Araceli Acosta 1207 Antioch Drive Dalton, GA 30721

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Form 1095-G
Department of the Treasury
Internal Revenue Service

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

TED 20**23**

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

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

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest in	itormation.						
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	vee (first name, m	iddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			8 En	nployer identifica	ation number (EIN)	
Araceli		Acosta	а		XXX-XX-6	760	Professional Eye Associates, Inc.					581148820		
3 Street address (i	including apartme	ent no.)		'			9 Street address	ss (including roor	m or suite no.)		10 Cd	10 Contact telephone number		
1207 Antioch	Drive						1111 Profe	ssional Blvd	i			706226	2020	
4 City or town	or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 C						13 Co	untry and ZIP or	foreign postal code					
Dalton	(SA		US 30	721		Dalton GA L					US 30720		
Part II Emp	oloyee Offer	r of Cove	rage		Employee ³	s Age on c	January 1		Plan Star	t Month (er	nter 2-digit ı	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2D											
17 ZIP Code			A st Notice on										1005 C (200	

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **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
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- 1W. Reserved for future use.
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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Mayra Adame 404 Ironwood Way Dalton, GA 30721

Form 1095- C
Department of the Treasury
Internal Revenue Service

17 ZIP Code

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2023 Part I Employee Applicable Large Employer Member (Employer) 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Mavra Adame XXX-XX-0931 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 404 Ironwood Way 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code Dalton GA US 30721 Dalton GA US 30720 **Employee Offer of Coverage** Part II **Employee's Age on January 1** Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1A 1A 1A 1A 1A required code) 1A 1A 1A 1A 1A 1A 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)

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Jashia Adams 112 Sunray Drive NW Apt 2 Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

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1 Name of employ	ee (first name, m	niddle initial, las	t name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	ployer			8 E	mployer identifica	ation number (EIN)		
Jashia		Adams	S		XXX-XX-85	595	Professional Eye Associates, Inc.					581148820			
3 Street address (i	ncluding apartm	ent no.)					9 Street addre	ss (including roo	m or suite no.)		10 C	10 Contact telephone number			
112 Sunray D	rive NW Ap	t 2					1111 Profe	ssional Blvd	i			706226	2020		
4 City or town 5 State or province 6 Country and ZIP or foreign posta						gn postal code	11 City or town		12 State or p	rovince	13 C	ountry and ZIP or	foreign postal code		
Dalton		GΑ		US 30	721		Dalton		GA		US	30720			
Part II Emp	oloyee Offe	r of Cover	age		Employee'	s Age on	January 1		Plan Star	rt Month (er	nter 2-digit	number):	01		
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- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Amanda F Alexander 309 FIELDSTONE DR RINGGOLD, GA 30736

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

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

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Internal Revenue Se	rvice		Go to www	v.irs.gov/For	<i>m10</i> 95C for in	structions an	id the latest in	nformation.							
Part I Emp	oloyee						A	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	vee (first name, m	niddle initial, la	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			8 En	nployer identific	ation number (EIN)		
Amanda		F Alexa	ınder		XXX-XX-94	417	Professiona	al Eye Asso		581148820					
3 Street address (including apartment no.)							9 Street addres	ss (including roo	n or suite no.)		10 Co	10 Contact telephone number			
309 FIELDST	ONE DR						1111 Profe	ssional Blvc				706226	2020		
4 City or town 5 State or province 6					ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	13 Co	untry and ZIP or	foreign postal code		
RINGGOLD		GA		US 30	0736		Dalton		GA		US	30720			
Part II Emp									Plan Star	t Month (e	nter 2-digit r	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			And Notice of										1005 C (2000)		

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Nov Dec		
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Instructions for Recipient (continued)

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

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

Part III. Covered Individuals, Lines 18–30

Judith Anguiano Palmerin 438 Campbell Rd Se Calhoun, GA 30701

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

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

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

and the latest information

2023

Internal Revenue Sei	rvice		Go to www.	ırs.gov/For	m 1095C for in	istructions ar	ia the latest ii	ntormation.				- \	
Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Meml	per (Emplo	yer)	
1 Name of employ	ee (first name, n	niddle initial, la	ast name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Ei	nployer identific	ation number (EIN)
Judith		Angui	iano Palmerin		XXX-XX-8	703	Profession	al Eye Asso		581148820			
3 Street address (i	ncluding apartm	nent no.)					9 Street addre	ss (including roo	10 C	10 Contact telephone number			
438 Campbell	Rd Se						1111 Profe	essional Blvo	d			706226	2020
4 City or town	4 City or town 5 State or province				ry and ZIP or fore	ign postal code	11 City or town		12 State or p	orovince	13 Cd	ountry and ZIP or	foreign postal code
Calhoun GA				US 30	US 30701				GA		US	30720	
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit	number):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code													a 1095-C /202

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

Cat. No. 60705M

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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.

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **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).
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- **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).
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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Nov Dec		
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Maria Arredondo 636 Virginia Ave Dalton, GA 30721

Form 1095-G	
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

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

OMB No. 1545-2251

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Part I Emp	loyee						Α	pplicable L	arge Emp	loyer Meml	oer (Emplo	yer)			
1 Name of employ	ee (first name, r	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identific	ation number (EIN)		
Maria		Arred	ondo		XXX-XX-2	190	Profession	al Eye Asso		581148820					
3 Street address (including apartment no.)							9 Street addre	ss (including roor	m or suite no.)		10 Cd	10 Contact telephone number			
636 Virginia A	ve						1111 Profe	essional Blvd	ł			706226	2020		
4 City or town	5	State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or p	province	13 Co	ountry and ZIP or	foreign postal code		
Dalton						US 30721			GA		US	30720			
Part II Emp	loyee Offe	r of Cove	rage		Employee	's Age on .	January 1		Plan Sta	irt Month (e	nter 2-digit ı	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code													1005 C (2222		

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

Cat. No. 60705M

Instructions for Recipient

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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- **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).
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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Nov Dec		
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Line 17. This line reports the applicable ZIP code your employer used for determining affordability if you were offered an individual coverage HRA. If code 1L, 1M, 1N, or 1T was used on line 14, this will be your primary residence location. If code 1O, 1P, 1Q, or 1U was used on line 14, this will be your primary employment site. For more information about individual coverage HRAs, visit IRS.gov.

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Ivana Becerra 30`1 North Tibbs Road Dalton, GA 30720

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

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OMB No. 1545-2251

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

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Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	per (Emplo	oyer)			
1 Name of employ	ee (first name, r	niddle initial, las	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	ployer			8 E	mployer identific	ation number (EIN)		
Ivana		Becerr	·a		XXX-XX-28	380	Professional Eye Associates, Inc.					58114	3820		
3 Street address (in	ncluding apartm	nent no.)					9 Street addres	ss (including roor	m or suite no.)		10 C	10 Contact telephone number			
30`1 North Tib		1111 Profe	ssional Blvd	l			7062262020								
4 City or town 5 State or province 6 Country and ZIP or foreign postal country						gn postal code	11 City or town		12 State or p	province	13 Co	13 Country and ZIP or foreign postal code			
Dalton		GA		US 30	720		Dalton		GA		US	30720			
Part II Emp	loyee Offe	er of Cover	age	Employee ³	s Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit	2-digit number): 01				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2D	2D	2D								
17 ZIP Code			A st Nation										1005 C (2222		

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Nelda A Benitez 496 Cedar Ridge Rd Dalton, GA 30721

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CORRECTED

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OMB No. 1545-2251

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Part I Emp	oloyee	•							Aı	pplicable La	arge Emplo	yer Memb	er (En	nploy	er)			
1 Name of employ		middl	e initial, la	st name)	2 So	cial security	number (SSN	1)	7 Name of emp	oloyer				8 Emp	loyer identifica	ation number (EIN)		
Nelda		Α	Benite	ez		XXX->	(X-8584		Professional Eye Associates, Inc.					581148820				
3 Street address (i	including apart	ment r	10.)						9 Street addres	ss (including roon	n or suite no.)			10 Contact telephone number				
496 Cedar Ric	dge Rd								1111 Profe	ssional Blvd					706226	2020		
4 City or town		5 Sta	te or prov	ince	6 Cou	intry and ZIP	or foreign pos	stal code	11 City or town		12 State or pr	ovince		13 Coun	try and ZIP or	foreign postal code		
Dalton		GA			US	30721			Dalton		GA			US 30	0720			
Part II Emp	oloyee Off	er o	f Cove	rage	•	Emplo	yee's Aç	ge on Ĵ	anuary 1		Plan Star	t Month (e	nter 2-c	digit nu	mber):	01		
	All 12 Months	s	Jan	Feb	Mar	A	or	May	June	July	Aug	Sept	С	Oct	Nov	Dec		
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17 ZIP Code											N- 00705M					1005 C (2000)		

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Talynn Bennett 85 Fallbrooke Lane RINGGOLD, GA 30736

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Depart	tment	of the T	reasury
Interna	al Reve	enue Se	rvice

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

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OMB No. 1545-2251

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

internal Revenue Ser	vice		GO TO WWW	.iis.gov/Fort	1110930 101 111	structions ar	iu tile latest il	ioriiation.					
Part I Emp	loyee						Aı	oplicable La	arge Emplo	yer Memb	er (Emp	loyer)	
1 Name of employe	ee (first name, r	niddle initial, las	t name)	2 Social	security number	r (SSN)	7 Name of emp	loyer			8	Employer identifica	ation number (EIN)
Talynn		Benne	tt		XXX-XX-52	237	Professiona	al Eye Asso	ciates, Inc.			581148	3820
3 Street address (in	ncluding apartm	nent no.)		•			9 Street addres	s (including roor	n or suite no.)		10	Contact telephone	number
85 Fallbrooke	Lane						1111 Profe	ssional Blvd				706226	2020
4 City or town		5 State or provin	nce	6 Country	and ZIP or forei	gn postal code	11 City or town		12 State or pro	ovince	13	Country and ZIP or	foreign postal code
RINGGOLD		GA		US 30	736		Dalton		GA		U	S 30720	
Part II Emp	s Age on .	January 1		Plan Star	t Month (er	nter 2-dig	it number):	01					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D
17 ZIP Code			A at Nation										1005 C (2000)

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

Cat. No. 60705M

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Melandie Blair 120 Drivers Lane Cohutta, GA 30710

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

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OMB No. 1545-2251

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

2023 Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Melandie Blair XXX-XX-1915 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 120 Drivers Lane 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code Cohutta GA US 30710 Dalton GA US 30720 **Employee Offer of Coverage** Part II Employee's Age on January 1 Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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

Cat. No. 60705M

Instructions for Recipient

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Tiffany L Bolt 4522 Shelby Dr Dalton, GA 30721

