Cameron D M Berry 101 E 9th St Delavan, IL 61734 Form **1095–C**Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Emp	Name of employee 2 Social security number (SSN)											Applicable Large Employer Member (Employer)												
1 Name of employ	/ee					2 Socia	l security number	(SSN)	7 Name of employer 8 Employer identification number (E												ber (EIN)			
Cameron D M	1 Berry						XXX-XX-10	30	Wŀ	neelwo	rx Noi	rth, LLC	<u>;</u>						27291	5146				
3 Street address (i	including apartn	nent n	o.)						9 9	Street add	dress (in	cluding roo	om or sui	te no.)			10	Oontact	telephone	number				
101 E 9th St									148	80 Wo	odbine	e Avenu	ıe						205668	6720				
4 City or town		5 Sta	te or province	9		6 Countr	y and ZIP or foreig	n postal code	11 (City or tov	wn		12 St	ate or pro	ovince		13	Country a	and ZIP or f	oreign pos	tal code			
Delavan		IL			Įι	US 61	734		Ca	lera			AL				U	S 3504	10					
Part II Emp	oloyee Offe	er of	Coverag	je					Pla	an Sta	rt Mo	nth (En	ter 2-di	git num	ber): ()3								
	All 12 Months		Jan	Feb		Mar	Apr	May		June		July	P	Aug	Sep	ot	Oct		Nov	1	Dec			
14 Offer of Coverage (enter required code)			1E	1H		1H	1H	1H		1H		1H		1H	1⊦	1	1H		1H		1H			
15 Employee Required Contribution (see instructions)	\$	\$	132.57	8	\$	\$ \$			\$		\$		\$		\$	4	6	\$		\$				
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	2H 2B				2A	2A	2A		2A		2A		2A	2.4	Λ .	2A		2A		2A				
Part III Covered Individuals										nformation for each individual enrolled in coverage, including the employee.														
				1			(c) DOB (If SS or other TIN is	N (4) Cove	Covered (e) Months of Coverage															
(a) Name	e of covered ind	ividua	I(S)	(b) SSN o	r other	rTIN	all 12 mo		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec				
17																								
18																								
19																								
20																								
21																								
22																								

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Form 1095-C (2016) Page 3

Name of employee Social security number (SSN) XXX-XX-1030 Cameron D M Berry Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

Terry Biggs 206 Washington Pekin, IL 61554 Form **1095–C**Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

VOID	
	OMB No. 1545-2251
CORRECTED	2016

Part I Employee											Applicable Large Employer Member (Employer)														
1 Name of employ	ee					- 2	2 Social	securi	ty number	(SSN)) 7	7 Name of employer 8 Employer identification number												nber (EIN)	
Terry Biggs								XXX	-XX-91	93				rth, LL0								27	72915	146	
3 Street address (i	ncluding apartr	nent n	o.)			•					9	Street ac	dress (in	cluding ra	om c	or suit	e no.)			10) Conta	ct tele	ephone r	ıumber	
206 Washingt	on										14	480 Wc	odbine	e Aven	ue							20	56686	720	
4 City or town		5 Sta	te or provin	се		- (6 Country	and Z	IP or foreig	n pos	tal code 11	City or to	wn		1	12 Sta	ate or pro	vince		13	3 Countr	y and	ZIP or for	eign pos	stal code
Pekin		IL				Įι	JS 615	554			lc.	alera			1	٩L				U	S 350	040			
Part II Emp	oloyee Off	er of	Covera	ge		•					P	lan Sta	art Mo	nth (Er	iter :	2-dig	git num	ber): (03	•					
	All 12 Months		Jan		Feb	N	Mar		Apr		May	June		July		Α	ug	Sep	ot	Oct		1	Vov		Dec
14 Offer of Coverage (enter required code)			1E		1E		1E		1E		1E	1E		1E		1	IE	1E	Ξ	1E			1E		1E
15 Employee Required Contribution (see instructions)	\$	\$	132.57	\$	132.57	\$ 1	132.57 \$ 119.34 \$ 119.34		\$ 119	.34 \$	119.3	34 \$	\$ 119.34		\$ 11	9.34	3 11	9.34	\$ ^	119.34	1 \$	119.34			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C		2C	2	2C		2C		2C	2C		2C			2C	20		20		2	2C		2C
Part III Covered Individuals																		•			•				
If Em	ployer prov	ided	self-insu	red (coverage,	, che	ck the				e informat	ion for (each in	dividual	enr	ollec	d in cov	verage,	includi	ng the	emplo	oyee	e. 🗀		
(a) Name	of covered ind	lividua	l(s)		(b) SSN or	other	TIN	(c) E	DOB (If SSN other TIN is	N.	(d) Covered						(e)	Months							
					(0, 00.10.		not available)			all 12 month	s Jan	Feb	Mar	A	\pr	May	June	July	Aug	Sep	ot	Oct	Nov	Dec	
																						1			
17															-										
18																									
19]			
20]					
21]					
22																									

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Page 3 Name of employee Social security number (SSN) XXX-XX-9193 Terry Biggs Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

Shannon M Bikai 108 Worner St Green Valley, IL 61534 Form 1095-C
Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

VOID	
	OMB No. 1545-2251
CORRECTED	

internal revenue oc	VICC					- aa oopa.													
Part I Emp	loyee				Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification number (EIN														
1 Name of employ	ee				2 Socia	I security number	(SSN)	7 Name of	employer	r					8	Employe	identifica	ation num	ber (EIN)
Shannon M B	ikai					XXX-XX-30	54	Wheelwo	orx Nor	th, LLC)					:	272915	146	
3 Street address (i	ncluding apartr	nent no.)			'			9 Street ac	dress (ind	cluding ro	om or sui	te no.)			10	Contact t	telephone	number	
108 Worner S	t							1480 Wc	odbine	e Aveni	Je					2	205668	6720	
4 City or town		5 State or prov	ince		6 Counti	ry and ZIP or foreig	n postal code	11 City or to	wn		12 S	ate or pr	ovince		13	Country a	nd ZIP or fo	oreign pos	tal code
Green Valley		IL			US 61	534		Calera			AL				US	3504	0		
	loyee Offe	er of Cove	rage		•			Plan Sta	art Mo	nth (En	ter 2-di	git num	nber): (03	•				
	All 12 Months	Jan	Fel	b	Mar	Apr	May	June	:	July	/	Aug	Se	pt	Oct		Nov		Dec
14 Offer of Coverage (enter required code)		1A	1/	A	1A	1A	1A	1A		1A		1A	1,	4	1A		1A		1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$			\$	\$	\$		\$		\$	9		\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		Y				•	<u>·</u>						<u> </u>			<u> </u>			
	ered Indiv		ured cov	erage, c	heck the	box and ente	r the inforn	nation for e	each ind	dividual	enrolle	d in co	/erage,	includi	ng the	employ	ee. []	
(a) Namo	of covered ind	ividual(s)	(b)	SSN or ot	hor TINI	(c) DOB (If SSN	(d) Cove	ered				(e) Months	of Covera	age				
(a) Name	or covered ind	ividuai(5)	(6)	SSIN OF OU	ner min	or other TIN is not available)	all 12 mo	^{nths} Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																			
18																			
19																			
20																			
21																			
22																			

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Name of employee Social security number (SSN) XXX-XX-3054 Shannon M Bikai Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

Steven M Blome 1007 Black St Pekin, IL 61554 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Employee										Applicable Large Employer Member (Employer)												
1 Name of employ	ee					2	Social	security number	(SSN)	7 Name of employer 8 Employer identification number (E												
Steven M Blor	me							XXX-XX-43	30	Whe	elwo	rx Nor	th, LLC	·						272915	146	
3 Street address (i	ncluding apartr	ment r	10.)							9 Stre	eet add	dress (inc	luding roo	om or sui	te no.)			10	Contact t	elephone	number	
1007 Black St										1480) Wo	odbine	Avenu	ıe					2	05668	6720	
4 City or town		5 Sta	ate or provinc	се		6	Country	and ZIP or foreig	n postal code	11 City	y or to	wn		12 S	ate or pro	ovince		13	Country a	nd ZIP or f	oreign post	tal code
Pekin		IL				US	S 615	554		Cale	ra			AL				US	3504	0		
Part II Emp	oloyee Off	er of	f Covera	ge					-	Plan	ո Sta	rt Moi	nth (Ent	ter 2-di	git num	nber): (03					
	All 12 Months		Jan		Feb	M	ar	Apr	May		June		July	1	Aug	Sep	pt	Oct		Nov		Оес
14 Offer of Coverage (enter required code)			1E		1E	1	E	1E	1H		1H		1H		1H	11	4	1H		1H		1H
15 Employee Required Contribution (see instructions)	\$	\$	132.57	\$	132.57	\$ 13	132.57 \$ 119.34 \$			\$		\$		\$		\$	\$	8	\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C 2C			20	С	2C	2B		2A		2A		2A		Α	2A		2A		2 A
	ered Indiv ployer prov			ed c	coverage	, chec	k the	box and ente		nation	for e	ach inc	dividual	enrolle	d in cov	/erage,	includi	ng the	employ	ee.]	
(a) Name	of covered inc	lividua	ıl(s)		(b) SSN or	other T	IN	(c) DOB (If SSI or other TIN is	(d) Cove							Months						
					(,		not available) all 12 m			nths	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																						
18																						
10				_																		
19																						
20										'												
21										[
							-														\vdash	
22																						

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Name of employee Social security number (SSN) XXX-XX-4330 Steven M Blome Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30

31

32

33

Michael Buckley 817 Charlotte Street Pekin, IL 61554 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Employee										Applicable Large Employer Member (Employer)												
1 Name of employ	1 Name of employee 2 Social security number (SSN)									7 Name of employer 8 Employer identification number (EIN												
Michael Buckl	ey						Х	(XX-XX-30	49	W	heelwo	rx Nor	th, LLC						:	272915	146	
3 Street address (i	ncluding apartr	ment r	10.)			'				9	Street ad	dress (inc	cluding ro	om or sui	te no.)			10	Contact t	elephone	number	
817 Charlotte	Street									14	80 Wo	odbine	e Aveni	ле					2	05668	6720	
4 City or town		5 Sta	te or provinc	се		6 Cou	ıntry a	and ZIP or foreig	n postal code	11	City or to	wn		12 S	tate or pr	ovince		13	Country a	nd ZIP or f	oreign pos	tal code
Pekin		IL				US 6	5155	54		Ca	alera			AL				US	3504	0		
	oloyee Off	er of	f Covera	ge		-					lan Sta	rt Mo	nth (En		igit nun	nber): (03					
	All 12 Months	3	Jan		Feb	Mar		Apr	May	Ή	June		July	,	Aug	Sep	pt	Oct		Nov		Оес
14 Offer of Coverage (enter required code)			1E		1E	1E		1E	1H		1H		1H		1H	11	1	1H		1H		1H
15 Employee Required Contribution (see instructions)	\$	\$	132.57		132.57	\$ 132	132.57 \$ 119.34 \$			9		\$		\$		\$	\$	3	\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H 2H			2H		2H	2B		2A		2A		2A		Α	2D		2D	2	2D	
	ered Indiv ployer prov			red c	overage	check t		ox and ente		nati	ion for e	each ind	dividual	enrolle					employ	ee.		
(a) Name	of covered inc	dividua	l(s)		(b) SSN or	other TIN		(c) DOB (If SSN or other TIN is	(d) Cove						`) Months						
					(,		not available) all 12 m			onths	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																						
18																						
10																						
19																						
20																						
21																						
22																						

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Page 3 Name of employee Social security number (SSN) Michael Buckley XXX-XX-3049 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Sept Jan Feb Mar Apr May Jun Jul Aug Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

