 Hassen \times \times \times \times \times \times \times |X||X||X||X||X|0 Picon Villanue XXX-XX-7790 Hassen 21 22 23 24 25 26 27 28 29 30

Instructions for Recipient (continued)

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Charlene Vinall 61 Gordon Road Taylorsville, GA 30178

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records. Go to www irs gov/Form1095C for instructions and the latest information

CORRECTED

VOID

OMB No. 1545-2251

2023

Internal Revenue Ser	rvice	Go to www.irs.gov/Form1095C for instructions and the latest information.													
Part I Emp	loyee						App	olicable La	rge Emplo	yer Membe	r (Employ	er)			
1 Name of employe	ee (first name,	middle initial, las	t name)	2 Social	security number	(SSN)	7 Name of emplo	yer			8 Emp	loyer identification	on number (EIN)		
Charlene		Vinall			XXX-XX-4728			Premier Yarn Dyers, Inc.					580831676		
3 Street address (in	ncluding apartr	ment no.)		•		!	9 Street address	(including room	or suite no.)		10 Con	10 Contact telephone number			
61 Gordon Ro	ad					-	128 East Ge	orge Street	t			7707733695			
4 City or town		5 State or provin	ice	6 Country	and ZIP or foreig	n postal code 1	11 City or town		12 State or pro	vince	13 Cour	itry and ZIP or for	eign postal code		
					178		Adairsville		GA		US 30	0103			
Part II Employee Offer of Coverage Employee's Age of							anuary 1		Plan Start	Month (ente	er 2-digit nu	-digit number): 01			
All 12 Months Jan Feb Mar				Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
17 ZIP Code															

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Instructions for Recipient

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Pa	I rt III Covere If Emplo	ed Indi oyer pro	viduals vided self-insur	ed coverage, check th			on for e	ach inc	lividual	enrolle					employe	e. 🗵		
	(a) Name of of First name, mi	covered ir iddle initia	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Charlene		Vinall	XXX-XX-4728			X	X	X	X	X	X	×	X	X	\times	\times	\times
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Part III. Covered Individuals, Lines 18–30

Karen Y Whitfield 19 Reynolds Bridge Rd Kingston, GA 30145

Form 1095- C
Department of the Treasury
Internal Davisaria Camilas

Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	loyee						Aı	pplicable L	arge Empl	oyer Memb	er (Employ	er)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Soci	al security number	r (SSN)	7 Name of emp	oloyer			8 Emp	oloyer identificatio	n number (EIN)		
Karen	.	Y Whitfi	eld		XXX-XX-32	229	Premier Yarn Dyers, Inc.					580831676			
3 Street address (in	ncluding apartr	nent no.)					9 Street addres	ss (including roo	m or suite no.)		10 Con	10 Contact telephone number			
19 Reynolds E	Bridge Rd						128 East G	eorge Stree	et			7707733695			
4 City or town 5 State or province 6 Country and ZIP or foreign postal code							11 City or town	<u></u>	12 State or p	province	13 Cou	ntry and ZIP or fore			
Kingston GA US 30145							Adairsville		GA		US 3	0103			
	loyee Offe	er of Cove	rage		Employee'	s Age on .	January 1		Plan Sta	rt Month (en	iter 2-digit nu	umber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$ 108.33	\$ 108.33		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2C	2C		
17 ZIP Code															

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Cat. No. 60705M

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insured				on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. 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, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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, visit IRS.gov.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Earl Wilburn Jr 201 Iron Belt Ct Apt 201 Carter, GA 30120