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

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OMB No. 1545-2251

Internal Revenue Se	ervice			GO TO WWI	v.irs.gov/Fo	rm1095C for in	structions ar	na tne latest i	intormation.							
Part I Emp	oloyee							Α	Applicable L	arge Emplo	yer Meml	oer (Emplo	yer)			
1 Name of employ	ee (first name,	middle	initial, las	st name)	2 Soc	ial security numbe	r (SSN)	7 Name of em	nployer			8 Er	mployer identifica	ation number (EIN)		
Tiffany		L	Bolt			XXX-XX-0014			nal Eye Asso		581148820					
3 Street address (i	including apartr	ment n	o.)					9 Street addre	ess (including roo	10 Ce	10 Contact telephone number					
4522 Shelby I	Dr							1111 Profe	essional Blvd		7062262020					
4 City or town		5 Stat	te or provi	nce	6 Cour	6 Country and ZIP or foreign postal code			1	12 State or pro	ovince	13 Cd	ountry and ZIP or	foreign postal code		
Dalton		GA			US 3	0721	Dalton		GA		US	30720				
Part II Employee Offer of Coverage Employee's Age o							s Age on .	January 1 Plan Start Month (enter					2-digit number): 01			
	All 12 Months	;	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)			1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1A		
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
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17 ZIP Code																

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Cat. No. 60705M

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
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- **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).
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- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Shinjini Bose 1348 Passenger St, Apt 331 Chattanooga, TN 37408

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Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		GO to WWW.	irs.gov/For	<i>m10</i> 95C for in	structions an	d the latest ii	ntormation.							
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	/er)			
1 Name of employ	ee (first name, r	middle initial, la	ıst name)	2 Socia	l security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
Shinjini		Bose			XXX-XX-0!	501	Profession	al Eye Asso		581148820					
3 Street address (i	ncluding apartm	nent no.)					9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
1348 Passeng	ger St Apt 3	31					1111 Profe	ssional Blvd	ł			706226	2020		
4 City or town		5 State or prov	rince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	province	13 Co	intry and ZIP or	foreign postal code		
Chattanooga	408		Dalton		GA		US :	30720							
Part II Emp	loyee Offe	er of Cove	rage		Employee	's Age on J	lanuary 1		Plan Sta	rt Month (e	nter 2-digit r	umber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1H	1H	1H	1H	1H	1H	1H	1H	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	2A	2A	2A	2A		
17 ZIP Code									No. 60705M				1095-C (2022)		

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

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Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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

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Part III. Covered Individuals, Lines 18–30

Ashley Boswell 231 Hazel Lane NE Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

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Part I Emp	loyee									Applicable Large Employer Member (Employer)														
1 Name of employe	ee (first name,	middle	initial, las	t name)		2 Social	secu	rity number	(SSN)	7	Name of empl	oye	er						8 Emp	loye	r identificatio	n number	(EIN)	
Ashley			Boswe	·II			XXX	X-XX-39	91	Р	Professiona	ΙE	ye Assoc	iate	s, Inc.						5811488	20		
3 Street address (in	ncluding apartr	ment n	o.)							9	Street address	s (ir	ncluding room	or su	uite no.)				10 Cont	10 Contact telephone number				
231 Hazel Lar	ne NE									1	111 Profes	sic	onal Blvd							7	0622620	20		
4 City or town 5 State or province 6 Country and ZIP or foreign postal of								n postal code	11 City or town 12 State or province					13 Country and ZIP or foreign postal code										
Dalton GA US 30721								D	Dalton			G٨	١				US 30)72	20					
Part II Employee Offer of Coverage Employee's Age									Age on .	Ja	nuary 1			Pla	an Start	Мо	1th (en	ter 2	-digit nu	igit number): 01				
	All 12 Months	;	Jan	Feb		Mar		Apr	May		June		July		Aug	S	Sept		Oct		Nov	Dec	;	
14 Offer of Coverage (enter required code)			1H	1A		1A		1A	1A		1A		1A		1A		1A		1A		1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$		\$		\$	\$		\$		\$		\$		\$		\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2D																					
17 ZIP Code																								

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

Cat. No. 60705M

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

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Part III. Covered Individuals, Lines 18–30

Carrie B Brown 444 Hooker Rd Chatsworth, GA 30705

Form	10)95 .	-C
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251 2023

Do not attach to your tax return. Keep for your records. Go to www.irs.gov/Form1095C for instructions and the latest information. Internal Revenue Service Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Carrie В Brown XXX-XX-8897 Professional Eye Associates, Inc. 581148820

3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 444 Hooker Rd 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ Chatsworth US 30705 Dalton GA US 30720 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions)

17 ZIP Code For Privacy Act and Paperwork Reduction Act Notice, see separate instructions. Form **1095-C** (2023) Cat. No. 60705M

Instructions for Recipient

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

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

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Linzee Brown 904 Long Avenue Chatsworth, GA 30701

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Employ	/er)	
1 Name of employ	ree (first name, i	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)
Linzee		Brown	1		XXX-XX-0	718	Profession	al Eye Asso	ciates, Inc.			581148	3820
3 Street address (i	ncluding apartn	nent no.)		•			9 Street addre	ss (including roo	m or suite no.)		10 Co	ntact telephone	number
904 Long Ave	enue						1111 Profe	essional Blvd	i			706226	2020
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or p	province	13 Cou	ıntry and ZIP or	foreign postal code
Chatsworth		GA		US 30	0701		Dalton		GA		US 3	30720	
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit n	umber):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1H	1H	1H	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
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Cat. No. 60705M

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Sonya Brown 125 Charlie Walls Rd Chatsworth, GA 30705

Form I UUU U	Form 10	95 -	U
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

Internal Revenue Se	ervice		GO TO WW	/w.irs.gov/Fo	rm 1095C for in	structions ai	na the latest i	ntormation.							
Part I Emp	ployee						Α	Applicable L	arge Emplo	yer Memb	er (Employ	/er)			
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Soci	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identifica	ation number (EIN)		
Sonya		Brow	n		XXX-XX-35	589	Profession	nal Eye Asso	ciates, Inc.			581148	8820		
3 Street address (i	including apartr	ment no.)		•			9 Street addre	ess (including roc	m or suite no.)		10 Co	10 Contact telephone number			
125 Charlie W	Valls Rd						1111 Profe	essional Blv	b			7062262020			
4 City or town		5 State or pro	vince	6 Coun	try and ZIP or forei	gn postal code	11 City or town	1	12 State or pro	ovince	13 Cou	13 Country and ZIP or foreign postal coo			
Chatsworth		GA		US 3	US 30705				GA		US 3	30720			
Part II Employee Offer of Coverage Employee					's Age on	January 1		Plan Star	t Month (er	nter 2-digit number): 01					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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17 ZIP Code															

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Cat. No. 60705M

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- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Courtney Brumlow 25 Paul Lane Ringgold, GA 30736

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

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OMB No. 1545-2251

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

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

2023

Internal Revenue Ser	vice		GO to www.	is.gov/roi	11110950 101 111	structions ar	iu trie latest li	mormation.				_ ~			
Part I Emp	loyee						Α	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)			
1 Name of employe	ee (first name, r	middle initial, la	st name)	2 Socia	I security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
Courtney		Bruml	OW		XXX-XX-8	783	Professional Eye Associates, Inc.					581148	3820		
3 Street address (in	ncluding apartm	nent no.)					9 Street address (including room or suite no.)					10 Contact telephone number			
25 Paul Lane								1111 Professional Blvd				7062262020			
4 City or town	Ę	5 State or prov	ince	6 Countr	6 Country and ZIP or foreign postal code				12 State or p	rovince	13 Co	13 Country and ZIP or foreign postal code			
Ringgold		GA		US 30	US 30736				GA		US :	US 30720			
Part II Emp	loyee Offe	er of Cove	rage	·	Employee	's Age on c	January 1		Plan Star	rt Month (ei	nter 2-digit r	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	5	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A		
17 ZIP Code			Act Notice and						N- 00705M				1005 C (2000)		

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

Cat. No. 60705M

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- 11. Reserved for future use.
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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Kayle Calloway 227 Hays Street, Apt 28 Fort Oglethorpe, GA 30742

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

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

2023 Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Kavle Calloway XXX-XX-7625 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 227 Hays Street Apt 28 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code Fort Oglethorpe GA US 30742 Dalton GA US 30720 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1H 1H 1H 1H 1A 1A 1H 1H 1A 1A 1A 1H required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2D 2D 2D 2D 2B 2A 2A code, if applicable) 17 ZIP Code

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

Cat. No. 60705M

Instructions for Recipient

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2023)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Amber Cargile 715 Cove Road Chickamauga, GA 30707

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Employer-Provided Health Insurance Offer and Coverage

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VOID

OMB No. 1545-2251

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

2023

Internal Revenue Se	rvice		Go to www	.irs.gov/Fori	<i>m10</i> 95C for in	structions ar	nd the latest ii	ntormation.					
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Meml	per (Emplo	yer)	
1 Name of employ	ee (first name, m	niddle initial, las	st name)	2 Socia	l security numbe	r (SSN)	7 Name of em	ployer			8 Em	nployer identific	ation number (EIN)
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Part II Emp	oloyee Offe	r of Cove	rage		Employee	s Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit r	number):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2D	2D							
17 ZIP Code			Acabatha										1005 0

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Jessica Carter 1449 Price Bridge Road Lyerly, GA 30730

Form	109	5-C
Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar									
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Employ	/er)			
1 Name of employ	vee (first name, m	niddle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	ployer			8 Em	ployer identific	ation number (EIN)		
Jessica		Carter	-		XXX-XX-01	185	Profession	al Eye Asso	ciates, Inc.			58114	8820		
3 Street address (i	including apartm	ent no.)					9 Street address (including room or suite no.)					10 Contact telephone number			
1449 Price Br	idge Road						1111 Professional Blvd					7062262020			
4 City or town	5	State or prov	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town 12 State or province 13				13 Cou	13 Country and ZIP or foreign postal code			
Lyerly								Dalton GA							
Part II Emp	oloyee Offe	r of Cove	rage		Employee'	s Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit n	umber):	01		
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Part III. Covered Individuals, Lines 18–30

Haley Caskins 112 Diane Dr Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

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

2023

Internal Revenue Sei	rvice		GO to www	v.irs.gov/Foi	rm 1095C for II	istructions ar	na the latest i	ntormation.				- \			
Part I Emp	loyee						Α	pplicable L	arge Emp	loyer Meml	ber (Emplo	yer)			
1 Name of employ	ee (first name, r	middle initial, la	st name)	2 Soci	al security numb	er (SSN)	7 Name of em	ployer			8 Er	mployer identific	ation number (EIN)		
Haley		Caski	ns		XXX-XX-3	815	Profession	al Eye Asso	ciates, Inc.			58114	8820		
3 Street address (in	ncluding apartm	nent no.)		<u>'</u>			9 Street addre	ess (including roo	10 C	10 Contact telephone number					
112 Diane Dr							1111 Profe	essional Blvo		7062262020					
4 City or town	į	5 State or prov	rince	6 Count	try and ZIP or fore	ign postal code	11 City or town 12 State or province					13 Country and ZIP or foreign postal co			
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Part II Emp	loyee Offe	er of Cove	rage	•	Employee	's Age on c	January 1		Plan Sta	art Month (e	enter 2-digit	number):	01		
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- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Leeanna S Charles PO BOX 2666 Calhoun, GA 30703