Robert Burton 616 S 11th St Pekin, IL 61554 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Emp	oloyee					Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification number (EIN												
1 Name of employ	ee			2 Social	security number	(SSN)	7 Name of	employe	r					8	Employe	r identifica	tion num	ber (EIN)
Robert Burton	1				XXX-XX-164	47	Wheelwo	orx No	rth, LLC	;						272915	146	
3 Street address (i	ncluding apartr	nent no.)		•			9 Street ac	ldress (in	cluding roo	om or su	ite no.)			10	Contact	telephone	number	
616 S 11th St							1480 Wo	odbin	e Avenu	ıe					2	205668	5720	
4 City or town		5 State or provin	ce	6 Country	and ZIP or foreig	n postal code	11 City or to	wn		12 S	tate or pr	ovince		13	Country a	nd ZIP or fo	reign pos	tal code
Pekin		IL		US 615	554		Calera			AL				U:	S 3504	0		
Part II Emp	oloyee Offe	er of Covera	ige	•			Plan Sta	art Mo	nth (Ent	ter 2-d	igit nun	nber): (03	•				
	All 12 Months	Jan	Feb	Mar	Apr	May	June)	July		Aug	Se	pt	Oct		Nov	[Dec
14 Offer of Coverage (enter required code)		1E	1E	1E 1E 1E		1E		1E		1E	16	Ξ	1E		1E		1E	
15 Employee Required Contribution (see instructions)	\$	\$ 132.57					1 \$ 119	0.34 \$							9.34 \$	119.3		119.34
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C		2C		2C	20		2C		2C		2C
Part III Cov	ered Indiv	iduals	'									•						
If Em	ployer prov	ided self-insu	red coverage	e, check the	box and enter	r the inform	ation for	each in	dividual	enrolle	d in co	verage,	includi	ng the	employ	ee. L		
(a) Name	of covered ind	ividual(s)	(h) SSN o	r other TIN	(c) DOB (If SSN or other TIN is	(u) Cove					(e) Months	of Cover	age				
(a) 11a.110			(5) 33113	Totalor Till	not available) all 12 mo			Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																		
18																		
19																		
20																		
21																		
22																		

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Form 1095-C (2016)	Page
1 0111 1033-0 (2010)	raue

Name of employee

Robert Burton

Part III Covered Individuals — Continuation Sheet

(e) Months of coverage

Part	Part III Covered Individuals — Continuation Sheet (a) Name of a covered individual's — (b) CON and the TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other	(d) Covered												
			TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
23																
24																
25																
26																
27																
28																
29																
30																
31																
32																
33																
34																

Cyle Canevit 19147 North St Hwy 78 Canton, IL 61521 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Emp	ployee			Appli	cable L	.arge	Emplo	yer M	ember	· (Emp	loyer)										
1 Name of employ	/ee	7 N	Name of	employe	r					8	Employe	r identifica	tion num	nber (EIN)							
Cyle Canevit			Wh	neelwo	rx Nor	th, LLC							272915	146							
3 Street address (i	including apartm	ent no.)	9 8	Street ad	dress (inc	cluding roc	m or su	ite no.)			10	Contact t	telephone	number							
19147 North 9	St Hwy 78		148	30 Wc	odbine	e Avenu	ie					2	205668	6720							
4 City or town	5	State or provi	n postal code	11 (City or to	wn		12 9		13	Country a	nd ZIP or fo	oreign pos	stal code							
Canton	11	L		US 6	1521		Cal	lera			AL				US	US 35040					
Part II Emp	ployee Offe	r of Cover	age	•			Pla	an Sta	rt Mo	nth (Ent	er 2-c	ligit num	nber):	03	•						
	All 12 Months	Jan	Feb	Mar	Apr	May		June		July		Aug		pt	Oct		Nov		Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H		1E		1E		1E	11	E	1E		1E		1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	119	.34 \$	119.3	4 \$	\$ 119.34		19.34	§ 119	.34 \$	119.3	4 \$	119.34		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2D 2D 2		2C 2C			2C	2C		2C	C 2C			2C				
	ered Individual		ired coverage	e check th	e box and enter	r the inform	natio	on for 6	each ind	dividual	enrolle	ed in cov	verage.	includi	na the i	employ	ee]			
					(c) DOB (If SSN or other TIN is)	2011 1110	arriadar	01110110			of Covera		ыпроу	<u> </u>				
(a) Name	e of covered indiv	/idual(s)	(b) SSN c	or other TIN	er TIN or other TIN is not available)		nths	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
17																					
18																					
19																					
20																					
21																					
												I_{\square}									
22								Ш			Ш										

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Form 1095-C (2016)	Page 3

Name of employee Social security number (SSN) Cyle Canevit XXX-XX-5985 Covered Individuals — Continuation Sheet Part III (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

Darren R Connett 305 Linden St. Pekin, IL 61554 Department of the Treasury

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

VOID	
	OMB No. 1545-2251
CORRECTED	2016

Internal Revenue Se	rvice	► into	rmation a	ibout Fo	orm 1095-	C and its sepai	ate instruc	tions is at i	www.irs	.gov/torr	n1095c					- 1		· - •		
Part I Emp	oloyee								Appli	cable L	arge	Emplo	yer Me	ember	(Emp	loyer)				
1 Name of employ	/ee		7 Name of	employe	r					8	Employer	identifica	ation numl	ber (EIN)						
Darren R Con	nett					XXX-XX-01	28	Wheelwo	orx Noi	th, LLC	;					:	272915	146		
3 Street address (i	including apartn	9 Street ac	ddress (in	cluding roo	om or sui	te no.)			10	Contact t	elephone	number								
305 Linden St	1480 Wo	odbine	e Avenu	ıe					2	05668	6720									
4 City or town		5 State or provi	nce		6 Count	ry and ZIP or foreig	n postal code	11 City or to	own		12 S	tate or pr	ovince		13	Country ar	nd ZIP or fo	or foreign postal code		
Pekin		IL			US 61	554		Calera			AL				US	US 35040				
	oloyee Offe	er of Cover	age					Plan St	art Mo	nth (En	ter 2-di	igit num	nber): (03						
	All 12 Months	Jan	Feb)	Mar	Apr	May	June		July		Aug	Sep		Oct		Nov	1	Dec	
14 Offer of Coverage (enter required code)		1A			1A	1A		1A		1A	1/	Δ .	1A		1A		1A			
15 Employee Required Contribution (see instructions)	\$	\$ \$		\$		\$	\$	\$	\$		\$		\$	9	8	\$		\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																				
	ered Indivingloyer provi		ured cove	erage, c	check the	box and ente			each in	dividual	enrolle					employ	ee.]		
(a) Name	e of covered ind	ividual(s)	(b) S	SSN or ot	her TIN	(c) DOB (If SSI or other TIN is not available)	(d) Coverall 12 mg		Feb	Mar	Apr	May) Months June	July	Aug	Sept	Oct	Nov	Dec	
17																				
18																				
19																				
20																				
21																				
22																				

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Form 1095-C (2016) Page 3

Name of employee Social security number (SSN) Darren R Connett XXX-XX-0128 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32

33

Leo E Davis 108 S First St, PO Box 23 South Pekin, IL 61564 Form 1095-C
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

VOID	
	OMB No. 1545-2251
CORRECTED	2016

Part I Employee												Applicable Large Employer Member (Employer)														
1 Name of employee 2 Social security number (SSN) 7													of er	mployer								8 E	mployer	identifica	ition nu	mber (EIN)
															th, LL0								2	272915	146	
3 Street address (including apartment no.)													addı	ress (inc	cluding ro	om (or suit	e no.)				10 C	ontact t	elephone	numbe	r
108 S First St PO Box 23													/oo	odbine	e Aven	ue							2	05668	6720	
4 City or town 5 State or province 6 Country and ZIP or foreign postal code																								d ZIP or fo	oreign p	stal code
South Pekin		IL				Į	US 615	64			c	Calera										US	35040)		
Part II Emp	loyee Off	er of	Covera	ige							P	lan S	tar	rt Moi	nth (Er	nter	•									
	All 12 Months		Jan		Feb		Mar		Apr		May	Jui	пе		July		Α	lug	Sep	pt	Oct Nov					Dec
14 Offer of Coverage (enter required code)			1E		1E		1E		1E		1E	11	E		1E		1	1E	16	Ξ	1	E		1E		1E
15 Employee Required Contribution (see instructions)	\$	\$	132.57	\$	132.57	\$	132.57	\$	119.34	\$	119.34	4 \$ 119.34 \$ 119.34 \$				\$ 11	9.34	_{\$} 1	19.3	34 \$	119.3	4 \$	119.34			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C		2C		2C 2C		2C		2C	20	2C 2C			2	2C	2C		2C			2C		2C	
	ered Indiv													·						·			·		7	
If Em	ployer prov	ided	self-insu	red	coverage	, che	eck the				e informat	ion fo	r ea	ach inc	dividual	l en	rolled					ne er	nploye	e. L		
(a) Name	of covered ind	ividua	l(s)		(b) SSN or	other	· TIN	(c)	DOB (If SSN other TIN is	\ :	(d) Covered							. ,	Months	age						
				\perp					not available)		all 12 month	s Jar	1	Feb	Mar	<i>F</i>	Apr	May	June	July	Au	ıg	Sept	Oct	Nov	Dec
													1									7				
17												-	1			ļ.						-				
18																										
19																										
20																										
21																										
22																										

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Name of employee Social security number (SSN) Leo E Davis XXX-XX-1908 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29

30

31

32

33

Perry R Denning 33529 North Norris Blacktop Farmington, IL 61531 Form 1095-C
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

VOID	
	OMB No. 1545-2251
CORRECTED	2016

1 Name of employee 2 Social security number (SSN)										Applicable Large Employer Member (Employer) 8 Employer identification number												
										7 Name of employer Wheelworx North, LLC 8 Employer identification of the control of the contro										ation nun	nber (EIN)	
Perry R Denn	ing						XXX-XX	-2107	7	Wh	eelwo	rx Noi	rth, LLC)						272915	146	
3 Street address (i	including apartme	ent no.	.)							9 S	Street add	dress (in	cluding ro	om or su	ite no.)			10	Contact	telephone	number	
33529 North N	Norris Black	top								148	30 Wo	odbine	e Aveni	ле					1	205668	6720	
4 City or town	5	State	or province	Э		6 Country	and ZIP or f	oreign p	oostal code	11 C	City or to	wn		12 S	tate or pro	ovince		13	Country a	nd ZIP or f	oreign po	stal code
Farmington	li li	L				US 615	31			Cal	lera			AL				U:	S 3504	0		
Part II Emp	ployee Offe	r of (Coveraç	ge		•				Pla	an Sta	rt Mo	nth (En	ter 2-d	igit num	nber): ()3					
	All 12 Months	,	Jan	Feb		Mar	Apr		May		June		July		Aug	Sep	ot	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)	\$	\$, v			132.57	\$ 119	.34 \$; 119.34	4 \$	119	.34 \$	119.3	4 \$	119.34	\$ 11	9.34	\$ 119	9.34 \$	119.3	4 \$	119.34
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	e Harbor and er Relief (enter e, if applicable) 2C 2C					2C	2C		2C		2C		2C		2C			2C		2C		2C
																					1	
If Em	nployer provid	ded s	elf-insure	ed coverag	e, c	heck the l			the inform	atio	n for e	ach in	dividual	enrolle					employ	ee.		
(a) Name	e of covered indiv	/idual(s	s)	(b) SSN o	or ot	her TIN	(c) DOB (I	f SSN IN is	(d) Cover						· · · · ·	Months		-				
				, ,			not avail		all 12 mon	าเกร	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																						
18																						
19																						
20																						
21																						
22																						

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Name of employee Social security number (SSN) Perry R Denning XXX-XX-2107 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Sept Jan Feb Mar Apr May Jun Jul Aug Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33 34