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

Internal Revenue Sei	vice		GO to www.ii	s.gov/romm	USSC TOT ITIS	iructions an	u tile latest il	normation.				_ ~						
Part I Emp	loyee						A	pplicable L	arge Emplo	nployer Member (Employer)								
1 Name of employ	ee (first name, n	niddle initial, last n	name)	2 Social se	ecurity number ((SSN)	7 Name of emp	oloyer	8 Em	8 Employer identification number (EIN)								
Earl		Wilburn		X	XX-XX-592	27	Premier Ya	rn Dyers, In	IC.			580831676						
3 Street address (in	ncluding apartm	ent no.)					9 Street addres	ss (including roor	n or suite no.)		10 Co	10 Contact telephone number						
201 Iron Belt (Ct Apt 201						128 East G	eorge Stree	et			770773	3695					
4 City or town	5	State or province	e	6 Country a	nd ZIP or foreign	postal code	11 City or town		12 State or pr	rovince	13 Co	3 Country and ZIP or foreign postal code						
Carter	(GA		US 3012	20		Adairsville		GA		US :	US 30103						
Part II Emp	loyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Star	rt Month (e	nter 2-digit r	umber):	01					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec					
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1H	1H	1H	1H	1H	1H	1H					
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33 \$	108.33	5 108.33	\$ 108.33	3 \$	\$	\$	\$	\$	\$	\$					
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2A	2A	2A	2A	2A	2A	2A					
17 ZIP Code									N- 00705M				1005 C (2000)					

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions 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 about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive 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, you may receive 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.



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.

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

Part I. Employee

Lines 1-6. Part I, lines 1 through 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 employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7–13. Part I, lines 7 through 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 or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14–17

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%, visit 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).
- 11. Reserved for future use.
- **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).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	Covered Individuals If Employer provided self-insured				on for e	ach ind	ividual	enrolle					employe	ee. 🗵		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of coverage July Aug		Sept Oct		Nov	Dec
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Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. 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, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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, visit IRS.gov.

Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30

Cassie B Womack 19 Herring Street Cartersville, GA 30120

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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

Go to www.irs.gov/Form1095C for instructions and the latest information.

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Part I Emp	oloyee						Applicable Large Employer Member (Employer)									
1 Name of employ	ee (first name,	middle initial, last	name)	2 Social se	ecurity number	(SSN)	7 Name of emplo	oyer	8 Emplo	8 Employer identification number (EIN)						
Cassie	X	(XX-XX-27	50	Premier Yar	n Dyers, Ind	3.			5808316	76						
3 Street address (i	ncluding apartr	ment no.)		•			9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	number			
19 Herring Str	eet						128 East Ge	eorge Street	t			77077336	95			
4 City or town		5 State or provin	ce	6 Country a	and ZIP or foreigr							intry and ZIP or foreign postal code				
Cartersville	US 3012	20		Adairsville		GA		US 30	US 30103							
Part II Emp	oloyee Off	er of Covera	age	E	imployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nun	oyer identification number (EIN 580831676) act telephone number 7707733695 try and ZIP or foreign postal code 0103 mber): 01 Nov Dec 1E 1E				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E			
15 Employee Required Contribution (see instructions)	\$	\$ 108.33	\$ 108.33\$	108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	\$ 108.33	5 108.33	\$ 108.33			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C			
17 ZIP Code													005 0			

For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions 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 about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

If your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive 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, you may receive 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.



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.

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

Part I. Employee

Lines 1-6. Part I, lines 1 through 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 employer is required to report your complete SSN to the IRS.

Part I. Applicable Large Employer Member (Employer)

Lines 7–13. Part I, lines 7 through 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 or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14–17

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%, visit 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).
- 11. Reserved for future use.
- **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).
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- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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	(a) Name of of First name, mi			(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Cassie	В	Womack	XXX-XX-2750			X	×	X	X	×	X	X	X	Ж	X	×	X
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

Line 15. This line reports the employee required contribution, which is the monthly cost to you for the lowest cost self-only minimum essential coverage providing minimum value that your employer offered you. For an individual coverage HRA, the employee required contribution is the excess of the monthly premium based on the employee's applicable age for the applicable lowest cost silver plan over the monthly individual coverage HRA amount (generally, the annual individual coverage HRA amount divided by 12). See the Instructions for Forms 1094-C and 1095-C for more details. 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, 1E, 1J, 1K, 1L, 1M, 1N, 1O, 1P, 1Q, 1T, or 1U is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report "0.00" for the amount. For more information, including on how your eligibility for other healthcare arrangements might affect the amount reported on line 15, visit IRS.gov.

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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

Part III. Covered Individuals, Lines 18–30