Form	109:	5-C
Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

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

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Part I Emp	loyee						Α	pplicable L	arge Emp	loyer Meml	oer (Emplo	yer)			
1 Name of employ	ee (first name, i	middle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identific	ation number (EIN)		
Leeanna		S Charle	es		XXX-XX-2	935	Profession	al Eye Asso		58114	8820				
3 Street address (in	ncluding apartn	nent no.)		•			9 Street addre	ss (including roor	m or suite no.)		10 Co	10 Contact telephone number			
PO BOX 2666)						1111 Profe	essional Blvd	l			706226	2020		
4 City or town		5 State or provi	nce	6 Countr	ry and ZIP or fore	ign postal code	e 11 City or town 12 State or province				13 Co	13 Country and ZIP or foreign postal code			
Calhoun		GA		US 30	703		Dalton		GA		US	US 30720			
Part II Emp	loyee Offe	er of Cove	rage	•	Employee	's Age on .	January 1		Plan Sta	art Month (e	nter 2-digit	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2D	2D									
17 ZIP Code													1005 0 711		

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
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- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Lisa A Cline 1534 Beaverdale Rd NE Dalton, GA 30721

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Form	I UJJ-	U
Depart	ment of the Tre	asury
Interna	I Revenue Serv	ice ·

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

internal Revenue Service do to www.irs.gov/i om/10950 for instruction									structions an	u tile latest ili	1101	mation.									
Part I Emp	Part I Employee									Applicable Large Employer Member (Employer)											$\overline{}$
1 Name of employ	ee (first name,	middle	e initial, las	st name)		2 Social	secur	rity number	r (SSN)	7 Name of emp	oloye	er					8 Emp	loye	r identificatio	n number (E	IN)
Lisa		Α	Cline				XXX	X-XX-30)84	Professional Eye Associates, Inc.							581148820				
3 Street address (including apartment no.)									9 Street address	ss (ir	ncluding room	or suite no.)				10 Cont	act t	telephone nu	mber		
1534 Beaverd	lale Rd NE									1111 Profe	ssi	onal Blvd						7062262020			
4 City or town 5 State or province 6 Country and ZIP or foreign postal coo							gn postal code	11 City or town			12 State or p	orovi	ince		13 Coun	try a	nd ZIP or fore	eign postal c	ode		
Dalton GA US 3072						Dalton			Dalton			GA				US 30)72	20			
Part II Emp	oloyee Off	er of	Cover	age			Emp	ployee':	s Age on J	anuary 1			Plan Sta	rt l	Month (en	ter 2	2-digit nu	mb	er):	01	
	All 12 Months	6	Jan	Feb		Mar		Apr	May	June		July	Aug		Sept		Oct		Nov	Dec	
14 Offer of Coverage (enter required code)			1A	1A		1A		1A	1A	1A		1A	1A		1A		1A		1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$		\$	\$	\$		\$	\$;	\$		\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																					
17 ZIP Code																					

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

Cat. No. 60705M

Instructions for Recipient

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

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

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Part III. Covered Individuals, Lines 18–30

EMMA C COATS 213 Diamond DR Chickamauga, GA 30707

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

VOID

OMB No. 1545-2251

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

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Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Employ	/er)			
1 Name of employ	ee (first name, r	middle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
EMMA		C COAT	S		XXX-XX-08	376	Profession	al Eye Asso		581148	3820				
3 Street address (in	ncluding apartm	nent no.)					9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
213 Diamond	DR						1111 Profe	essional Blvd	i			7062262020			
4 City or town	gn postal code					13 Cou	13 Country and ZIP or foreign postal code								
Chickamauga	(GA		US 30	707		Dalton		GA		US 3	US 30720			
Part II Emp	loyee Offe	er of Cover	age	•	Employee	's Age on	January 1		Plan Sta	rt Month (er	nter 2-digit n	umber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$ \$	i	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D		
17 ZIP Code													1005 0		

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

Cat. No. 60705M

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- **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).
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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Luz Contreras 707 Delta Street Dalton, GA 30720

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		of the Tre	

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

OMB No. 1545-2251

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Internal Revenue Se	rvice		Go to www.	irs.gov/For	<i>m10</i> 95C for in	structions ar	d the latest ir	nformation.							
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name, m	niddle initial, las	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	ployer			8 En	nployer identific	ation number (EIN)		
Luz		Contre	eras		XXX-XX-03	308	Professiona	al Eye Asso		581148	3820				
3 Street address (i	ncluding apartme	ent no.)		<u>'</u>			9 Street addres	ss (including roo	m or suite no.)		10 Cd	10 Contact telephone number			
707 Delta Stre	707 Delta Street							ssional Blvd	k			7062262020			
4 City or town	4 City or town 5 State or province 6 Country and ZIP or foreign postal co						11 City or town 12 State or province 13				13 Co	untry and ZIP or	foreign postal code		
Dalton GA US 30720							Dalton		GA		US	30720			
Part II Employee Offer of Coverage Employee's Age							January 1		Plan Star	t Month (er	nter 2-digit ı	number):	01		
	All 12 Months	Jan	Feb	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D				
17 ZIP Code			Act Notice and						N- 00705M				1005 C (2000		

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Instructions for Recipient (continued)

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Shaina Costello 1110 Riverbend Drive Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

 $\ensuremath{\text{\textbf{Do}}}$ not attach to your tax return. Keep for your records.

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

2023

Internal Revenue Sei	rvice		GO to www.	irs.gov/For	m 1095C for in	istructions ar	ia the latest ii	ntormation.							
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Employ	/er)			
1 Name of employ	ee (first name, m	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)		
Shaina		Coste	llo		XXX-XX-1	190	Profession	al Eye Asso		581148	3820				
3 Street address (in	ncluding apartme	ent no.)					9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
1110 Riverber	nd Drive						1111 Profe	essional Blvo	k			706226	2020		
4 City or town	5	State or provi	ince	6 Countr	ry and ZIP or forei	ZIP or foreign postal code 11 City or town 12 State or province					13 Cou	intry and ZIP or	foreign postal code		
Dalton GA US 30721							Dalton		GA		US 3	30720			
Part II Emp	loyee Offe	r of Cove	rage		Employee	's Age on .	January 1		Plan Star	rt Month (er	nter 2-digit n	umber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D			
17 ZIP Code									No 60705M				1005-C (2022		

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

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

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

Part III. Covered Individuals, Lines 18–30

Luisa Crandell 622 Pine Oaks Drive Tunnel Hill, GA 30755

Form	1U	95	- U
Depart	tment	of the T	reasury
Interna	al Reve	enue Se	rvice

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Mem	ber (Emplo	oyer)		
1 Name of employ	ee (first name, r	niddle initial, la	st name)	2 Socia	al security numb	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)	
Luisa		Crano	dell		XXX-XX-0	217	Profession	al Eye Asso		581148	3820			
3 Street address (i	ncluding apartm	nent no.)					9 Street addre	ess (including roo	m or suite no.)		10 C	10 Contact telephone number		
622 Pine Oak	s Drive						1111 Profe	essional Blvd	d			706226	2020	
4 City or town	5	5 State or prov	vince	6 Count	ry and ZIP or fore	ign postal code	11 City or town 12 State or province				13 C	ountry and ZIP or	foreign postal code	
Tunnel Hill		GA		US 30	0755		Dalton		GA		US	30720		
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	rt Month (e	enter 2-digit	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code			Act Notice of						N- 00705M				1005 C (2000	

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Ana Cruz 1216 McDaniel Street, Apt 11 Dalton, GA 30720

Form	109:	5-C
Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		Go to www	ı.ırs.gov/Fori	m1095C for in	structions an	nd the latest ir	nformation.							
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	per (Emplo	yer)			
1 Name of employ	ee (first name, m	niddle initial, la	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	oloyer			8 Em	ployer identific	ation number (EIN)		
Ana		Cruz			XXX-XX-73	328	Professional Eye Associates, Inc.					581148820			
3 Street address (i	ncluding apartm	ent no.)		•			9 Street addres	ss (including roo	n or suite no.)		10 Co	10 Contact telephone number			
1216 McDaniel Street Apt 11							1111 Profe	ssional Blvd	I			706226	2020		
4 City or town	5 State or province					gn postal code	11 City or town		12 State or p	rovince	13 Co	untry and ZIP or	foreign postal code		
Dalton							Dalton		GA		US :	30720			
Part II Emp	oloyee Offe	r of Cove	rage		Employee'	s Age on J	January 1		Plan Sta	rt Month (e	nter 2-digit r	2-digit number): 01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			ALNUM										1005 0		

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

Cat. No. 60705M

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

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

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Part III. Covered Individuals, Lines 18–30

Connie R Cunningham 903 Probasco Street North Lafayette, GA 30728

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

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

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Part I Emp	oloyee						А	pplicable L	arge Empl	oyer Memb	per (Emplo	yer)			
1 Name of employ	ree (first name, r	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	8 Employer identification number (EIN)			
Connie		R Cunni	ngham		XXX-XX-8	570	Professional Eye Associates, Inc.					581148820			
3 Street address (i	ncluding apartn	nent no.)		•			9 Street addre	ss (including roor	n or suite no.)		10 C	10 Contact telephone number			
903 Probasco	903 Probasco Street North							essional Blvd				7062262020			
4 City or town		5 State or prov	ince	6 Count	6 Country and ZIP or foreign postal code			11 City or town		province	13 Cd	ountry and ZIP or	foreign postal code		
Lafayette		GA		US 30	0728		Dalton		GA		US	30720			
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code													1005 0		

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

Cat. No. 60705M

Instructions for Recipient

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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- **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).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Sandra Curd 134 REVERE RUN TUNNEL HILL, GA 30755

Form 1095-C
Form IUJJ-U
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.