Jacob Donald 2201 Sierra Dr Pekin, IL 61554 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Emp		Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification number																
1 Name of employ	ree	(SSN)	7 Name of employer 8 Employer identification number Wheelworx North, LLC 272915146															
Jacob Donald					XXX-XX-532	29	Wheelwo	orx Noi	rth, LLC	,						272915	146	
3 Street address (i	ncluding apartme	ent no.)		·			9 Street ac	ldress (in	cluding roo	om or su	ite no.)			10	Contact t	elephone	number	
2201 Sierra D	r						1480 Wo	odbine	e Avenu	ıe					2	05668	6720	
4 City or town	5	State or prov	ince	6 Cour	try and ZIP or foreigr	n postal code	11 City or to	wn		12 9	State or pr	ovince		13	Country a	nd ZIP or f	oreign pos	tal code
Pekin	11			US 6	1554		Calera			AL				US	3504	0		
Part II Emp	oloyee Offe	r of Cover	rage				Plan Sta	art Mo	nth (Ent	ter 2-d	ligit num	nber):	03					
	All 12 Months	Jan	Feb	Mar	Apr	May	June)	July		Aug	Sept		Oct		Nov		Оес
14 Offer of Coverage (enter required code)		1H	1H	1H	1E	1E	1E		1E		1E	11	Н	1H	H 1H		1H	
15 Employee Required Contribution (see instructions)	ion (see ns) \$ \$ \$			\$	\$ 119.34	\$ 119.34	34 \$ 119.34 \$ 119.34		4 \$	119.34	\$	\$	\$	\$		\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	e Harbor and er Relief (enter e, if applicable) 2A 2D			2D	2C	2C	2C 2C			2C	21	В	2A	A 2A		2A		
	ered Individual		ation for	each in	dividual	enrolle	ed in co	verage,	includi	ng the	employee.							
(a) Name	of covered indiv	/idual(s)	(b) SSN c	or other TIN	(c) DOB (If SSN or other TIN is	(d) Cover					`) Months	of Covera					
(4)		(0)	(5) 5511 5		not available)	all 12 mor	^{nths} Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																		
18																		
10																		
19																		
20																		
21	21																	
22																		

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Form 1095-C (2016) Page 3 Name of employee Social security number (SSN) XXX-XX-5329 Jacob Donald Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

Brett A Duley 1408 Howard Ct Pekin, IL 61554 Form 1095-C
Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

VOID	OMB No. 1545-2251
CORRECTED	2016

internal nevertue Service Financial about 1 offin 1000-0 and its Separate											o io at w	VV VV.11 3	.gov/ioi	1110000	,				- 1			
Part I Employee										Applicable Large Employer Member (Employer) N) 7 Name of employer 8 Employer identification number (Employer)												
										7	Name of	employe	r					8	Employ	er identifica	ation nur	nber (EIN)
Brett A Duley							Χ	XX-XX-874	17	Wł	neelwo	rx No	rth, LLC)						272915	5146	
3 Street address (in	ncluding apartr	ment r	no.)			<u>'</u>				9 :	Street add	dress (in	cluding ro	om or su	ite no.)			10) Contac	t telephone	number	
1408 Howard	Ct									14	80 Wo	odbin	e Aveni	ue						205668	6720	
4 City or town		5 Sta	ate or provinc	e		6 Cou	ntry a	ınd ZIP or foreigr	n postal code	11 (City or to	wn		12 9	State or pr	ovince		13	3 Country	and ZIP or f	oreign po	stal code
Pekin		IL				US 6	155	54		Са	llera			AL				lυ	S 350	40		
	loyee Off	er o	f Covera	ge		Į						rt Mo	nth (En		ligit num	nber): (03					
	All 12 Months	3	Jan	Feb		Mar		Apr	May		June		July		Aug	Sep		Oct	:	Nov		Dec
14 Offer of Coverage (enter required code)			1E	1E		1E		1E	1E		1E		1E		1E	16	-	1E		1E		1E
15 Employee															· <u>-</u>	1						
Required Contribution (see instructions)	\$	\$	132.57	\$ 132.5	57	\$ 132.	57 s	\$ 119.34	\$ 119.3	4 \$; 119	.34 \$	119.3	\$4 \$	119.34	\$ 11	9.34	\$ 11 ⁴	9.34	119.3	\$4 \$	119.34
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) Part III Covered Individuals			2H		2H		2H	2H		2H		2H		2H	2H		2H		2H		2H	
								'								1						
If Em	ployer prov	rided	self-insure	ed covera	ige	, check th	ne bo	ox and enter	the inform	nation for each individual enrolled in coverage, including the employee. $lacksquare$												
(a) Name	of covered ind	lividus	al(e)	(b) 99h	l or	other TIN		(c) DOB (If SSN or other TIN is	(4, 00.0						(e) Months	of Cover	age				
(a) Name	or covered inc	iividuc	11(3)	(b) 331) SSN or othe			not available)	all 12 mo	nths	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
17																						
																	l					
18																					<u> </u>	
														$ \Box$								
19																						
20																						
21																			\perp			
22																						
				1					1		1	I	1	1	1	1	1	1	1	1	1	1

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Page 3 Name of employee Social security number (SSN) XXX-XX-8747 **Brett A Duley** Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

Tayler Durm 307 W Washington St Manito, IL 61546 Form 1095-C
Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

VOID	
	OMB No. 1545-2251
CORRECTED	2016

internal nevertue ser	rvice	P 111101	ate monact	ons is at v	, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,, ,	goviion	1110000											
Part I Emp	oloyee				Applicable Large Employer Member (Employer)													
1 Name of employe	ee		(SSN)	7 Name of	employer	r					8	Employe	r identifica	ation num	ber (EIN)			
Tayler Durm					XXX-XX-268	38	Wheelwo	rx Nor	th, LLC							272915	5146	
3 Street address (in	ncluding apartr	nent no.)		<u>'</u>			9 Street ad	dress (ind	cluding ro	om or sui	te no.)			10	0 Contact t	elephone	number	
307 W Washir	ngton St						1480 Wo	odbine	e Avenu	ле					2	205668	6720	
4 City or town		5 State or provin	nce	6 Count	ry and ZIP or foreigr	n postal code	11 City or to	wn		12 St	ate or pr	ovince		13	3 Country a	nd ZIP or f	oreign pos	tal code
Manito		IL		US 61	546		Calera			AL				U	IS 3504	0		
Part II Emp	oloyee Off	er of Covera	age				Plan Sta	rt Mo	nth (En		git num	nber): (03	-				
	All 12 Months	Jan	Feb	Mar	Apr	May	June		July		Aug	Sep		Oct	t	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1E	1H	1H		1H		1H	11	4	1H	1	1H		 1H
15 Employee Required Contribution (see	equired ontribution (see structions) \$ \$			\$	\$ 119.34		\$	\$		\$		\$			\$		\$	
6 Section 4980H			\$	Ψ	Ψ	Ψ	Ψ	Ψ		-		Ψ		,	-		Ψ	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) Part III Covered Individuals			2D	2D	2C	2B	2A		2A		2 A	24	Α	2A		2A		2A
				•			·					•					7	
If Em	ployer prov	ided self-insu	red coverage	e, check the	box and enter		ation for e	each ind	dividual	enrolle					employ	ee. L		
(a) Name	of covered ind	lividual(s)	(b) SSN o	r other TIN	(c) DOB (If SSN or other TIN is	(a) 0000					(e) Months	of Covera	age	_			
(4)			(2) 55.15		not available)	all 12 mor	^{nths} Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
										l								l
17																		
											l							l
18																		
										l				l —				l
														$ \sqcup $				
19																		
								l —		l —			l —			l —	l —	l —
														ш				
20																		
										l —		l —	l m					l —
21																		
<u> </u>									-									
22																		
					1	1		I	1	1	1	1	1	1	1	1	1	1

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Form 1095-C (2016) Page 3 Name of employee Social security number (SSN) XXX-XX-2688 Tayler Durm Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Sept Jan Feb Mar Apr May Jun Jul Aug Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

Frank M Figurski 616 S 11th St Pekin, IL 61554 Form 1095-C
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Emp		Applicable Large Employer Member (Employer) N) 7 Name of employer 8 Employer identification number (
1 Name of employe	ee	(SSN)	7 Name of employer Wheelworx North, LLC 8 Employer identification numb 272915146											ber (EIN)				
Frank M Figur	ski				XXX-XX-819	99	Wheelwo	orx No	rth, LLC							272915	5146	
3 Street address (in	ncluding apartr	ment no.)		<u>'</u>			9 Street ac	ddress (in	cluding roo	om or sui	te no.)			10	Contact	elephone	number	
616 S 11th St							1480 Wo	odbine	e Avenu	ле					2	05668	6720	
4 City or town		5 State or provi	nce	6 Count	ry and ZIP or foreig	n postal code	11 City or to	own		12 St	ate or pro	ovince		13	Country a	nd ZIP or f	oreign pos	tal code
Pekin		IL		US 61	554		Calera			AL				U:	S 3504	0		
	oloyee Off	er of Cover	age	!			Plan Sta	art Mo	nth (Ent	ter 2-di	git num	nber): (03	<u>.</u>				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	,	July	l A	Aug	Sep	ot	Oct		Nov	П	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A		1A		1A	1A		1H		1H		1H
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$		\$	\$	\$		\$		\$	9	6	\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														2B		2A		2A
	If Employer provided self-insured coverage, check the box and enter the info									enrolle					employ	ee.		
(a) Name	of covered inc	dividual(s)	(b) SSN o	r other TIN	(c) DOB (If SSN or other TIN is	(d) Cove						Months						
					not available)	all 12 mo	^{nths} Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																		
18																		
10																		
19																		
20																		
									I_{\square}									
21								$\perp \square$							\perp		\perp	╙
22																		

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Page 3 Name of employee Social security number (SSN) Frank M Figurski XXX-XX-8199 Covered Individuals — Continuation Sheet Part III (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

Derik W Flairty 23776.5 NCR 2900 E. Manito, IL 61546 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Employee 1 Name of employee 2 Social security number (SSN)									Applicable Large Employer Member (Employer) 7. Name of employer 8. Employer identification number													
									7 Name of employer 8 Employer identification numb Wheelworx North, LLC 272915146												ber (EIN)	
Derik W Flairt	У						XXX-XX-38	43	W	heelwo	rx Noi	rth, LLC)					:	272915	146		
3 Street address (i	ncluding apartr	nent n	10.)						9	Street ad	dress (in	cluding ro	om or si	ite no.)			10	Contact t	elephone	number		
23776.5 NCR	2900 E.								14	180 Wo	odbine	e Aveni	Je					2	05668	6720		
4 City or town		5 Sta	te or provinc	е		6 Country	y and ZIP or foreig	gn postal cod	e 11	City or to	wn		12 3	State or pr	ovince		13	Country a	nd ZIP or f	oreign pos	tal code	
Manito		IL				US 615	546		Ca	alera			AL				US	3504	0			
Part II Emp	oloyee Offe	er of	f Covera	ge					Р	lan Sta	rt Mo	nth (En	ter 2-c	ligit num	nber): (03	•					
	All 12 Months		Jan	Feb		Mar	Apr	May		June		July		Aug	Sept		Oct		Nov		Оес	
14 Offer of Coverage (enter required code)			1E	1E		1E	1E	1E		1E		1E		1E	1E		1E		1H		1H	
15 Employee Required Contribution (see instructions)	\$ \$ 132.57 \$ 132.5			57 \$	3 132.57	1 \$ 119.34	\$ 119	.34	34 \$ 119.34 \$ 119.34		4 \$	119.34	\$ 11	9.34	3 119	.34 \$		\$				
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	Harbor and er Relief (enter e, if applicable)				2H	2C	2C		2C		2C		2C	20		2C	C 2B		2	2 A		
										ion for e	each ind	dividual	enroll	ed in co	verage,	includi	ng the e	employ	ee.			
(a) Name	of covered ind	lividua	l(s)	(b) SS	V or o	ther TIN	(c) DOB (If SS or other TIN is	N (d) Co						(e	Months	of Covera	age					
(4)			(0)	(5) 00			not available	all 12 r	nonths	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
17																						
18																						
10																						
19																						
									7													
20																						
21																						
														+								
22																						