CORRECTED

VOID

OMB No. 1545-2251

to usual iro gov/Form100FC for instructions and the letest info

RECTED 2023

Internal Revenue Se	rvice		Go to www.irs.gov/Form1095C for instructions and the latest information.											
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	vee (first name, n	niddle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer			8 E	mployer identifica	ation number (EIN)	
Sandra		Curd			XXX-XX-57	749	Professional Eye Associates, Inc.					581148820		
3 Street address (i	including apartm	ent no.)		<u>'</u>			*					10 Contact telephone number		
134 REVERE	134 REVERE RUN						1111 Profe	ssional Blvc				706226	2020	
4 City or town	4 City or town 5 State or province					gn postal code	11 City or town		12 State or pr	ovince	13 Co	ountry and ZIP or	foreign postal code	
TUNNEL HILL						US 30755			GA		US	30720		
Part II Emp	rage	Employee'	s Age on J	January 1		Plan Star	t Month (er	nter 2-digit	number):	01				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code									N. 00705M				1005 C (2000)	

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

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

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

Part I. Applicable Large Employer Member (Employer)

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

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- **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).
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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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

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

Part III. Covered Individuals, Lines 18–30

Kaley Davenport 302 Elbert Street Chatsworth, GA 30705

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

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

Internal Revenue Se	rvice		Go to www	.irs.gov/Fori	m1095C for in	structions ar	id the latest ir	ntormation.							
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Meml	per (Emplo	yer)			
1 Name of employ	ee (first name, m	iddle initial, las	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	ployer			8 Em	nployer identific	ation number (EIN)		
Kaley		Daver	port		XXX-XX-41	141	Professional Eye Associates, Inc.					581148820			
3 Street address (i	ncluding apartme	ent no.)					9 Street addres	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
302 Elbert Str	302 Elbert Street							1111 Professional Blvd					7062262020		
4 City or town	5	State or provi	nce	6 Countr	y and ZIP or forei	gn postal code	e 11 City or town 12 State or province 1				13 Co	untry and ZIP or	foreign postal code		
Chatsworth								Dalton GA					US 30720		
Part II Employee Offer of Coverage Employee's Age							January 1 Plan Start Month (enter 2-di				nter 2-digit r	digit number): 01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2D	2D	2D										
17 ZIP Code													1005 0		

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Cat. No. 60705M

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

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Part III. Covered Individuals, Lines 18–30

Van A Davis 59 Ireland Drive Kingston, GA 30145

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

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OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable La	arge Emplo	yer Memb	er (Emp	loyer)			
1 Name of employ	ee (first name,	, middle initial, l	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			8	Employer identifica	tion number (EIN)		
Van		A Davis	S		XXX-XX-7	179	Professiona	al Eye Asso	ciates, Inc.			581148	820		
3 Street address (i	including apart	ment no.)					9 Street addres	ss (including roor	n or suite no.)		10	10 Contact telephone number			
59 Ireland Dri	59 Ireland Drive							1111 Professional Blvd				7062262020			
4 City or town								e 11 City or town 12 State or province				13 Country and ZIP or foreign postal code			
Kingston	S .							Dalton GA					US 30720		
Part II Emp	oloyee Off	er of Cove	erage	Employee	's Age on c	January 1 Plan Start Month (ent			nter 2-digi	it number):	01				
	All 12 Months	s Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			Addition										1005 0		

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

Cat. No. 60705M

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- 11. Reserved for future use.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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

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Part III. Covered Individuals, Lines 18–30

Lorena Diaz 704 Stillwood Dr Dalton, GA 30721

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OMB No. 1545-2251

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

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

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Internal Revenue Se	ervice		Go to www.	.irs.gov/Foi	<i>m10</i> 95C for in	structions ar	nd the latest ii	nformation.							
Part I Emp	oloyee						Α	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name, n	middle initial, la	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer			8 Ei	mployer identifica	ation number (EIN)		
Lorena		Diaz			XXX-XX-80	058	Profession	al Eye Asso	ciates, Inc.			581148	3820		
3 Street address (i	including apartm	nent no.)		<u> </u>			9 Street addre	ss (including roo	m or suite no.)		10 C	10 Contact telephone number			
704 Stillwood	704 Stillwood Dr							essional Blvo	k			7062262020			
4 City or town	5	State or prov	vince	6 Count	ry and ZIP or forei	gn postal code	e 11 City or town 12 State or province				13 Cd	13 Country and ZIP or foreign postal code			
Dalton									GA		US	US 30720			
Part II Emp	rage	Employee	s Age on												
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2B	2A	2A	2A	2A	2A	2A	2A	2A	2A	2A		
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Cat. No. 60705M

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Part III. Covered Individuals, Lines 18–30

Veronica Diaz 240 Angus St Dalton, GA 30721

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OMB No. 1545-2251

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

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

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Part I Emp	oloyee									Applicable Large Employer Member (Employer)										_
1 Name of employ	vee (first name,	middle	initial, las	st name)		2 Social	secu	rity number	(SSN)	7 Name of emp	loyer					8 Emp	loyer i	dentificatio	n number (EIN)
Veronica			Diaz				XXX	X-XX-15	598	Professional Eye Associates, Inc.							5	8114882	20	
3 Street address (i	including aparti	ment n	o.)							9 Street address (including room or suite no.)						10 Contact telephone number				
240 Angus St										1111 Profes	ssion	al Blvd				7062262020				
4 City or town		5 Stat	te or provii	nce		6 Country and ZIP or foreign postal code			gn postal code	11 City or town			12 State or province			13 Coun	try an	d ZIP or fore	eign postal code	•
Dalton		GΑ				US 30721			Dalton G			GA US 30720)			
Part II Employee Offer of Coverage Employee's Age of							s Age on J	January 1 Plan Start Month (enter 2-					2-digit number): 01							
	All 12 Months	;	Jan	Feb		Mar		Apr	May	June		July	Aug	Sept		Oct		Nov	Dec	
14 Offer of Coverage (enter required code)			1A	1A		1A		1A	1A	1A		1A	1A	1A		1A		1A	1A	_
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$		\$	\$	\$		\$	\$	\$		\$		\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																				_
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Cat. No. 60705M

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

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- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee.		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Jennifer Dunn 888 Carter Stealey jRd Chatsworth, GA 30705

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OMB No. 1545-2251 2023

Internal Revenue Service

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

Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Jennifer Dunn XXX-XX-8029 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 888 Carter Stealey ¡Rd 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ Chatsworth US 30705 Dalton GA US 30720 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Sahara N Dye 160 Lamoian Drive Tunnel Hill, GA 30755

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OMB No. 1545-2251

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

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

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Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employe	ee (first name, n	niddle initial, las	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	ployer			8 Em	ployer identific	ation number (EIN)	
Sahara		N Dye			XXX-XX-55	528	Professiona	al Eye Asso		581148820				
3 Street address (in	ncluding apartm	nent no.)		<u> </u>			9 Street addres	ss (including roor	10 Co	10 Contact telephone number				
160 Lamoian	160 Lamoian Drive											7062262020		
4 City or town	5	State or provi	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	13 Co	untry and ZIP or	foreign postal code	
Tunnel Hill GA US					755		Dalton		GA		US:	30720		
Part II Emp	s Age on c	lanuary 1		Plan Sta	rt Month (ei	nter 2-digit r	2-digit number): 01							
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)											2B	2A	2A	
17 ZIP Code													1005.0	

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Cat. No. 60705M

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Form 1095-C (2023)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Elisa Escutia 505 Dantzler Ave Dalton, GA 30721

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OMB No. 1545-2251

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

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Part I Emp	loyee									Applicable Large Employer Member (Employer)								
1 Name of employe	ee (first name,	middle	e initial, last	t name)		2 Social	security nur	mber (S	SSN)	7 Name of empl	oyer				8 Empl	oyer identificati	on number (EIN)	
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3 Street address (in	ncluding apartı	ment n	0.)						!	9 Street address (including room or suite no.)					10 Contact telephone number			
505 Dantzler Ave									1111 Professional Blvd					7062262020				
4 City or town 5 State or province 6 Count					6 Country	Country and ZIP or foreign postal code			11 City or town		12 State or pro	ovince		13 Coun	try and ZIP or fo	reign postal code		
Dalton GA US 30721							Dalton		GA			US 30	0720					
Part II Employee Offer of Coverage Employee's Age of							Age on Ja	January 1 Plan Start Month (enter 2-c			ter 2-d	-digit number): 01						
	All 12 Months	3	Jan	Feb		Mar	Apr		May	June	July	Aug	Sept	0	ct	Nov	Dec	
14 Offer of Coverage (enter required code)			1A	1A		1A	1A		1A	1A	1A	1A	1A	1	A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$	\$	3	\$	\$	\$	\$	\$		\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																		
17 ZIP Code																		

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

Cat. No. 60705M

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Part III. Covered Individuals, Lines 18–30

Maritzha Fraire 1419 Kammi St Dalton, GA 30720

Form 1095-	J
Department of the Treas	ury

CORRECTED

VOID

OMB No. 1545-2251

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

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

CORRECTED 2023

Internal Revenue Service Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Maritzha Fraire XXX-XX-6973 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1419 Kammi St 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code Dalton GA US 30720 Dalton GA US 30720 **Employee Offer of Coverage** Part II Employee's Age on January 1 Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1H 1H 1H 1H 1H 1H 1H 1H 1H required code) 1A 1H 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2B 2A 2A 2A 2A 2A 2A 2A 2A 2A code, if applicable) 17 ZIP Code

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Yolanda Franco 643 Houston Valley Road Tunnel Hill, GA 30755

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Form	UJJ-	U
Departme	ent of the Tre	asury
Internal F	Revenue Serv	ice .

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			8 Em	ployer identific	ation number (EIN)	
Yolanda		France)		XXX-XX-82	220	Professional Eye Associates, Inc.					581148820		
3 Street address (in	ncluding apartn	nent no.)		'			9 Street addre	ss (including roo	n or suite no.)		10 Co	10 Contact telephone number		
643 Houston \	Valley Roa	d					1111 Profe	ssional Blvd	I			706226	2020	
4 City or town		5 State or provi	nce	6 Counti	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	13 Co	untry and ZIP or	foreign postal code	
Tunnel Hill		GA		US 30	755		Dalton		GA		US :	30720		
Part II Emp	oloyee Offe	er of Cove	age		Employee'	s Age on c	January 1		Plan Star	rt Month (er	nter 2-digit r	iumber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Jessica L Gallegos 1004 Coogler Rd DALTON, GA 30721

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OMB No. 1545-2251

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

Internal Revenue Se	ervice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest in	itormation.							
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	/ee (first name, mi	iddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			8 En	nployer identific	ation number (EIN)		
Jessica	L	Galle	gos		XXX-XX-67	745	Professiona	al Eye Asso	ciates, Inc.			581148	3820		
3 Street address (i	including apartme	ent no.)	•				9 Street address	ss (including roor	m or suite no.)		10 Co	10 Contact telephone number			
1004 Coogler	Rd						1111 Professional Blvd					7062262020			
4 City or town	5	State or prov	rince	6 Counti	ry and ZIP or forei	gn postal code	11 City or town 12 State or province 1				13 Co	untry and ZIP or	foreign postal code		
DALTON GA US 30721							Dalton		GA		US	30720			
Part II Employee Offer of Coverage Employee's Age of							January 1		Plan Star	t Month (e	nter 2-digit r	ligit number): 01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code													1005 C (2000)		

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct Nov Dec		
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Instructions for Recipient (continued)

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

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

Part III. Covered Individuals, Lines 18–30

Lauren Gazaway 107 Cessna Drive Dalton, GA 30721

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OMB No. 1545-2251

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

Internal Revenue Ser	vice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest in	nformation.							
Part I Emp	loyee						Α	pplicable L	arge Emp	loyer Memb	per (Employ	/er)			
1 Name of employ	ee (first name, m	iddle initial, las	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	ployer			8 Em	ployer identific	ation number (EIN)		
Lauren		Gazav	vay		XXX-XX-6	100	Profession	al Eye Asso	ciates, Inc.			58114	8820		
3 Street address (in	ncluding apartme	ent no.)	•	•			9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
107 Cessna D	rive						1111 Profe	essional Blvo		7062262020					
4 City or town	5	State or provi	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town 12 State or province 1					13 Country and ZIP or foreign postal code			
Dalton GA US 30721							Dalton	lton GA US					S 30720		
Part II Employee Offer of Coverage Employee's Age of							January 1		Plan Sta	rt Month (e	nter 2-digit n	umber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2D	2D	2D	2D						
17 ZIP Code			A at Nation										1005 C (200		

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

Cat. No. 60705M

Instructions for Recipient

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

Part I. Applicable Large Employer Member (Employer)

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

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- **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).
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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct Nov Dec		
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Instructions for Recipient (continued)

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

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Part III. Covered Individuals, Lines 18–30

MARIELLE GENTER 195 E LONG HOLLOW ROCK SPRING, GA 30739

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Form	1	09	IJ.	·U
Depar	tmer	nt of th	ne Tre	asury

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OMB No. 1545-2251

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

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

2023

Internal Revenue Se	rvice		GO to www	.irs.gov/Forr	n1095C for in	structions ar	na the latest in	itormation.							
Part I Emp	loyee						Aı	oplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name, m	niddle initial, las	t name)	2 Social	security number	r (SSN)	7 Name of emp	oloyer			8 Er	nployer identifica	tion number (EIN)		
MARIELLE		GENT	ER		XXX-XX-25	578	Professiona	al Eye Asso	ciates, Inc.			581148	8820		
3 Street address (i	ncluding apartme	ent no.)		•			9 Street addres	ss (including roor	n or suite no.)		10 C	10 Contact telephone number			
195 E LONG I	HOLLOW				1111 Profe	ssional Blvd		7062262020							
4 City or town 5 State or province 6 Country and ZIP or foreign postal co							e 11 City or town 12 State or province					13 Country and ZIP or foreign postal code			
ROCK SPRING GA US 30739							Dalton		GA		US	30720			
Part II Emp	loyee Offe	r of Cover	age	Employee'	s Age on .	January 1		Plan Star	t Month (e	nter 2-digit	digit number): 01				
All 12 Months Jan Feb Mar Api						May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D		
17 ZIP Code													1005.0		

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **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).
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Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct Nov Dec		
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Redia K Gibson 1479 TOM TERRY ROAD CHATSWORTH, GA 30705

Form 1095-G	
Department of the Treasury	
Internal Revenue Service	

VOID

OMB No. 1545-2251

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

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Part I Emp	loyee							Α	pplicable La	arge Emplo	yer Memb	er (En	nploye	er)		
1 Name of employe	ee (first name	, middle init	ial, last name)		2 Social	security number	(SSN)	7 Name of emp	ployer				8 Empl	oyer identifica	tion number (EIN)	
Redia		K Gi	ibson			XXX-XX-06	84	Profession	al Eye Asso	ciates, Inc.			581148820			
3 Street address (in	3 Street address (including apartment no.)								ss (including roon	n or suite no.)			10 Contact telephone number			
1479 TOM TE	RRY ROA	AD						1111 Profe	ssional Blvd					7062262	2020	
4 City or town 5 State or province 6 Country and ZIP or foreign postal code						n postal code	11 City or town 12 State or province					13 Count	try and ZIP or f	oreign postal code		
CHATSWORTH GA US 30705								Dalton		US 30	720					
Part II Employee Offer of Coverage Employee's							ployee's Age on January 1 Plan Start Mo						ligit nu	mber):	01	
	All 12 Month	s Ja	ın F	eb	Mar	Apr	May	June	July	Aug	Sept	0	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1/	Α 1	A	1A	1A	1A	1A	1A	1A	1A	1	Α	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$		\$	\$	\$	\$	\$	\$	\$		\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code																

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

Cat. No. 60705M

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Part III. Covered Individuals, Lines 18–30

Heather Gilbert 218 Castle Road Dalton, GA 30720

Form 1095-	J
Department of the Treas	ury

VOID

OMB No. 1545-2251

Internal Revenue Se	ervice		GO to www	v.irs.gov/ro	/////095C 10/ III	structions a	ind the latest	imormation.	_ ~							
Part I Em	ployee						<i>I</i>	Applicable L	arge Emplo	yer Mem	ber (Emplo	yer)				
1 Name of employ	yee (first name,	middle initial, la	ast name)	2 Soci	ial security numbe	er (SSN)	7 Name of en	nployer			8 En	nployer identific	ation number (EIN)			
Heather		Gilbe	rt		XXX-XX-9!	594	Profession	nal Eye Asso	ciates, Inc.			581148	3820			
3 Street address (including aparti	ment no.)					9 Street addre	ess (including roo	10 Cc	10 Contact telephone number						
218 Castle Re	oad						1111 Professional Blvd					7062262020				
4 City or town		5 State or prov	vince	6 Coun	6 Country and ZIP or foreign postal code			า	12 State or pr	ovince	13 Co	untry and ZIP or	foreign postal code			
Dalton		GA		US 3	US 30720				GA		US	30720				
Part II Employee Offer of Coverage Employee's Age on							January 1		Plan Star	nter 2-digit r	r 2-digit number): 01					
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	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	2A	2A	2A	2A	2A			
17 ZIP Code																

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Cat. No. 60705M

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

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Angeliz Gonzalez 230 Brittney Dr SE Calhoun, GA 30701

Form	109:	5-C
Departi	ment of the	Treasury
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OMB No. 1545-2251

Internal Revenue Se	ervice		Go to www.	irs.gov/For	m1095C for ins	structions a	nd the latest i	information.							
Part I Emp	ployee						_ A	Applicable L	arge Emplo	yer Meml	oer (Emplo	yer)			
1 Name of employ	yee (first name,	middle initial, las	t name)	2 Socia	al security number	(SSN)	7 Name of em	nployer			8 Er	nployer identific	ation number (EIN)		
Angeliz		Gonza	lez		XXX-XX-52	64	Profession	nal Eye Asso		581148820					
3 Street address (including apartr	nent no.)		•			9 Street addre	ess (including roo	Contact telephone number						
230 Brittney D	Dr SE				1111 Professional Blvd						7062262020				
4 City or town		5 State or provin	nce	6 Count	6 Country and ZIP or foreign postal code			า	12 State or pro	ovince	13 Co	ountry and ZIP or	foreign postal code		
Calhoun		GA		US 30	701		Dalton		GA		US	30720			
Part II Employee Offer of Coverage Employee's Ag							January 1 Plan Start Month (enter					number):	01		
All 12 Months Jan Feb					Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1H	1H	1H	1H	1H	1H	1H	1H	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	2A	2A	2A	2A		
17 ZIP Code															

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other) (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Tiffany Hammontree 324 Norton Bridge Rd Chatsworth, GA 30705

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OMB No. 1545-2251

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

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Part I Emp	loyee						Α	pplicable La	arge Emplo	yer Memb	er (Emp	loyer)			
1 Name of employe	ee (first name,	middle initial, las	t name)	2 Social	security numbe	r (SSN)	7 Name of emp	oloyer			8	Employer identifica	tion number (EIN)		
Tiffany		Hamm	ontree		XXX-XX-79	905	Professiona	al Eye Asso	ciates, Inc.			581148	820		
3 Street address (in	ncluding apartr	ment no.)		<u>.</u>			9 Street addres	ss (including roor	n or suite no.)		10	10 Contact telephone number			
324 Norton Br	24 Norton Bridge Rd											7062262020			
4 City or town	gn postal code	11 City or town 12 State or province					13 Country and ZIP or foreign postal code								
Chatsworth		GA		US 30	705		Dalton		GA		U:	S 30720			
Part II Emp	loyee Off	er of Cover	age		Employee'	s Age on	January 1		Plan Star	t Month (er	nter 2-digi	it number):	01		
	Jan	May	June	July	Aug	Sept	Oct	Nov	Dec						
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D			
17 ZIP Code													1005.0		

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

Cat. No. 60705M

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

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

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

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Cassie Harris 1043 Laura Dr Dalton, GA 30721

Form	109:	5-C
Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

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

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

2023

internal Revenue Se	rvice		GO to www	.irs.gov/rori	1110950 101 111	structions ar	id the latest in	normation.				~				
Part I Emp	oloyee						A	pplicable La	arge Emplo	yer Memb	er (Emplo	yer)				
1 Name of employ	/ee (first name, r	niddle initial, la	ıst name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	oloyer			8 Em	ployer identifica	ation number (EIN)			
Cassie		Harris	S		XXX-XX-97	759	Professiona	al Eye Asso	ciates, Inc.			581148	8820			
3 Street address (i	including apartm	nent no.)		<u>'</u>			9 Street addres	ss (including roor	n or suite no.)		10 Co	10 Contact telephone number				
1043 Laura D	r						1111 Profes	ssional Blvd				706226	2020			
4 City or town	5	5 State or prov	rince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	13 Co	13 Country and ZIP or foreign postal cod				
Dalton		GA		US 30	721		Dalton		GA		US :	30720				
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee'	s Age on c	January 1		Plan Star	t Month (er	nter 2-digit r	2-digit number): 01				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code													1005.0			

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

Cat. No. 60705M

Instructions for Recipient

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

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Maryann J Harrison 508 W Fort Street Chatsworth, GA 30705

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OMB No. 1545-2251

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

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Maryann J Harrison XXX-XX-9407 Professional Eye Associates, Inc. 58114882C 3 Street address (including apartment no.) 508 W Fort Street 4 City or town 5 State or province GA US 30705 Dalton GA US 30720 Part II Employee Offer of Coverage Employee's Age on January 1 14 Offer of Coverage (enter required code) 15 Employee Required Contribution (see instructions) \$	Part I Em	ployee								Α	pplicable L	arge Empl	oyer Memb	er (Emp	oloyer)			
3 Street address (including apartment no.) 508 W Fort Street 1111 Professional Blvd 706226202 4 City or town 5 State or province GA US 30705 Dalton Chatsworth Employee Offer of Coverage Employee's Age on January 1 Dalton 14 Offer of Coverage (enter required code) 14 Offer of Coverage (enter required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 18 Street address (including room or suite no.) 10 Contact telephone number 10 Contract telephone number 11 City or town 12 State or province 13 Country and ZIP or foreign postal code 14 City or town 15 Employee Offer of Coverage 18 Employee's Age on January 1 19 Street address (including room or suite no.) 10 Contact telephone number 10 Contact telephone number 11 City or town 12 State or province 13 Country and ZIP or foreign postal code 14 City or town 12 State or province 13 Country and ZIP or foreign postal code 14 Offer of Coverage 15 Employee's Age on January 1 16 Section 480H 17 State or province 18 Country and ZIP or foreign postal code 19 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code 14 Offer of Coverage 15 Employee's Age on January 1 16 Employee 17 April 17 April 18 April 19 Apr	1 Name of employ	yee (first name,	middle	e initial, la	st name)	2 Soc	cial security	number (SS	SN)	7 Name of emp	ployer			8	Employe	r identifica	tion number (EIN)	
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4 City or town GA US 30705 Dalton GA US 30720 Part II Employee Offer of Coverage Employee's Age on January 1 4 Offer of Coverage (enter required code) TA	3 Street address (including apart	ment n	10.)		<u> </u>				9 Street addre	ss (including roor	n or suite no.)		10	10 Contact telephone number			
Chatsworth GA US 30705 Dalton GA US 30720 Part II Employee Offer of Coverage Employee's Age on January 1 Plan Start Month (enter 2-digit number):	508 W Fort S	treet								1111 Profe	essional Blvd				7062262020			
Part II Employee Offer of Coverage	4 City or town		5 Sta	te or prov	ince	6 Cou	ntry and ZIP	or foreign po	ostal code	e 11 City or town 12 State or province					13 Country and ZIP or foreign postal code			
All 12 Months Jan Feb Mar Apr May June July Aug Sept Oct Nov 14 Offer of Coverage (enter required code) 15 Employee Required Contribution (see instructions) \$\$\$ \$	Chatsworth		GA			US 3	30705			Dalton		GA		U	IS 3072	.0		
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Safe Harbor and Other Relief (enter code, if applicable)	Required Contribution (see	\$	\$		\$	\$	\$	\$		\$	\$	\$	\$	\$	\$		\$	
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	17 ZIP Code																	