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Page 3 Name of employee Social security number (SSN) Derik W Flairty XXX-XX-3843 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

John M R Hilton 1621 N. Caroline Apt 6 Pekin, IL 61554 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Employee								Applicable Large Employer Member (Employer)																	
1 Name of employee 2 Social security number (SSN)								7 Name of employer 8 Employer identification number (EIN)																	
							Wheelworx North, LLC 272915146																		
3 Street address (including apartment no.)							9	9 Street address (including room or suite no.) 10 Contact telephone number																	
1621 N. Caro	line Apt 6										1480 Woodbine Avenue 2056686720														
4 City or town		5 Sta	te or provin	се		(6 Country	and ZIP or foreig	ın po	ostal code 1	1 City	or town	1		12	State or p	rovince			13 Co	untry an	d ZIP or fo	reign pos	tal code	
Pekin		IL				L	JS 615	54			Caler				AL					US 3	35040)			
Part II Emp	oloyee Offe	er of	Covera	ge						F	Plan	Start	t Mo	nth (En	ter 2-	03									
	All 12 Months		Jan		Feb	N	Лar	Apr		May	June			July		Aug	Se	pt	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)	\$	\$	132.57	\$	132.57	\$ 1	32.57	\$ 119.34	\$	119.34	\$	119.3	4 \$	119.3	4 \$		\$;	\$		\$		\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2H		2H	2	2H	2C		2C		2C		2C		2B	2.	A	2A		A 2A		2A		
	ered Indivi			ed	coverage	, che	ck the l	box and ente		ne informa	ition	for ead	ch ind	dividual	enrol					ne em	nploye	e.]		
(a) Name	of covered ind	ividua	l(s)		(b) SSN or	other	TIN		(d) Covere																
(b) o		(2) 001101	outer the		not available)	e)	all 12 monti	hs .	lan	Feb	Mar	Apr	May	June	July	Au	ıg (Sept	Oct	Nov	Dec				
17																									
18																									
				+																					
19																									
20																									
20				+												+									
21																									
											 	\exists							1	7					
22																									

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Name of employee Social security number (SSN) XXX-XX-8161 John M R Hilton Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30

31

32

33

Tyler M Jank 1419 Lincoln Street Pekin, IL 61554 Department of the Treasury Internal Revenue Service

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

VOID	•
	OMB No. 1545-2251
CORRECTED	2016

Part I Employee							Applicable Large Employer Member (Employer)														
							7 Name of employer 8 Employer identification number (EIN)														
Tyler M Jank XXX-XX-8206							Wheelworx North, LLC 272915146														
3 Street address (including apartment no.)								9 Street address (including room or suite no.) 10 Contact telephone number													
1419 Lincoln S	Street						1480 Woodbine Avenue 2056686720														
4 City or town		5 State or provi	nce	6 Count	ry and ZIP or foreign	n postal code	11 City or tov	vn		12 St	ate or pro	ovince		13	Country ar	nd ZIP or fo	reign pos	tal code			
Pekin		IL		US 61	554		Calera							US	3504	0					
	oloyee Off	er of Cover	age	!			Plan Sta	rt Mo	nth (Ent	ter 2-di	git num	nber): (03								
	All 12 Months	Jan	Feb	Mar	Apr	May	June		July		Aug	Sept		Oct		t Nov		Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H		1H		1H	11-	4	1E	1E			1E			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$		\$	\$	\$		\$		\$	4		.34 \$	119.3		119.34			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2D	2B	2A		2D] :	2D	2[)	2C		2C		2C			
	ered Indiv ployer prov		ured coverage	e, check the	e box and enter		ation for e	ach ind	dividual	enrolle	d in cov	verage,	includi	ng the e	employe	ee.					
(a) Name	of covered ind	lividual(s)	(b) SSN c	or other TIN	(c) DOB (If SSN or other TIN is	(d) Cove															
(a) Name	or covered ma	ividual(b)	(5) 0011 0	o other this	not available)		^{nths} Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
17																					
17																					
18																					
19																					
20																					
21																					
									+												
22																					

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Form 1095-C (2016)	Page .

Page 3 Name of employee Social security number (SSN) Tyler M Jank XXX-XX-8206 Covered Individuals — Continuation Sheet Part III (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30

31

32

33

William J Jenkins 17308 West St Rd Brimfield, IL 61517 Form 1095-C
Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

VOID	
	OMB No. 1545-2251
CORRECTED	2016

internal revenue oc	I VICC				- u oopu.														
Part I Emp	oloyee							Appli	cable l	arge l	Emplo	yer Me	ember	(Emp	oloyer)				
1 Name of employ	/ee			2 Socia	al security number ((SSN)	7 Name of	employe	r					8	B Employe	r identifica	tion num	ber (EIN)	
William J Jenkins XXX-XX-6692							Wheelworx North, LLC 272915146												
3 Street address (i	including apartr	ment no.)		'			9 Street ad	dress (in	cluding ro	om or sui	te no.)			10	0 Contact	telephone	number		
17308 West S	St Rd						1480 Woodbine Avenue 2056686720												
4 City or town		5 State or provi	ince	6 Count	ry and ZIP or foreigi	n postal code	11 City or to	wn		12 St	ate or pr	ovince		13	3 Country a	nd ZIP or f	oreign pos	tal code	
Brimfield		IL		US 61	517		Calera			AL				U	IS 3504	0			
Part II Employee Offer of Coverage				!			Plan Sta	art Mo	nth (En		03								
	All 12 Months	Jan	Feb	Mar	Apr	May	June		July		Aug	Se		Oc.	t Nov		[Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A			1A		1A		A	1A			A 1,		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$		\$	\$	\$		\$		\$	\$		\$		\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																			
	ered Indiv		ured coverso	ne check the	e box and ente	r the inform	ation for	ach in	dividual	enrolle	d in co	verage	includi	na the	employ	00	<u></u>		
II LIII	ipioyei piov	ided sell-lilis	The Coverage	je, check the	(c) DOB (If SSN			acii iii	uividuai	erirone) Months			employ	ee. <u> </u>			
(a) Name	e of covered ind	lividual(s)	(b) SSN	or other TIN	or other TIN is not available)	all 12 mor		Feb	Mar	Apr	May	June Jul				Sept Oct		Dec	
					not available)									1 3			Nov		
17																			
18																			
19																			
20																			
21																			
22																			

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Form 1095-C (2016) Page 3

Name of employee Social security number (SSN) William J Jenkins XXX-XX-6692 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32

33

Bradley Kister 1422 Camden St Pekin, IL 61554 Form 1095-C
Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

VOID	
	OMB No. 1545-2251
CORRECTED	2016

Part I Emp	loyee											Appl	icable	: La	arge l	Emplo	yer Me	ember	(Emp	loyer)			
1 Name of employ	ee					2 Social s	securi	ity number	(SSN)) 7	Name of	employ	er						8	Employe	r identifica	ation nu	mber (EIN)
Bradley Kister	•						XXX	(-XX-09	18	lw.	heelw	orx No	rth, Ll	_C							272915	5146	
3 Street address (in	ncluding apartn	nent n	0.)							9	Street a	ddress (ii	ncluding	roon	n or sui	te no.)			10	Contact	telephone	numbe	r
1422 Camden	st St									14	180 W	odbir	e Ave	nue	9						205668	6720	
4 City or town		5 Sta	te or provinc	e		6 Country	and Z	ZIP or foreig	n pos	tal code 11	City or to	own			13	13 Country and ZIP or foreign postal code							
Pekin		IL				US 615	54			lc.	alera				AL				US	S 3504	.0		
	loyee Offe	er of	Coverage	ge								art Mo	onth (E	nte		git num	ber): (03					
	All 12 Months		Jan	Feb		Mar		Apr		May	June		July		_	lug	Sep		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)	\$	\$	132.57		7 s				\$	119.34				.34						9.34 \$		4 \$	119.34
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C	<u> </u>	2C		2C	<u> </u>	2C	2C	·	2C			2C	20		2C		2C		2C
Part III Cove	ered Indiv	idua	ls				•											·					
If Em	ployer prov	ided	self-insure	ed coverag	e, ch	eck the l				informat	ion for	each ir	ndividu	al e	nrolle	d in cov	erage,	includi	ng the	employ	ee.		
(a) Name of covered individual(s) (b) SSN or other TIN or other TIN is							(d) Covered						(e)	Months	of Covera	age							
(a) Name	or covered ind	ividua	1(3)	(b) 33N (or othe	ZI IIIN	no	ot available)	, -	all 12 month	s Jan	Feb	Mai	•	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																							
18																							
10														+									
19																							
20																							
21																							
22																							

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Form 1095-C (2016)	Page 3

Name of employee Social security number (SSN) **Bradley Kister** XXX-XX-0918 Covered Individuals — Continuation Sheet Part III (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33 34

Brad A McKinley 1331 Cherry Drive Pekin, IL 61554 Form 1095-C
Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

VOID	1
	OMB No. 1545-2251
CORRECTED	9M16

Part I Emp	oloyee								Appli	cable I	arge	Emplo	yer M	ember	(Emp	loyer)			
1 Name of employ	ee				2 Socia	I security number	(SSN)	7 Name of	employer	r					8	Employe	identifica	tion num	ber (EIN)
Brad A McKin	ley					XXX-XX-139	93	Wheelwo	orx Nor	th, LLC)						272915	146	
3 Street address (i	ncluding apartr	nent no.)						9 Street ac	dress (ind	cluding ro	om or sui	te no.)			10	Contact t	elephone	number	
1331 Cherry [Orive							1480 Wo	odbine	e Aveni	ле					2	05668	6720	
4 City or town		5 State or prov	rince		6 Count	ry and ZIP or foreig	n postal code	11 City or to	wn		12 S	tate or pr	ovince		13	Country a	nd ZIP or f	oreign pos	tal code
Pekin		IL			US 61	554		Calera			AL				US	3504	0		
Part II Emp	oloyee Off	er of Cove	rage		•			Plan Sta	art Mo	nth (En	ter 2-di	git nun	nber):	03	•				
	All 12 Months	Jan	Fe	b	Mar	Apr	May	June		July	/	Aug	Se	pt	Oct		Nov	[Оес
14 Offer of Coverage (enter required code)		1A	1,	Δ	1A	1A	1A	1A		1A		1A	1/	4	1A		1A		1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$			\$	\$	\$		\$		\$	4		\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		•					<u>·</u>		•				·						
	ered Indiv		ured cov	erage, c	check the	box and ente		nation for	each ind	dividual	enrolle	d in co	verage,	includi	ng the	employ	ee.]	
(a) Nama	of covered ind	lividual(c)	(b)	SSN or ot	hor TINI	(c) DOB (If SSN	(d) Cove	ered				(e) Months	of Covera	age				
(a) Name	or covered ind	ividuai(5)	(6)	3311 01 01	TIEL LIIN	or other TIN is not available)	all 12 mo	nths Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																			
18																			
19																			
20																			
21																			
22																			

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Form 1095-C (2016) Page 3

Name of employee Social security number (SSN) XXX-XX-1393 Brad A McKinley Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

34

Richard L McKinley 414 Woodland Pekin, IL 61554 Department of the Treasury Internal Revenue Service