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

Cat. No. 60705M

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

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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

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Part III. Covered Individuals, Lines 18–30

Joshua F Hendrix 1919 Canterbury NW Dalton, GA 30720

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

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OMB No. 1545-2251

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

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14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
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Cat. No. 60705M

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

Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other) (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Natalie Hernandez 1068 BONNY OAKS DR DALTON, GA 30721

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

VOID

OMB No. 1545-2251

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

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Part I Emp	loyee						Α	pplicable L	arge Emp	loyer Meml	oer (Emplo	yer)	
1 Name of employ	ee (first name, ı	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identific	ation number (EIN)
Natalie		Herna	ındez		XXX-XX-5	375	Profession	al Eye Asso	ciates, Inc.			58114	8820
3 Street address (in	ncluding apartn	nent no.)					9 Street addre	ss (including roo	m or suite no.)		10 C	ontact telephone	e number
1068 BONNY	OAKS DR						1111 Profe	essional Blvd	k			706226	2020
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or	province	13 Cd	ountry and ZIP or	foreign postal code
DALTON		GA		US 30	0721		Dalton		GA		US	30720	
Part II Emp	loyee Offe	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	irt Month (e	nter 2-digit	number):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code			And Madica and										1005 C (2222

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other) (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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

Part III. Covered Individuals, Lines 18–30

Shondra D Hidalgo 99 Catoosa Pkwy Tunnel Hill, GA 30755

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Form 1095-C	
Department of the Treasury	/
Internal Decreases Country	

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

CORRECTED

VOID

OMB No. 1545-2251

2023

Internal Revenue Service Go to www.irs.gov/Form1095C for instruction							nd the latest in	nformation.						
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	ee (first name,	middle initial, I	ast name)	2 Soci	al security number	r (SSN)	7 Name of em	oloyer			8 Em	nployer identific	cation number (EIN)	
Shondra		D Hida	go		XXX-XX-44	135	Profession	al Eye Asso	ciates, Inc.			58114	8820	
3 Street address (in	ncluding apartr	ment no.)		•			9 Street addre	ss (including roc	10 Co	10 Contact telephone number				
99 Catoosa Pkwy							1111 Profe	ssional Blv		7062262020				
4 City or town 5 State or province 6 Country and ZIP or foreign postal coordinates to the country and ZIP or foreign postal cou						gn postal code	e 11 City or town 12 State or province					13 Country and ZIP or foreign postal code		
Tunnel Hill GA US 30755							Dalton GA					US 30720		
Part II Employee Offer of Coverage Employee's Age							January 1	Plan Star	nter 2-digit r	er 2-digit number): 01				
All 12 Months Jan Feb M					Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code														

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **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).
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- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other) (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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Part III. Covered Individuals, Lines 18–30

Brittany Hobbs 43 Quail Run CHATSWORTH, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

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OMB No. 1545-2251

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

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

RRECTED 2023

Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	d the latest ir	nformation.							
Part I Emp	oloyee						Α	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)			
1 Name of employ	vee (first name, r	niddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	ployer			8 En	nployer identifica	ation number (EIN)		
Brittany		Hobbs	S		XXX-XX-58	383	Professional Eye Associates, Inc.					581148820			
3 Street address (i	including apartm	nent no.)					9 Street address (including room or suite no.)					10 Contact telephone number			
43 Quail Run							1111 Profe	essional Blvd	i			706226	2020		
4 City or town	4 City or town 5 State or province 6 Coun				ry and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	13 Co	13 Country and ZIP or foreign postal code			
CHATSWORTH GA US 30705					Dalton GA				US	US 30720					
Part II Emp	oloyee Offe	r of Cove	rage		Employee	s Age on J	lanuary 1		Plan Star	rt Month (er	nter 2-digit r	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2D	2D	2D						
17 ZIP Code			A.1.N.1										1005 0 2222		

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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Part III. Covered Individuals, Lines 18–30

Stacy Jacobs 1012 HOLLY GROVE DR DALTON, GA 30721

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Depar	tme	nt of	the T	rea	sury

Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Ser	rvice		Go to www	v.irs.gov/For	<i>m10</i> 95C for in	structions an	id the latest ir	nformation.						
Part I Emp	oloyee						Α	pplicable L	arge Empl	loyer Meml	per (Emplo	yer)		
1 Name of employ	vee (first name, m	niddle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	ployer			8 Em	nployer identific	ation number (EIN)	
Stacy		Jacob	S		XXX-XX-78	386	Professional Eye Associates, Inc.					581148820		
3 Street address (i	including apartm	ent no.)					9 Street address (including room or suite no.)					10 Contact telephone number		
1012 HOLLY	GROVE DR	2					1111 Profe	essional Blvd	ł			706226	2020	
4 City or town	5	State or prov	ince	6 Counti	y and ZIP or forei	gn postal code	11 City or town		12 State or p	orovince	13 Co	untry and ZIP or	foreign postal code	
DALTON		GΑ		US 30	721		Dalton		GA		US:	30720		
Part II Emp	oloyee Offe	r of Cove	rage		Employee ³	s Age on J	January 1		Plan Sta	rt Month (e	nter 2-digit r	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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Instructions for Recipient (continued)

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Brianna Johnston 1930 Meadowbrook Cir NW Dalton, GA 30720

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

CORRECTED

OMB No. 1545-2251

VOID

2023

Go to www.irs.gov/Form1095C for instructions and the latest information. Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Brianna Johnston XXX-XX-8696 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1930 Meadowbrook Cir NW 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ Dalton US 30720 Dalton GA US 30720 **Employee Offer of Coverage** Part II **Employee's Age on January 1** Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1A 1A 1A 1H 1H 1H 1H 1H 1A 1H 1H required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2B 2A 2A 2A 2A 2A 2A code, if applicable) 17 ZIP Code

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

Par	Covered Individuals If Employer provided self-insure	d coverage, check th	e box and enter th	e informatio	on for e	ach inc	lividual	enrolle					employe	ee.		
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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

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Part III. Covered Individuals, Lines 18–30

Dooho Kim 1912 Wycliffe Dalton, GA 30720

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

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

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Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)			
1 Name of employ	vee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer	8 En	nployer identific	ation number (EIN)				
Dooho		Kim			XXX-XX-0	779	Profession	al Eye Asso		581148820					
3 Street address (i	including apartr	ment no.)		<u>'</u>			9 Street addre	ss (including roor	m or suite no.)		10 Cd	ontact telephone	e number		
1912 Wycliffe							1111 Profe	essional Blvd	l			706226	2020		
4 City or town 5 State or province 6 Country and ZIP or foreign postal code						11 City or town		12 State or p	province	13 Co	untry and ZIP or	foreign postal code			
Dalton GA US 30720							Dalton		GA		US	US 30720			
Part II Emp	oloyee Off	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit ı	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code													1005 0 2222		

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

Cat. No. 60705M

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
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- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Heather Kitchens 1704 White Oak Ln 24 Dalton, GA 30721

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

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OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Mem	ber (Emplo	yer)			
1 Name of employ	/ee (first name, r	middle initial, la	ast name)	2 Soci	al security numb	er (SSN)	7 Name of em	ployer			8 Er	mployer identific	ation number (EIN)		
Heather		Kitche	ens		XXX-XX-0	109	Profession	al Eye Asso		581148820					
3 Street address (i	3 Street address (including apartment no.)							ess (including roo	om or suite no.)		10 C	10 Contact telephone number			
1704 White O	ak Ln 24						1111 Profe	essional Blv	d			706226	2020		
4 City or town 5 State or province 6 Country and ZIP or foreign						ign postal code	e 11 City or town 12 State or province					13 Country and ZIP or foreign postal cod			
Dalton		GA		US 30	0721		Dalton		GA		US	US 30720			
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee	's Age on .	January 1		Plan Sta	art Month (e	enter 2-digit	2-digit number):			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code									N- COZOSM				1005 € (2000		

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Cat. No. 60705M

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

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Part III. Covered Individuals, Lines 18–30

Jordan Kotwicki 422 Coahulla Creek Dr Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

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

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

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2023

Internal Revenue Sei	vice		GO TO WW	/w.irs.gov/Foi	m 1095C for in	istructions a	and the latest i	ntormation.				`				
Part I Emp	loyee						A	pplicable L	arge Empl	oyer Memb	er (Em	ployer)				
1 Name of employ	ee (first name, m	niddle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer				8 Employer identific	cation number (EIN)			
Jordan	1	Kotwi	cki		XXX-XX-7	XX-XX-7591 Professional Eye Associates, Inc.						581148820				
3 Street address (in	ncluding apartme	ent no.)					9 Street addre	ess (including roo	m or suite no.)		1	10 Contact telephon	e number			
422 Coahulla	Creek Dr						1111 Profe	essional Blv	t			70622	52020			
4 City or town	5	State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town	1	12 State or p	orovince	1	3 Country and ZIP o	r foreign postal code			
Dalton		GΑ		US 30	0721		Dalton		GA		Įι	US 30720				
Part II Emp	loyee Offe	r of Cove	rage		Employee	's Age on	January 1		Plan Sta	rt Month (e	nter 2-di	igit number):	01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Od	ct Nov	Dec			
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1/	A 1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code													m 1005-C (2022			

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

Cat. No. 60705M

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



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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
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Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Shady Leal 2539 Turf Dr Dalton, GA 30721