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

VOID	
	OMB No. 1545-2251
CORRECTED	9016

Part I Emp	loyee		Applicable Large Employer Member (Employer)																
1 Name of employe				2 Socia	(SSN)	7 Name of employer 8 Employer identification number (E													
Richard L Mck	Kinley				XXX-XX-22	36	Wheelwo	orx Nor	th, LLC	,						27291	5146		
3 Street address (in		nent no.)					9 Street ac				e no.)			10	0 Contact	telephone			
414 Woodland	l						1480 Wc	odbine	e Avenu	ıe						205668	6720		
4 City or town		5 State or provi	nce	6 Count	ry and ZIP or foreig	n postal code	11 City or to	own		12 St	ate or pro	ovince		1:	3 Country	and ZIP or f	oreign pos	tal code	
Pekin		IL		US 61	554		Calera			AL				U	JS 3504	10			
	loyee Off	er of Cover	age				Plan Sta	art Mo	nth (Ent	ter 2-di	git num	nber): (03						
	All 12 Months	Jan	Feb	Mar	Apr	May	June		July		lug	Sep	ot	Oc	t	Nov	1	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A		1A		1A	1,4	\ \ \	14		1A		1A	
15 Employee Required Contribution (see	\$	\$	\$	\$		\$	\$	\$		\$		\$	\$		\$		\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																			
	ered Indiv		•	•	<u>.</u>										•				
If Em	ployer prov	ided self-insı	ured coverag	e, check the	e box and ente		ation for e	each ind	dividual	enrolle					employ	/ee. L			
(a) Name	of covered ind	ividual(s)	(b) SSN (or other TIN	(c) DOB (If SSN or other TIN is	(a) cover						Months							
					not available)	all 12 mor	iths Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
17																			
18																			
19																			
20																			
21																			
22																			

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Name of employee Social security number (SSN) Richard L McKinley XXX-XX-2236 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33 34

Maxwell R McLinden 142 Jay St East Peoria, IL 61611 Form **1095-C**Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Employee										Applicable Large Employer Member (Employer)														
1 Name of employee 2 Social security number (SSN)											7 Name of employer 8 Employer identification number (
Maxwell R Mc	Linden						XX	X-XX-049	9	W	heelwo	rx No	rth, LLC								27291	5146		
3 Street address (in	ncluding apartr	nent n	10.)							9	Street ad	dress (in	cluding ro	om or	suite no.)			10	Contact	telephone	number		
142 Jay St										14	80 Wo	odbin	e Aveni	ue						1	205668	6720		
4 City or town		5 Sta	te or provinc	e		6 Country	and and	ZIP or foreign	n postal cod	e 11	City or to	wn		12	State o	r pro	vince		13	Country a	nd ZIP or f	oreign pos	tal code	
East Peoria		IL				US 616	511			Ca	alera			AL	_				U:	S 3504	0			
Part II Emp	loyee Off	er of	Coverage	ge		•				P	lan Sta	rt Mo	nth (En	ter 2-	digit n	uml	ber): ()3	•					
	All 12 Months		Jan	Feb		Mar		Apr	May		June		July		Aug		Sep	ot	Oct		Nov	П	Dec	
14 Offer of Coverage (enter required code)			1E	1E		1E		1E	1E		1E		1E		1E		1E	<u> </u>	1H		1H		1H	
15 Employee Required Contribution (see instructions)	\$	\$	132.57	\$ 132.57	\$	132.57	\$	119.34	\$ 119.	34 8	_{\$} 119	.34 \$	119.3	34 \$	119.	34	\$ 11	9.34	6	\$		\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C		2C		2C	2C		2C		2C		2C		20	;	2B		2A		2 A	
	ered Indiv			ed coverage	e, c	heck the	box	and enter	the infor	mati	ion for e	ach in	dividual	enro	lled in	cov	erage,	includi	ng the	employ	ee.			
				1			(c)	DOB (If SSN									Months of							
(a) Name	of covered ind	iividua	II(S)	(b) SSN o	r oti	ner I IIN		r other TIN is not available)	all 12 n	onths	Jan	Feb	Mar	Ар	r Ma	ay	June	July	Aug	Sept	Oct	Nov	Dec	
																7								
17															, _	_								
18																						<u> </u>		
19																								
																_								
20																								
21																								
										1						7								
22										_				_	, _	_								

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Form 1095-C (2016) Page 3

Name of employee Social security number (SSN) XXX-XX-0499 Maxwell R McLinden Covered Individuals — Continuation Sheet Part III (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

34

Christopher D McMillan 205 E. Chestnut Hartsburg, IL 62643 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Employee									Applicable Large Employer Member (Employer)														
1 Name of employ	1 Name of employee 2 Social security number (SSN)									7 Name of employer 8 Employer identification number (I													
Christopher D	McMillan						XXX-XX-64	89	Whee	owle	rx Nor	th, LLC	,					:	272915	i146			
3 Street address (i	ncluding apartr	ment n	0.)						9 Stre	et add	dress (inc	cluding ro	om or sui	te no.)			10	Contact t	elephone	number			
205 E. Chestr	nut								1480	Woo	odbine	Avenu	ıe					2	205668	6720			
4 City or town		5 Sta	te or provinc	е		6 Countr	y and ZIP or foreig	gn postal code	11 City	or tov	vn		12 S	tate or pr	ovince		13	Country a	nd ZIP or f	oreign post	tal code		
Hartsburg IL US 62643									Caler	alera AL US 35040													
Part II Emp	oloyee Off	er of	Covera	ge		-					rt Mo	nth (En		git num	nber): (03							
	All 12 Months	3	Jan	Feb		Mar	Apr	May	'	June		July	/	Aug	Se	pt	Oct		Nov	1	Оес		
14 Offer of Coverage (enter required code)			1E	1E		1E	1E	1E		1H		1H		1H	11	1	1H		1H		1H		
15 Employee Required Contribution (see instructions)	\$	\$	132.57		.57	\$ 132.57	7 \$ 119.34	\$ 119.3			\$		\$		\$	\$	3	\$		\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C		2C	2C	2C		2B		2A		2 A	2/	Α	2A		2A		2 A		
	ered Indiv			ed cove	rage,	check the	box and ente	er the infor	mation 1	for ea	ach ind	dividual	enrolle	d in co	verage,	includi	ng the	employ	ee.				
(a) Name	of covered inc	dividua	l(e)	(b) S	SNor	other TIN	(c) DOB (If SS or other TIN is	N (d) Cov						(е) Months	of Covera	age						
(a) Name	or covered inc	arviduu	(0)	(6)	514 01 0	Strict Till	not available	all 12 m	onths J	an	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
17																							
40																							
18																							
19] [
									1 [
20									_ _														
21																							
																				 			
22] [

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Form 1095-C (2016) Page 3

Name of employee Social security number (SSN) XXX-XX-6489 Christopher D McMillan Covered Individuals — Continuation Sheet Part III (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Sept Jan Feb Mar Apr May Jun Jul Aug Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

34

Richard P Montgomery Jr 1504 S. 8th St Pekin, IL 61554 Form **1095–C**Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Employee										Applicable Large Employer Member (Employer)															
1 Name of employ	ee					- :	2 Social s	security number	(SSN)	7	7 Name of employer 8 Employer identification										tion nu	mber (EIN)			
Richard P Mo	ntgomery .	Jr					,	XXX-XX-48	00	Wł	neelwo	rx Noi	rth, LLC			272915	146								
3 Street address (i	ncluding apartr	ment i	no.)			•				9 :	Street ad	dress (in	cluding ro	10	Contact t	elephone	numbe	r							
1504 S. 8th S	t									14	80 Wo	odbine	e Avenu	ле					2	205668	6720				
4 City or town		5 Sta	ate or provin	се			6 Country	and ZIP or foreig	n postal code	11 City or town 12 State or province								13 Country and ZIP or foreign postal code							
Pekin		IL				lι	JS 615	54		Ca	Calera AL								US 35040						
Part II Emp	loyee Off	er o	f Covera	age		•				PI	Plan Start Month (Enter 2-digit number): 03														
	All 12 Months	5	Jan	Fe	eb	1	Mar	Apr	May		June Jul		July	July Au		Aug Sept		Oct		Nov		Dec			
14 Offer of Coverage (enter required code)			1E	1	E		1E	1E	1E		1E		1E		1E	1E		1E	1E			1E			
15 Employee Required Contribution (see instructions)	\$	\$	132.57			\$ ^	132.57	\$ 119.34	\$ 119.3	4 \$	\$ 119.34		119.3	4 \$	119.34	9.34 \$ 119		§ 119	.34 \$	119.3	4 \$	119.34			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2	:C		2C	2C	2C		2C		2C		2C	20		2C		2C		2C			
Part III Cov	ered Indiv	idua	als		•												·				7				
If Em	ıployer prov	rided	l self-insu	red co	verage	, che	ck the l	oox and ente		natio	on for e	ach in	dividual	enroll		-		-	employ	ee. L					
(a) Name	of covered inc	dividua	al(s)	(b)) SSN or	other	TIN	(c) DOB (If SSI or other TIN is	(d) Cove) Months									
				``				not available	all 12 mc	ontns	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
17																					<u> </u>				
18																									
10																									
19																									
20																									
21																									
22																									

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Page 3 Name of employee Social security number (SSN) XXX-XX-4800 Richard P Montgomery Jr Covered Individuals — Continuation Sheet Part III (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

34

Andrew C Osborn 114 Fourth St, PO Box 233 South Pekin, IL 61564 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Employee										Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification number (
1 Name of employ	/ee					2 9	Social s	security number	(SSN)	7	7 Name of employer 8 Employer identification														
Andrew C Os	born)	XXX-XX-84	29	l w	heelwc	rx No		272915	146										
3 Street address (i	including apartr	ment r	no.)							9	Street ad	dress (in	cluding ro	om or s	suite no.)			10	Contact	telephone	number				
114 Fourth St	PO Box 23	33								14	180 Wo	odbin	e Aveni	ле					2056686720						
4 City or town		5 Sta	ate or provinc	се		6 C	ountry	and ZIP or foreig	ın posta	al code 11	City or to	wn		12	State or pr	ovince		13	Country a	nd ZIP or fo	reign pos	tal code			
South Pekin		IL				US	615	64		C	alera			AL		US	3504	0							
Part II Emp	oloyee Off	er o	f Covera	ge						P	lan Sta	rt Mo	nth (En	ter 2-)3										
	All 12 Months	;	Jan		Feb	Ма	r	Apr	N	Лау	June		July		Aug	Sep	ot	Oct		Nov		Dec			
14 Offer of Coverage (enter required code)			1E		1E	1E	<u>:</u>	1E		1E	1E		1E		1E	16	Ξ	1E		1E		1E			
15 Employee Required Contribution (see instructions)	\$	\$	132.57	\$	132.57	\$ 13.	2.57	\$ 119.34	\$ 1	119.34	\$ 119	.34 \$	119.3	4 \$	119.34	\$ 11	9.34	§ 119	.34 \$	119.3	4 \$	119.34			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2H		2H	20)	2C	2	2C	2C		2C		2C	20		2C		2C		2C			
	ered Indiv																				7				
If Em	nployer prov	rided	self-insur	ed c	coverage	, check	the b	oox and ente		informat	ion for e	each in	dividual	enrol					employ	ee. L					
(a) Name	e of covered ind	dividua	al(s)		(b) SSN or	other TIN	١	(c) DOB (If SSI or other TIN is	. '	d) Covered I 12 months			1			Months									
								not available)) ai	12 1110111118	s Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
												$ \Box$													
17									_																
18																									
19																									
20																									
21																									
22																									

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Form 1095-C (2016) Page 3

Name of employee Social security number (SSN) Andrew C Osborn XXX-XX-8429 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32