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

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OMB No. 1545-2251

epartment of the Treasury

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

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Internal Revenue Se	rvice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	d the latest in	nformation.					
Part I Emp	oloyee						A	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)	
1 Name of employ	vee (first name, i	middle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer			8 Er	nployer identific	ation number (EIN)
Shady		Leal			XXX-XX-3	183	Professiona	al Eye Asso		581148820			
3 Street address (i	including apartn	nent no.)		<u>'</u>			9 Street address	ss (including roor	10 C	10 Contact telephone number			
2539 Turf Dr							1111 Profe	ssional Blvd		7062262020			
4 City or town	ţ	5 State or prov	ince	6 Countr	6 Country and ZIP or foreign postal code				12 State or pr	ovince	13 Cd	ountry and ZIP or	foreign postal code
Dalton		GA		US 30	721		Dalton		GA		US	30720	
Part II Emp	rage	Employee'	s Age on	January 1		Plan Star	t Month (er	nter 2-digit	nter 2-digit number):				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code			A Act Notice as						N- 00705M				1005 C (2000)

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

Cat. No. 60705M

Instructions for Recipient

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Torre Llewellyn 29 Jackson Kinnamon Rd Chatsworth, GA 30705

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

CORRECTED

OMB No. 1545-2251

VOID

2023

Go to www.irs.gov/Form1095C for instructions and the latest information. Part I Employee Applicable Large Employer Member (Employer) 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Torre Llewellvn XXX-XX-6079 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 29 Jackson Kinnamon Rd 1111 Professional Blvd 7062262020 5 State or province 4 City or town 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ Chatsworth US 30705 Dalton GA US 30720 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1H 1H 1H 1H 1H 1H 1H 1H 1A 1H 1H required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2B 2A 2A 2A 2A 2A 2A 2A 2A 2A code, if applicable) 17 ZIP Code

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

Cat. No. 60705M

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Instructions for Recipient (continued)

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

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

Part III. Covered Individuals, Lines 18–30

Laura B Long 205 Spring Place Smyrna Road Chatsworth, GA 30705

1 NOK_r
Form 1095-C
Department of the Treasury
Internal Decrease Complete

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

CORRECTED

VOID

OMB No. 1545-2251

2023

Internal Revenue Se	rvice		Go to www	ı.irs.gov/Forı	m1095C for ins	structions ar	nd the latest in	formation.						
Part I Emp	loyee						A	oplicable L	arge Emplo	yer Memb	er (Employ	/er)		
1 Name of employ	ee (first name, i	middle initial, las	t name)	2 Social	l security number	r (SSN)	7 Name of emp	loyer			8 Em	ployer identifica	ation number (EIN)	
Laura		B Long			XXX-XX-28	Professiona	al Eye Asso		581148820					
3 Street address (i	ncluding apartn	nent no.)					9 Street address	s (including roo	10 Cor	0 Contact telephone number				
205 Spring Pla	ace Smyrn	a Road					1111 Professional Blvd					7062262020		
4 City or town		5 State or provin	nce	6 Country	6 Country and ZIP or foreign postal code				12 State or pro	ovince	13 Cou	ntry and ZIP or	foreign postal code	
Chatsworth		GA		US 30	705	Dalton		GA	GA US					
Part II Emp	Employee's	ployee's Age on January 1 Plan Start Month (ent					er 2-digit number): 01							
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code														

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
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- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other) (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Thalia Madrigal-Salgado 203 PREIWINKLE WAY DALTON, GA 30721

Form 1095-	J
Department of the Treas	ury

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

VOID

OMB No. 1545-2251

yee						Ap	plicable La	arge Emplo	yer Membe	er (Employ	er)				
first name, n	niddle initial, las	t name)	2 Social	security numbe	r (SSN)	7 Name of emp	loyer			8 Emp	oloyer identificat	on number (EIN)			
	Madrig	al-Salgado		XXX-XX-44	491	Professiona	I Eye Assoc		581148820						
iding apartm	nent no.)					9 Street addres	s (including roon	10 Con	tact telephone r	umber					
E WAY						1111 Profes	ssional Blvd				7062262	020			
						11 City or town		12 State or pro	vince	13 Cou	13 Country and ZIP or foreign postal code				
(GA		US 30	721		Dalton GA					US 30720				
yee Offe	r of Cover	age		Employee'	s Age on J	lanuary 1		Plan Start	t Month (en	ter 2-digit nu	2-digit number): 01				
II 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
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f	ding apartm E WAY	irst name, middle initial, las Madrig ding apartment no.) E WAY 5 State or provin GA yee Offer of Cover	irst name, middle initial, last name) Madrigal-Salgado Madrigal-S	irst name, middle initial, last name) Madrigal-Salgado Madrigal-S	irst name, middle initial, last name) Madrigal-Salgado	irrst name, middle initial, last name) Madrigal-Salgado XXX-XX-4491 Madrigal-Salgado XXX-XX-4491 Madrigal-Salgado XXX-XX-4491 Madrigal-Salgado XXX-XX-4491 Madrigal-Salgado XXX-XX-4491 E WAY	First name, middle initial, last name) Madrigal-Salgado XXX-XX-4491 Professional XXX-XX-4491	First name, middle initial, last name) Madrigal-Salgado XXX-XX-4491 Professional Eye Associating apartment no.) E WAY State or province GA US 30721 Dalton	First name, middle initial, last name) Madrigal-Salgado	Tirst name, middle initial, last name) 2 Social security number (SSN) 7 Name of employer Professional Eye Associates, Inc.	Tirst name, middle initial, last name) 2 Social security number (SSN) 7 Name of employer Professional Eye Associates, Inc. Professional Eye Associates, Inc. 10 Conding apartment no.) 9 Street address (including room or suite no.) 10 Conding apartment no.) 1111 Professional Blvd 112 State or province GA	Social security number (SSN) 7 Name of employer Professional Eye Associates, Inc. 5811488 Inc. Street address (including room or suite no.) Street address (including room or suite no.) 10 Contact telephone in the contact telepho			

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

Cat. No. 60705M

Instructions for Recipient

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Kris Marshall 1180 PERCHERON DR NW DALTON, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

Internal Revenue Service

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

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

2023 Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Kris Marshall XXX-XX-1818 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1180 PERCHERON DR NW 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ DALTON US 30720 Dalton GA US 30720 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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

Cat. No. 60705M

Instructions for Recipient

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Deizy Martinez 99 S Spencer St Dalton, GA 30721

Form	109:	5-C
Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee										Ap	plicable La	arge Emplo	yer Memb	er (E	Employ	er)			-	
1 Name of employ	ee (first name,	middle	e initial, las	st name)		2 Social	secu	ırity number	r (SSN)	7 Name	of emplo	oyer				8 Emp	loyer i	dentificatio	n number (EIN)	i	
Deizy			Martin	ez			XX	X-XX-68	353	Profes	ssional	l Eye Asso	ciates, Inc.				5	811488	20		
3 Street address (i	ncluding apartr	ment n	0.)							9 Street address (including room or suite no.)						10 Contact telephone number					
99 S Spencer	St									1111 Professional Blvd						7062262020					
4 City or town		5 Stat	te or provi	nce		6 Country	/ and	ZIP or foreig	gn postal code	11 City or	r town		12 State or pr	ovince		13 Cour	try and	d ZIP or fore	eign postal code	,	
Dalton GA US 30721							Dalton	1		GA			US 30)72C)						
Part II Emp	oloyee Off	er of	Cover	age			Em	ployee's	s Age on J	Januar	y 1		Plan Star	t Month (en	ter 2	2-digit nu	ımbe	r):	01		
	All 12 Months	5	Jan	Feb		Mar		Apr	May	Ju	ıne	July	Aug	Sept		Oct		Nov	Dec		
14 Offer of Coverage (enter required code)			1A	1A		1A		1A	1A	1	Α	1A	1A	1A		1A		1A	1A	_	
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$		\$	\$		\$	\$	\$	\$		\$		\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																					
17 ZIP Code																				_	

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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

Part III. Covered Individuals, Lines 18–30

Esmeralda Martinez 510 N Varnell Road Tunnel Hill, GA 30755

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

VOID

OMB No. 1545-2251

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Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, l	last name)	2 Soc	ial security num	ber (SSN)	7 Name of emp	ployer			8 E	mployer ide	ntification number (EIN)		
Esmeralda		Marti	inez		XXX-XX-	3422	Profession	al Eye Asso	ciates, Inc.			581148820			
3 Street address (i	including apartr	ment no.)		•			9 Street addres	ss (including roo	10 C	10 Contact telephone number					
510 N Varnell	Road						1111 Profe	ssional Blvo		7062262020					
4 City or town		5 State or pro	ovince	6 Coun	try and ZIP or fo	reign postal code	11 City or town 12 State or province				13 Co	13 Country and ZIP or foreign postal code			
Tunnel Hill		GA		US 3	0755		Dalton GA					US 30720			
Part II Emp	e's Age on	January 1 Plan Start Month (enter 2					-digit number): 01								
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	No	ov Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1.	A 1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2D	2D	2D	2D				
17 ZIP Code															

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

Cat. No. 60705M

Instructions for Recipient

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

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Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other) (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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Part III. Covered Individuals, Lines 18–30

Daniel Mcbride 24 East Heritage Dr NE Rydal, GA 30171

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

CORRECTED

VOID

OMB No. 1545-2251

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2023

Internal Revenue Se	ervice		Go to www	v.irs.gov/Fo	<i>m10</i> 95C for in	structions a	nd the latest ii	nformation.							
Part I Em	ployee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)			
1 Name of employ	yee (first name,	middle initial, la	ast name)	2 Socia	al security numbe	er (SSN)	7 Name of em	oloyer			8 E	mployer identific	ation number (EIN		
Daniel		Mcbr	de		XXX-XX-7	723	Profession	al Eye Asso	ciates, Inc.			581148820			
3 Street address (including apart	ment no.)		<u>'</u>			9 Street addre	ss (including roc	10 C	10 Contact telephone number					
24 East Herita	age Dr NE						1111 Profe	ssional Blv		7062262020					
4 City or town	J	5 State or pro-	vince	6 Count	try and ZIP or forei	ign postal code	11 City or town		12 State or p	rovince	13 Co	13 Country and ZIP or foreign postal coo			
Rydal		GA		US 30	0171		Dalton		GA		US	30720			
Part II Employee Offer of Coverage Employee's Age							January 1 Plan Start Month (enter 2-					-digit number): 01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code															

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **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).
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- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other) (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Part III. Covered Individuals, Lines 18–30

Brett Mcdonough 910 ELK RIDGE CHATTANOOGA, TN 37419

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

VOID

OMB No. 1545-2251

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

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Part I Emp	Part I Employee							Applicable Large Employer Member (Employer)									
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	al security numb	er (SSN)	7 Name of emp	oloyer			8 Er	nployer identit	fication number (EIN)				
Brett		Mcdo	nough		XXX-XX-1	1459	Professiona	al Eye Asso	ciates, Inc.			5811	48820				
3 Street address (in	ncluding apartr	ment no.)		•			9 Street addres	ss (including roon	n or suite no.)		10 Co	10 Contact telephone number					
910 ELK RIDO	GE						1111 Professional Blvd					7062262020					
4 City or town		5 State or prov	vince	6 Count	try and ZIP or for	eign postal code	11 City or town		12 State or pr	ovince	13 Co	untry and ZIP	or foreign postal code				
CHATTANOO)GA	TN		US 37	7419		Dalton		GA		US	US 30720					
Part II Employee Offer of Coverage Employee's							January 1 Plan Start Month (e			t Month (en	ter 2-digit ı	er 2-digit number): 01					
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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Celina Mendez 1951 Tibbs Terrace Dalton, GA 30720