33

34

Lance C Peacock 723 E IL Ave Peoria, IL 61603 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Employee										Applicable Large Employer Member (Employer)														
1 Name of employe	e					2 Social	security number	(SSN)	7 Name of employer 8 Employer identification number															
Lance C Peace	ock						XXX-XX-54	75		heelwo'									27291	5146				
3 Street address (in	cluding apartn	nent no	o.)						9	Street ad	dress (ind	cluding roo	m or su	ite no.)			10	Oontact	telephone	numbe				
723 E IL Ave									14	180 Wo	odbine	e Avenu	ie					2056686720						
4 City or town		5 Stat	e or provinc	се		6 Country	and ZIP or foreig	n postal code	e 11	11 City or town 12 State or province								13 Country and ZIP or foreign postal code						
Peoria		IL				US 616	503		Ca	Calera AL US 35040 Plan Start Month (Enter 2-digit number): 03														
Part II Emp	loyee Offe	er of	Covera	ge					P	lan Sta	rt Mo	nth (En	er 2-c	ligit num	ber): (03								
	All 12 Months	All 12 Months Jan Feb Mar Apr May										July		Aug Sept			Oct	:	Nov		Dec			
14 Offer of Coverage (enter required code)			1E	1E		1E	1E	1E		1E		1E		1E	16	Ξ	1E		1E		1E			
15 Employee Required Contribution (see	\$	\$	132.57	\$ 132.	57 \$	132.57	\$ 119.34	\$ 119.	34 5	\$ 119	.34 \$	119.3	4 \$	119.34	s 11	9.34	§ 119	9.34 \$	119.3	34 \$	119.34			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	<u>*</u>		2C	2C		2C	2C	2C		2C		2C		2C	20		2C	•	2C		2C			
Part III Cove	ered Indivi	idua	ls				•				'				•					¬'				
If Em	ployer provi	ided :	self-insur	ed cover	age, (check the	box and ente		mat	ion for e	ach ind	dividual	enrolle	ed in cov	/erage,	includi	ng the	emplo	yee. L					
(a) Name	of covered ind	lividuali	(e)	(h) 99	N or o	ther TIN	(c) DOB (If SS or other TIN is	N (d) Co						(e)	Months	of Covera	age							
(a) Name	or covered ind	rridadii	(0)	(5) 00	14 01 0	ther my	not available	all 12 m	nonths	s Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
									7															
17																								
18																								
19																								
									7															
20																								
04																								
21												-												
22																								

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Name of employee

Lance C Peacock

XXX-XX-5475

Part III Covered Individuals — Continuation Sheet

Part III Covered Individuals — Continuation Sheet (a) Name of covered Individuals — Continuation Sheet (b) Name of covered Individuals — Continuation Sheet (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other	(d) Covered												
		TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
23															
24															
25															
26															
27															
28															
29															
30															
31															
32															
33															
34															

Kyle S Peterson 610 E. Jefferson Street Washington, IL 61571 Department of the Treasury Internal Revenue Service

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

VOID	
	OMB No. 1545-2251
CORRECTED	2016

Part Emp	oloyee			Applicable Large Employer Member (Employer)														
1 Name of employ	/ee			2 Socia	al security number	(SSN)	7 Name of	employe	r	8	8 Employer identification number (EIN							
Kyle S Peters	on				XXX-XX-79!	54	Wheelwo	rx Nor	th, LLC)					2	272915	146	
3 Street address (i	including apartn	ment no.)					9 Street ad	dress (ind	cluding roo	om or sui	te no.)			10	Contact t	elephone	number	
610 E. Jeffers	son Street						1480 Wo	odbine	e Avenu	ıe					2	05668	6720	
4 City or town		5 State or provi	nce	6 Count	ry and ZIP or foreig	n postal code	11 City or to	wn		12 S	tate or pr	ovince		13	Country ar	nd ZIP or fo	oreign pos	tal code
Washington		IL		US 61	571		Calera			AL				US	3504	0		
Part II Emp	oloyee Offe	er of Cover	age				Plan Sta	rt Mo	nth (Ent	ter 2-di	git nun	nber): (03					
	All 12 Months	Jan	Feb	Mar	Apr	May	June		July	/	Aug	Sep	pt	Oct		Nov	1	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H		1H		1H	11	4	1H		1H		 1H
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$		\$		\$	\$		\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2B	2A	2A	2A	2A	2A		2A		2 A	24	A	2A		2A		2 A
	ered Indiv		ured coverage	e, check the	box and ente			ach ind	dividual	enrolle					employe	ee.		
(a) Name	e of covered ind	ividual(s)	(b) SSN o	or other TIN	(c) DOB (If SSN or other TIN is	(d) Cover) Months						
					not available)	all 12 11101	^{nths} Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																		
17																		
18																		
19																		
20																		
21																		
22																		

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Name of employee	Social security number (SSN)
Kyle S Peterson	XXX-XX-7954
Part III Covered Individuals — Continuation Sheet	

Ryle 5 i etersori												()()()	/ //5-		
Part III Covered Individuals — Continuation Sheet (a) Name of covered individuals — Continuation Sheet (b) DOB (if SSN or other (d) Covered (e) Months of coverage															
(a) Name of covered individual(s)	(b) SSN or other TIN	(c) DOB (If SSN or other TIN is not available)	(d) Covered												
		Tilv is not available)	all 12 months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
23															
24															
25									Ш						
20															
26															
27															
28															
29															
30															
31															
32															
33															
34															

Richard A Phillips 249 Herget St Pekin, IL 61554 Form 1095-C
Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

VOID	
	OMB No. 1545-2251
CORRECTED	

internal revenue oc	I VICC				- aa oopa.														
Part I Emp	oloyee			Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification num															
1 Name of employ	/ee			2 Socia	al security number	(SSN)	7 Name of	employe	r					8	B Employe	r identifica	ation num	ber (EIN)	
Richard A Phi	illips				XXX-XX-812	26	Wheelwo	orx Nor	th, LLC							272915	5146		
3 Street address (i	including apartr	nent no.)					9 Street ac	dress (inc	cluding ro	om or sui	te no.)			10	0 Contact	telephone	number		
249 Herget St	t						1480 Wc	odbine	e Aveni	ле					2	205668	6720		
4 City or town		5 State or prov	rince	6 Coun	try and ZIP or foreig	n postal code	11 City or to	wn		12 St	ate or pr	ovince		1:	3 Country a	nd ZIP or f	or foreign postal code		
Pekin		IL		US 61	1554		Calera			AL				U	IS 3504	0			
Part II Emp	oloyee Off	er of Cove	rage				Plan Sta	art Mo	nth (En	ter 2-di	git num	nber): (03	•					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	:	July		Aug	Se	pt	Oc.	t	Nov	1	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A		1A		1A	1,	4	1A		1A		1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$		\$	\$	\$		\$		\$		6	\$		\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																			
	ered Indiv		ured covera	ne check the	e box and ente	r the inform	ation for	each inc	dividual	enrolle	d in co	verage	includii	na the	employ	99	7		
				_	(c) DOB (If SSN			34011 111	arriduai	01110110) Months			omploy	оо			
(a) Name	e of covered ind	lividual(s)	(b) SSN	or other TIN	or other TIN is not available)			Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
					Tiot available)						, , , , , , , , , , , , , , , , , , ,				'				
17														ľ					
18																			
19																			
20																			
21																			
22									1										

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Name of employee Social security number (SSN) Richard A Phillips XXX-XX-8126 Covered Individuals — Continuation Sheet Part III (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33 34

Amber M Sanders 3258 Mason Rd. 2600 N Manito, IL 61546 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Employee											Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification number (El															
1 Name of employ	ee						2 Social	security number	(SSN) 7	Name	of em	ployer							8 E	mployer	identifica	tion nun	nber (EIN)		
Amber M San								XXX-XX-61	40					th, LLC							2	272915	146			
3 Street address (i	ncluding apartr	nent n	10.)							9	Street	addre	ess (inc	luding roc	m or s	uite no.)				10 C	ontact t	elephone	number			
3258 Mason F	Rd. 2600 N									114	480 V	/ooc	dbine	. Avenu	ie						2	05668	6720			
4 City or town		5 Sta	ate or provin	се			6 Country	and ZIP or foreig	ın pos	stal code 11	City or	town			12	State or p	rovince			13 C	ountry ar	nd ZIP or fo	oreign po	stal code		
Manito		IL					US 615	46		c	alera				AL					US	3504	О				
Part II Emp	oloyee Offe	er of	f Covera	ge	1					P	lan S	tart	Moı	nth (Ent	er 2-0	digit nu	nber):	03		•						
	All 12 Months		Jan		Feb		Mar	Apr		May	Ju	ne		July		Aug	Se	pt	(Oct		Nov		Dec		
14 Offer of Coverage (enter required code)			1E		1E		1E 1E 1E		1	Ξ		1E		1E		E		1E		1E		1E				
15 Employee Required Contribution (see instructions)	\$	\$	132.57	\$	132.57	\$	132.57 \$ 119.34 \$ 119.34		\$ 1 [°]	9.3	4 \$	119.3	4 \$	119.3	1 \$ 11	19.34			34 \$	119.3	4 \$	119.34				
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2H		2H	-	2H	2C		2C	2C 2C			2C	20	C	2C		2C			2C				
Part III Cov	ered Indiv	idua	ıls					•																		
If Em	ployer prov	ided	self-insu	ed	coverage	, che	eck the l	box and ente	r the	e informat	ion fo	r eac	ch inc	dividual	enroll					he ei	mploye	ee. L				
(a) Name	of covered ind	lividua	ıl(s)		(b) SSN or	other	r TIN	(c) DOB (If SSI or other TIN is	. 1	(d) Covered							e) Months		rage							
(4)			(0)		(5) 001101	011101		not available)		all 12 month	s Jar	1	Feb	Mar	Apr	May	June	July	Aı	ug	Sept	Oct	Nov	Dec		
												1														
17												<u>'</u>														
]														
18				_							+															
19																										
00																			T							
20									-								-									
21	1																									
21														1	1		\dashv									
22																										

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Name of employee Social security number (SSN) XXX-XX-6140 Amber M Sanders Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31

32

33

34

Walter W Satterlee 338 Cole St. East Peoria, IL 61611 Department of the Treasury Internal Revenue Service

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

VOID	
	OMB No. 1545-2251
CORRECTED	2016

Part I Emp	oloyee			Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification of the second se														
1 Name of employ	/ee			2 Socia	al security number	(SSN)	7 Name of	employe	r					8	3 Employ	er identifica	ation num	ber (EIN)
Walter W Satt	terlee				XXX-XX-719	96	Wheelwo	orx Noi	rth, LLC	<u>;</u>						272915	5146	
3 Street address (i	including apartr	ment no.)		•			9 Street ac	ddress (in	cluding roo	om or sui	te no.)			1	0 Contact	telephone	number	
338 Cole St.							1480 Wo	odbine	e Avenu	ıe						205668	6720	
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or foreig	n postal code	11 City or to	own		12 St	ate or pr	ovince		1	3 Country	and ZIP or f	oreign pos	tal code
East Peoria		IL		US 61	611		Calera			AL				lι	JS 350	5040		
Part II Emp	oloyee Off	er of Cover	rage	•			Plan Sta	art Mo	nth (Ent	ter 2-di	git num	nber): () 3	•				
	All 12 Months	Jan	Feb	Mar	Apr	May	June Jul			P	Aug	Sep	ot	Oc	t	Nov	Г	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A		1A		1A	1,4	A .	1,4	A	1A		1A
15 Employee																		
Required Contribution (see																		
instructions)	\$	 \$	\$	\$	\$	\$	\$	\$		\$		\$	\$	3	\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																		
Part III Cov	ered Indiv	iduals															7	
If Em	nployer prov	ided self-ins	ured coverage	e, check the	box and ente		ation for	each in	dividual	enrolle					emplo	/ee.	<u></u>	
(a) Name	e of covered inc	lividual(s)	(b) SSN o	or other TIN	(c) DOB (If SSN or other TIN is	(a) 0000) Months				_		
			(4, 55115		not available)	all 12 mor	iths Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																		
														l				l
18																		
												l —		l			l —	l —
40													Ш	ГШ				
19																		
														-				
20														ΙШ			ГШ	ш
20																		
21																		
22																		

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

Name of employee Social security number (SSN) XXX-XX-7196 Walter W Satterlee Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31

32

33

34

Jakob Schoenfeldt 1711 Valle Vista Blvd Pekin, IL 61554 Department of the Treasury Internal Revenue Service

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

VOID	
	OMB No. 1545-2251
CORRECTED	2016

Part I Emp		Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification number																	
1 Name of employ	ree			:	2 Social	security number	(SSN)	7 Name of	employe	r					8	Employe	r identifica	ation num	ber (EIN)
Jakob Schoer	nfeldt					XXX-XX-95	74	Wheelwo	orx Nor	th, LLC)						272915	5146	
3 Street address (i	ncluding apartm	ent no.)						9 Street ac	ddress (inc	cluding ro	om or su	te no.)			10	Contact	telephone	number	
1711 Valle Vis	sta Blvd							1480 Wo	odbine	e Avenu	ıe					2	205668	6720	
4 City or town		5 State or provi	nce	(6 Countr	y and ZIP or foreig	n postal code	11 City or to	own		12 S	tate or pr	ovince		13	Country a	nd ZIP or f	oreign pos	tal code
Pekin	l l	L		lι	JS 61!	554		Calera			AL				U:	S 3504	0		
Part II Emp	oloyee Offe	r of Cover	age	•				Plan St	art Mo	nth (En	ter 2-d	igit nun	nber): (03	•				
	All 12 Months	Jan	Feb	ı	Mar	Apr	May	June)	July		Aug	Se	pt	Oct		Nov		Dec
14 Offer of Coverage (enter required code)		1A	1A		1A 1A 1A		1A		1A		1A		4	1A		1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$			\$	\$		\$		\$		\$	\$		\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	Ψ		Ψ	Ψ		Ψ	<u>Ψ</u>	Φ Φ Φ		Ψ				ν			Ψ		
	ered Indivi		ıred cover	age, che	ck the	box and ente			each ind	dividual	enrolle		-		-	employ	ee.		
(a) Name	e of covered indi	vidual(s)	(b) SS	N or other	TIN	(c) DOB (If SSN or other TIN is	(u) 0000		1) Months		-	1			_
						not available)	all 12 1110	nths Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
17																			
18																			
19																			
20																			
21																			
22																			

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Name of employee Social security number (SSN) Jakob Schoenfeldt XXX-XX-9574 Covered Individuals — Continuation Sheet Part III (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29

30

31

32

33

34

Joseph D Sipka 1507 South 6th St Pekin, IL 61554 Form 1095-C
Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Emp		Applicable Large Employer Member (Employer) 7 Name of employer 8 Employer identification number																	
1 Name of employ	/ee				2 Socia	l security number	(SSN)	7 Name of	employer						8	Employe	identifica	tion num	ber (EIN)
Joseph D Sipl	ka					XXX-XX-16	79	Wheelwo	rx Nor	th, LLC							272915	146	
3 Street address (i	including apartr	ment no.)			_			9 Street ac	dress (inc	cluding ro	om or sui	te no.)			10	Contact t	elephone	number	
1507 South 6t	th St							1480 Wc	odbine	e Aveni	ле					2	205668	6720	
4 City or town		5 State or prov	rince		6 Count	ry and ZIP or foreig	n postal code	11 City or to	wn		12 S	ate or pr	ovince		13	Country a	nd ZIP or fo	oreign pos	tal code
Pekin		IL			US 61	554		Calera			AL				U	3504	0		
Part II Emp	ployee Off	er of Cove	rage		•			Plan Sta	art Mo	nth (En	ter 2-di	git num	nber):	03					
	All 12 Months	Jan	Fe	eb	Mar	Apr	May	June		July	/	Aug	Se	pt	Oct		Nov		Dec
14 Offer of Coverage (enter required code)		1A	1,	A	1A	1A	1A 1A			1A		1A	1/	4	1A	A 1A			1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$				1A \$	\$		\$			4		\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	1980H and (enter licable)					<u> </u>							\$						
	rered Indiv		sured cov	verage,	check the	box and ente	r the inforn	nation for e	each inc	dividual	enrolle	d in co	verage,	includi	ng the	employ	ee.	_ .	
						(c) DOB (If SSN	(d) Cove) Months						
(a) Name	e of covered ind	iividuai(s)	(0)	SSN or o	otner I IIV	or other TIN is not available)	^{nths} Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
17																			
18																			
19																-			
20																			
21																			
22										1	1					1		1	

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Form 1095-C (2016) Page 3

Name of employee Social security number (SSN) Joseph D Sipka XXX-XX-1679 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29

Kelly Stillwell 1008 Rockwell St. Kewanee, IL 61443 Form **1095–C**Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

VOID	OMB No. 1545-2251
CORRECTED	2016

Part I Employee											Applicable Large Employer Member (Employer) 7. Name of employer 8. Employer identification number (Employer)														
1 Name of employe	ee						2 Social	security number	(22)	N) 7	7 Name of employer Wheelworx North, LLC 8 Employer identification nur 272915146											tion nun	nber (EIN)		
Kelly Stillwell								XXX-XX-14	90													2	272915	146	
3 Street address (in	ncluding apartr	ment n	o.)							9	Stre	et add	lress (ind	cluding ro	om or	suite	no.)				10 C	ontact t	elephone	number	
1008 Rockwel	ll St.									1.	480	Woo	odbine	e Aveni	ue							2	05668	6720	
4 City or town		5 Stat	te or provin	се			6 Country	and ZIP or foreig	jn po	stal code 11	1 City	or tov	vn		12	2 Sta	te or pro	vince			13 C	ountry ar	nd ZIP or f	oreign po	stal code
Kewanee		IL					US 614	143		c	aler	a			Al	L					US	3504	C		
Part II Emp	loyee Off	er of	Covera	ıge						F	Plan	Sta	rt Mo	nth (En	ter 2	-dig	it num	ber): (03						
	All 12 Months	;	Jan		Feb		Mar	Apr		May		June		July		Αı	ng	Sep	ot	(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)	\$	\$	132.57	\$	132.57	\$	132.57	\$ 119.34	\$	119.34	4 \$ 119.34		34 \$; 119.34		\$ 119.34		\$ 119.34		\$ 119		34 \$	119.3	4 \$	119.34
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C		2C		2C	2C		2C	2C			2C		2	С	2C		2C			2C		2C
Part III Cove	ered Indiv	idua	ls					•																7	
If Em	ployer prov	rided	self-insu	red	coverage	, ch	eck the	box and ente	r th	e informa	tion	for ea	ach ind	dividual	enro	lled	in cov	erage,	includ	ing tl	he e	mploye	ee. L		
(a) Name	of covered ind	dividual	l(s)		(b) SSN or	othe	r TIN	(c) DOB (If SS or other TIN is	N	(d) Covered							(e)	Months	of Cove	rage					
(4)			-(-)		(2) 00.10.			not available		all 12 month	ıs J	an	Feb	Mar	Ap	r	May	June	July	Αι	ug	Sept	Oct	Nov	Dec
											_	_,				,				_	_			_	
																╛╽					╛╽				
17																									
18				_										-											
19																									
20	20																								
									T					1				T	7						
21																									
22]					$\exists \mid$				

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Page 3 Name of employee Social security number (SSN) Kelly Stillwell XXX-XX-1490 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

34

Cody Stocke 1504 Center St Pekin, IL 61554 Department of the Treasury Internal Revenue Service

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

VOID	OMB No. 1545-2251
	OIVIB INO. 1545-2251
CORRECTED	2016

Part I Emp	Applicable Large Employer Member (Employer)																					
1 Name of employee 2 Social security number (SSN)									7 Name of employer 8 Employer identification number (EIN													
Cody Stocke				rth, LLC							272915	146										
3 Street address (in	9 Street address (including room or suite no.) 10 Contact telephone number																					
1504 Center S		1480 Woodbine Avenue 2056686720																				
4 City or town		5 State or provi	ince	6 Count	ry and ZIP or foreig	n postal code	11 City or town 12 State or province 13 Country and ZIP or foreign p												stal code			
Pekin		IL		US 61	554		Cal				AL				U	US 35040						
Part II Empl	loyee Offe	er of Cover	age				Pla	an Sta	rt Mo	nth (En	er 2-d	igit num	nber): (03	•							
	All 12 Months	Jan	Feb	Mar	Apr	May		June		July	,	Aug	Sep	ot	Oct		Nov		Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H		1E		1E		1E		<u> </u>	1E		1E		1E			
15 Employee Required Contribution (see																						
instructions)	\$	\$	\$	\$	\$	\$	\$	119	.34 \$	119.3	4 \$	119.34	\$ 11	9.34	119	9.34 \$	119.3	4 \$	119.34			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2D	2D		2H		2H		2H	21	1	2H		2H		2H			
Part III Cove	ered Indiv	iduals			'																	
If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																						
(a) Name (of covered ind	ividual(s)	(b) SSN o	r other TIN	(c) DOB (If SSI) or other TIN is	(d) Cove																
(2)		(0)	(5) 00.10	TOUTOT THE	not available)		nths	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
																1						
17																						
18																						
19																						
20																						
21																						
22																						

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Name of employee Social security number (SSN) Cody Stocke XXX-XX-6620 Part III Covered Individuals - Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Sept Jan Feb Mar Apr May Jun Jul Aug Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

34

Andrew L Stonier 601 Georgia Parkway Washington, IL 61571 Form 1095-C
Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

VOID	OMB No. 1545-2251
CORRECTED	2016

internal revenue oc										9												
Part I Emp	oloyee								Appli	cable L	arge	Emplo	yer Mo	ember	(Emp	loyer)						
1 Name of employee 2 Social security number (SSN)								7 Name of employer 8 Employer identification number (EIN														
Andrew L Stonier XXX-XX-4678								Wheelworx North, LLC 272915146														
3 Street address (including apartment no.)								9 Street address (including room or suite no.) 10 Contact telephone number														
601 Georgia Parkway									1480 Woodbine Avenue 2056686720													
4 City or town		5 State or prov	rince		6 Counti	ry and ZIP or foreig	n postal code	11 City or to	wn		12 S	ate or pr	ovince		13	Country a	nd ZIP or fo	oreign pos	tal code			
Washington		IL			US 61	571		Calera			AL				US	3504	0					
Part II Emp	oloyee Offe	er of Cove	rage					Plan Sta	art Mo	nth (En	ter 2-di	git num	nber): (03								
	All 12 Months	Jan	Fe	eb	Mar	Apr	May	June	June July		/	Aug	Se	pt	Oct	ct Nov		[Dec			
14 Offer of Coverage (enter required code)		1A	1,	A	1A	1A	1A	1A 1A			1A	1,	4	1A	. 1A		1A					
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$			\$				\$		\$		\$			\$				
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	Ψ	Ψ	Ψ	Ψ		Ψ	Ψ	Ψ	\$		Ψ		Ψ	4)	\$		Ψ				
	ered Indiv		ured cov	verage, o	check the	box and ente	r the inforn	nation for e	each ind	dividual	enrolle	d in co	verage,	includi	ng the	employ	ee.]				
(a) Nama	of covered ind	lividual(a)	(6)	L CCN or of	thay TINI	(c) DOB (If SSN	(d) Cove	ered				(e) Months	of Covera	age							
(a) Name	or covered ind	ividuai(S)	(6)	(b) SSN or other		or other TIN is not available)	all 12 mo	nths Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
17																						
18																						
19																						
20																						
21																						
22																						

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Page 3 Name of employee Social security number (SSN) Andrew L Stonier XXX-XX-4678 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

34

Donald Tackett 5005 N. Galena Rd Peoria Heights, IL 61616 Form 1095-C
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

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

VOID	
	OMB No. 1545-2251
CORRECTED	2016

Part I Emp	Applicable Large Employer Member (Employer)																		
1 Name of employ	7 Name of employer 8 Employer identification number (EIN																		
Donald Tacke	Wheelworx North, LLC 272915146																		
3 Street address (i	9 Street address (including room or suite no.) 10 Contact telephone number																		
5005 N. Galer	1480 Woodbine Avenue 2056686720																		
4 City or town		5 State or provin	nce	6 Cou	untry and ZIP or for	reign postal code													
Peoria Height	s	IL		US 6	51616		Calera			US	3504	0							
Part II Emp	Plan Start Month (Enter 2-digit number): 03																		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	9	July		Aug	Se	pt	Oct		Nov		Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1E	1E	1E		1E		1E	11	Ξ	1E		1E		1E	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$ 119.3	34 \$ 119.3	34 \$ 119	9.34 \$	119.3	4 \$	119.34	\$ 11	9.34	119	.34 \$	119.3	4 \$	119.34	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2C	2C	2C		2C		2C	20	2	2C		2C		2C	
Part III Cov	ered Indiv	iduals	·		·		•					•					7		
If Em	ployer prov	ided self-insu	red coverage	e, check t	he box and er		mation for	each in	dividual	enrolle	ed in co	verage,	includi	ng the	employ	ee. L			
(a) Name	of covered ind	ividual(s)	(b) SSN o	r other TIN	(c) DOB (If a or other TII	SSN (d) Cov					(e) Months							
(2)		(4, 55.15		not availal	ble) all 12 m	onths Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
							,	1			1			l	l				
17																			
_																			
18																			
19																			
20																			
04																			
21								+			-								
22																			

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17-22

Form 1095-C (2016) Page 3 Name of employee Social security number (SSN) **Donald Tackett** XXX-XX-9090 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Sept Jan Feb Mar Apr May Jun Jul Aug Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

34

Wheelworx North, LLC 1480 Woodbine Avenue Calera, AL 35040

James M Taylor 315 Edgewood Drive Pekin, IL 61554 Form 1095-C
Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

VOID	OMB No. 1545-2251
CORRECTED	2016

internal revenue oc	I VICC				- u oopu.				. 9												
Part I Emp	oloyee		Applicable Large Employer Member (Employer)																		
1 Name of employ	/ee			2 Soci	al security number	(SSN)	7 Name of	employe	r					8	B Employe	r identifica	ation num	ber (EIN)			
James M Tayl	lor				XXX-XX-693	37	Wheelwo	orx Noi	rth, LLC							272915	5146				
3 Street address (i	including apartn	nent no.)					9 Street ac	Idress (in	cluding ro	10	10 Contact telephone number										
315 Edgewoo	d Drive						1480 Wc	odbine	e Aveni	ue					2	205668	6720				
4 City or town		5 State or prov	rince	6 Coun	try and ZIP or foreig	n postal code	11 City or to	wn		12 S	tate or pr	ovince		13	3 Country a	nd ZIP or f	oreign pos	tal code			
Pekin		IL		US 6	1554		Calera			AL				U	US 35040						
Part II Emp	oloyee Offe	er of Cove	rage				Plan Sta	art Mo	nth (En	ter 2-di	git nun	nber): (03	•							
	All 12 Months	Jan	Feb	Mar	Apr	May	June		July		Aug	Se		Oc.	t	Nov	Г	Dec			
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A 1A			1A		1Δ		Α	1A		1A		1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$		\$	\$	\$		\$		\$		6	\$	\$					
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																					
	ered Indiv		urad aayara	go obook th	a hay and anta	r the inform	action for	acch in	dividual	oprollo	d in ac	vorage	ingludi	na tha	omploy		_ '				
	ipioyei prov	ided Sell-IIIS	ured covera	ge, check th	e box and ente			each in	uividuai	enrone) Months			employ	ee					
(a) Name of covered individual(s) (b) S		(b) SSN	I or other TIN	or other TIN is not available)	(d) Cover all 12 mor		Feb	Mar	Apr	May	June	July	Aug	Sept	Sept Oct		Dec				
					not available)		- Julia	1	11101	7 10.		0 4.1.0	0 ,	7.09			Nov	200			
17														ГШ							
18																					
19																					
20																					
21																					
22																					

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

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

Name of employee Social security number (SSN) XXX-XX-6937 James M Taylor Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Sept Jan Feb Mar Apr May Jun Jul Aug Oct Nov Dec 23 24 25 26 27 28 29 30

31

32

33

34

Wheelworx North, LLC 1480 Woodbine Avenue Calera, AL 35040

Braden A Tovrea 1500 Vista Grande Dr Pekin, IL 61554 Form 1095-C
Department of the Treasury

Employer-Provided Health Insurance Offer and Coverage

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

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

VOID	1
	OMB No. 1545-2251
CORRECTED	2016

internal revenue oci	VICC																								
Part I Emp	loyee								Т		Appli	cable I	arge	Emplo	yer Mo	ember	· (Emp	loyer)							
1 Name of employ	ee				2 S	ocial s	security number	(SSN)	7	Name of	employe	r					8	Employe	r identifica	ition nun	on number (EIN)				
Braden A Tov	rea)	XXX-XX-97	05	Wheelworx North, LLC									272915146							
3 Street address (in	ncluding apartn	nent no	o.)		•				9	Street ad	dress (in	cluding ro	om or su	ite no.)			10	Contact	telephone	number					
1500 Vista Gr	ande Dr								114	480 Wo	odbine	e Aveni	Jе					2	205668	6720					
4 City or town		5 Stat	e or provinc	e	6 Co	ountry	and ZIP or foreig	n postal code	11	City or to	wn		12 5	State or pro	ovince		13	Country a	nd ZIP or fo	oreign po	stal code				
Pekin IL				US	615	54		C	alera			AL				U:	US 35040								
Part II Emp	loyee Offe	er of	Coverag	ge	•				P	lan Sta	rt Mo	nth (En	•												
	All 12 Months		Jan	Feb	Mar		Apr	May	1	June		July		Aug	Se	pt	Oct		Nov		Dec				
14 Offer of Coverage (enter required code)			1E	1E	1E		1E	1E	1E 1E		1E		1E	16	E	1E		1E		1E					
15 Employee Required Contribution (see instructions)	\$	\$	132.57				\$ 119.34		34 9		.34 \$														
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)	Ψ	Ψ	2H	2 Н	2H		2H	Ψ 2Н		Ψ 2H	Ψ	2H		2H	21		2H	· · ·		2H					
Part III Cove	ered Indivi	idua	ls															•							
If Em	ployer provi	ided :	self-insure	ed coverage	e, check	the b	oox and ente	r the infor	mat	ion for e	ach in	dividual	enrolle	ed in cov	verage,	includi	ng the	employ	ee.						
(a) Name	of covered ind	lividual	(e)	(b) SSN c	or other TIN		(c) DOB (If SSI or other TIN is	(4)						(e)	Months	of Covera	age								
(a) Name of covered individual(s)		(6) 00110	(b) cort or other this		not available)	all 12 m	onths	s Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec						
17																									
18]																
19																									
20]																
21]																
22																									

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

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

Form 1095-C (2016) Page 3

Name of employee Social security number (SSN) Braden A Tovrea XXX-XX-9705 Part III Covered Individuals — Continuation Sheet (e) Months of coverage (c) DOB (If SSN or other TIN is not available) (d) Covered all 12 months (b) SSN or other TIN (a) Name of covered individual(s) all 12 months Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec 23 24 25 26 27 28 29 30 31 32 33

34

Wheelworx North, LLC 1480 Woodbine Avenue Calera, AL 35040

Peter J Wald II 101 Schramm Drive Apt 1 Pekin, IL 61554 Department of the Treasury Internal Revenue Service

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

▶ Information about Form 1095-C and its separate instructions is at www.irs.gov/form1095c

VOID	
	OMB No. 1545-2251
CORRECTED	2016

Part I Employee									Applicable Large Employer Member (Employer)													
1 Name of employe	ee					2 Social	security numb	er (SSN)	7 Name of employer 8 Employer identification number													
Peter J Wald I	I						XXX-XX-()212				th, LLC							272915	146		
3 Street address (in	ncluding apartm	nent no	o.)						9	Street ad	dress (inc	10	10 Contact telephone number									
101 Schramm	101 Schramm Drive Apt 1									180 Wo	odbine	. Avenu	е					2	205668	5720		
4 City or town		5 State	e or provinc	е		6 Country	y and ZIP or for	eign postal co	de 11	City or to	wn		12 S	tate or pro	ovince		13	Country a	nd ZIP or fo	reign po	stal code	
Pekin		IL				US 615	554		C	alera			AL				US	S 3504	0			
Part II Emp	loyee Offe	er of	Covera	ge					P	lan Sta	rt Mo	nth (Ent	er 2-di	igit num	ber): (03						
	All 12 Months		Jan	Fel	b	Mar	Apr	May		June		July	/	Aug	Sep	ot	Oct		Nov		Dec	
14 Offer of Coverage (enter required code)			1E	1E	Ξ	1E	1E	1E		1E		1E		1E	1E		1E		1E		1E	
15 Employee Required Contribution (see	\$	\$	132.57	\$ 13	2.57	3 132.57	' \$ 119.3	34 \$ 119	0.34	4 \$ 119.34 \$		119.34	1 8	119.34			3 119	9.34 \$			119.34	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	20		2C	2C	2C		2C		2C		2C	20		2C		2C		2C	
Part III Covered Individuals																						
If Em	ployer provi	ided s	self-insur	ed cov	erage,	check the			ormat	ion for e	ach inc	dividual e	enrolle	d in cov	erage,	includi	ng the	employ	ee. L			
(a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (If SSN or other TIN is all 12 m												Months	of Covera	age								
(a) Name of covered individual(s)		7.11.01 111.1	not available)		months	s Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec					
17																						
18																					-	
19																						
20																						
21																						
22																						

Instructions for Recipient

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

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

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



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

Part I. Employee

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

Line 2. This is your social security number (SSN). For your protection, this form may show only the last four digits of your SSN. However, the employer is required to report your complete SSN to the IRS.



If you do not provide your SSN and the SSNs of all covered individuals to the plan administrator, the IRS may not be able to match the Form 1095-C to determine that you and the other covered individuals have complied with the individual shared responsibility provision. For covered individuals other than the employee listed in

Part I, a Taxpayer Identification Number (TIN) may be provided instead of an SSN. See Part III.

Part I. Applicable Large Employer Member (Employer)

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

Line 10. This line includes a telephone number for the person whom you may call if you have questions about the information reported on the form or to report errors in the information on the form and ask that they be corrected.

Part II. Employer Offer of Coverage, Lines 14-16

- Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.
- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, see IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14.
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- Line 15. 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. 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, or 1K is entered on line 14. If you were offered coverage but there is no cost to you for the coverage, this line will report a "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, see 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, see IRS.gov.

Part III. Covered Individuals, Lines 17–22

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

Form 1095-C (2016)	Page .

Name of employee
Peter J Wald II

Part III Covered Individuals — Continuation Sheet

Part III Co	vered Individuals – Con	tinuation Chast											\\\\-\\.	<u> </u>	<u>-</u>			
		(b) SSN or other TIN	(c) DOB (If SSN or other	(d) Covered	vered (e) Months of coverage													
(a) Nan	ne of covered individual(s)	(b) 55N or other TIN	(c) DOB (If SSN or other TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec		
23																		
24																		
25																		
27																		
28																		
29																		
30																		
31																		
32																		
33																		
34																		