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

VOID

OMB No. 1545-2251

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Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)			
1 Name of employ	ree (first name, r	middle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)		
Celina		Mende	ez		XXX-XX-4	380	Profession	al Eye Asso		581148	3820				
3 Street address (in	ncluding apartn	nent no.)		•			9 Street addre	ss (including roor	m or suite no.)		10 C	10 Contact telephone number			
1951 Tibbs Te	errace						1111 Profe	ssional Blvd	l			706226	2020		
4 City or town		5 State or provi	ince	6 Countr	ry and ZIP or forei	gn postal code	11 City or town 12 State or province					13 Country and ZIP or foreign postal code			
Dalton		GA		US 30	720		Dalton	Dalton GA US 30720							
Part II Emp	oloyee Offe	er of Cover	rage	•	Employee	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit	number):	01		
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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Rebecca Mendoza 1200 W Crawford St DALTON, GA 30720

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

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OMB No. 1545-2251

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Internal Revenue Se	rvice		Go to www	v.irs.gov/For	<i>m10</i> 95C for in	structions ar	d the latest in	nformation.						
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	vee (first name, i	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			8 Er	nployer identifica	ation number (EIN)	
Rebecca		Mend	oza		XXX-XX-40	069	Professiona	al Eye Asso		581148	3820			
3 Street address (i	including apartn	nent no.)					9 Street address	ss (including roor	n or suite no.)		10 C	10 Contact telephone number		
1200 W Craw	ford St						1111 Profe	ssional Blvc				706226	2020	
4 City or town 5 State or province 6 Country and ZIP or foreign postal co						gn postal code					13 Cd	ountry and ZIP or	foreign postal code	
DALTON GA US 30720							Dalton		GA		US	30720		
Part II Emp									Plan Star	t Month (er	nter 2-digit	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July Aug Sept Oct			Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code									N- 00705M				1005 C (2000)	

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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Part III. Covered Individuals, Lines 18–30

Rosa Montes 345 McGaughey Chapel Rd DALTON, GA 30721

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

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OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Meml	ber (Emplo	yer)	
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identific	ation number (EIN)
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3 Street address (in	ncluding apartn	ment no.)		'			9 Street addre	ss (including roo	m or suite no.)		10 Cd	ontact telephone	e number
345 McGaugh	ney Chapel	Rd					1111 Profe	essional Blvd	ł			706226	2020
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or forei	ign postal code	11 City or town		12 State or p	province	13 Co	ountry and ZIP or	foreign postal code
DALTON		GA		US 30	0721		Dalton		GA		US	30720	
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on c	January 1		Plan Sta	irt Month (e	nter 2-digit ı	number):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code			A at Nation and										1005 C (2222

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

Cat. No. 60705M

Instructions for Recipient

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Iliana Moreno 207 10th Ave Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

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

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

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Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (En	nploye	r)			
1 Name of employ	ee (first name, i	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer				8 Employ	yer identifica	tion number (EIN)		
Iliana		Morer	าด		XXX-XX-7	099	Profession	al Eye Asso	ciates, Inc.				581148	820		
3 Street address (i	ncluding apartn	nent no.)					9 Street addre	ess (including roo	m or suite no.)			10 Contact telephone number				
207 10th Ave							1111 Profe	essional Blvd	ł				7062262	2020		
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or p	province		13 Country and ZIP or foreign postal code				
Chatsworth		GA		US 30	0705		Dalton		GA			US 307	720			
Part II Emp	loyee Offe	er of Cove	rage		Employee	's Age on	January 1		Plan Sta	rt Month (e	nter 2-c	ligit num	nber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	0	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1	А	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	}	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code			Act Notice of						No. COZOEM					1005 C (2000		

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

Cat. No. 60705M

Instructions for Recipient

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



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Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Part III. Covered Individuals, Lines 18–30

Mandy Moses 133 Pankey Ln Benton, TN 37307

Form	109:	5-C
Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Ser	vice		GO to www	.irs.gov/rori	1110950 101 111	structions ar	iu trie latest ili	normation.				~			
Part I Emp	loyee						Aı	pplicable La	arge Emplo	yer Membe	er (Emplo	yer)			
1 Name of employe	ee (first name,	middle initial, la	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	oloyer			8 En	nployer identifica	tion number (EIN)		
Mandy		Moses	6		XXX-XX-91	l12	Professiona	al Eye Asso	ciates, Inc.			581148	8820		
3 Street address (in	ncluding apartr	ment no.)		<u>'</u>			9 Street address	ss (including roon	n or suite no.)		10 Cd	10 Contact telephone number			
133 Pankey Li	n						1111 Profes	ssional Blvd		7062262020					
4 City or town		5 State or provi	ince	6 Countr	y and ZIP or forei	ZIP or foreign postal code 11 City or town 12 State or province						13 Country and ZIP or foreign postal code			
Benton		TN		US 37	307		Dalton		GA		US	30720			
Part II Emp	loyee Off	er of Cove	rage	•	Employee'	s Age on c	January 1		Plan Star	t Month (en	ter 2-digit r	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code For Privacy Act a									No. 60705M				1095-C (2023		

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Cat. No. 60705M

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Part III. Covered Individuals, Lines 18–30

Timothy O'Boyle 2007 Chatham Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

OMB No. 1545-2251

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VOID

internal Nevenue Service															- 1				
Part I Emp	loyee					Applicable Large Employer Member (Employer)													
1 Name of employe	ee (first name,	middle ir	nitial, last	name)		2 Social	security n	umber	(SSN)	7 Name of emp	loyer				8 Empl	oyer identificati	on number (EIN)		
Timothy		(D'Boyle	9			XXX-X	X-70	45	Professiona	I Eye Assoc	ciates, Inc.				5811488	320		
3 Street address (in	ncluding apartr	ment no.))							9 Street address	s (including roon	n or suite no.)			10 Contact telephone number				
2007 Chathan	n									1111 Profes	ssional Blvd				7062262020				
4 City or town		5 State	or provinc	се		6 Country	and ZIP o	r foreig	n postal code	11 City or town 12 State or province			ovince		13 Coun	try and ZIP or for	reign postal code		
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All 12 Months Jan Feb M							Ap	r	May	June	July	Aug	Sept	Oct		Nov	Dec		
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- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Ivey O'Neal 35 Acorn Hill Summerville, GA 30747

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

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OMB No. 1545-2251

Internal Revenue Se	ervice		Go to www.	irs.gov/Fo	<i>rm10</i> 95 C for in	structions a	nd the latest ir	nformation.		~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~					
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Soci	al security numbe	r (SSN)	7 Name of emp	oloyer			8 Er	nployer identifica	tion number (EIN)		
Ivey		O'Nea	al		XXX-XX-64	114	Professiona	al Eye Asso		581148820					
3 Street address (i	3 Street address (including apartment no.)							ss (including roo	m or suite no.)		10 Cd	10 Contact telephone number			
35 Acorn Hill							1111 Professional Blvd					7062262020			
4 City or town		5 State or prov	vince	try and ZIP or forei	gn postal code	e 11 City or town 12 State or province					ountry and ZIP or f	oreign postal code			
Summerville								Dalton GA			US	30720			
Part II Employee Offer of Coverage Employee's Age or							January 1		Plan Star	rt Month (en	ter 2-digit ı	number):	01		
	All 12 Months Jan Feb Mar Apr May						June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	8	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D	2D			
17 ZIP Code															

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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Part III. Covered Individuals, Lines 18–30

Fernanda Palacios Flores 2125 Arbordale Place Unit 56 Dalton, GA 30720

Form	109:	5-C
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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

reasury Do not attach to your tax return. Keep for your record

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

2023

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Part I Emp	ployee						Applicable Large Employer Member (Employer)								
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 En	nployer identific	ation number (EIN)		
Fernanda		Palac	ios Flores		XXX-XX-5	307	Profession	al Eye Asso	ciates, Inc.			581148	3820		
3 Street address (i	including apartr	ment no.)					9 Street addre	ss (including roor	10 Co	10 Contact telephone number					
2125 Arborda	ile Place Ui	nit 56					1111 Professional Blvd					7062262020			
4 City or town								e 11 City or town 12 State or province					13 Country and ZIP or foreign postal code		
Dalton								Dalton GA							
Part II Emp	's Age on .	January 1		Plan Sta	rt Month (ei	nter 2-digit r	number):	01							
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1H	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		
17 ZIP Code															

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

Cat. No. 60705M

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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

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Part III. Covered Individuals, Lines 18–30

Susan Parker 199 Cleveland St Chatsworth, GA 30705

Form	109:	5-C
Departi	ment of the	Treasury
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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

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OMB No. 1545-2251

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

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Part I Emp	oloyee						А	pplicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employ	ree (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 En	nployer identific	ation number (EIN)	
Susan		Parke	r		XXX-XX-0	388	Profession	al Eye Asso	ciates, Inc.			58114	8820	
3 Street address (i	ncluding apartr	ment no.)		<u>'</u>			9 Street addre	ess (including roor	10 Co	10 Contact telephone number				
199 Cleveland	d St						1111 Profe	essional Blvd	l			706226	2020	
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town 12 State or province				13 Co	13 Country and ZIP or foreign postal code		
Chatsworth		GA		US 30	0705		Dalton GA L					US 30720		
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit r	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code													1005 0 700	

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

Cat. No. 60705M

Instructions for Recipient

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



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Part I. Applicable Large Employer Member (Employer)

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

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Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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

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

Part III. Covered Individuals, Lines 18–30

Maria Patino Carrillo 3028 Saratoga Drive Dalton, GA 30720

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

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OMB No. 1545-2251

Internal Revenue Se	ervice		GO LO WWI	w.irs.gov/ror	11110936 101 1	nstructions at	iu tile latest i	mormation.		1 -	<i>-</i>			
Part I Em	ployee						P	Applicable L	arge Empl	oyer Memb	er (Emplo	yer)		
1 Name of employ	yee (first name,	middle initial, la	st name)	2 Socia	al security numb	er (SSN)	7 Name of em	nployer			8 E	mployer identific	ation number (EIN)	
Maria		Patino	Carrillo		XXX-XX-6	5977	Profession	nal Eye Asso		581148820				
3 Street address (including apart	ment no.)		•			9 Street addre	ess (including roo	10 C	10 Contact telephone number				
3028 Saratog	ja Drive						1111 Professional Blvd					7062262020		
4 City or town		5 State or prov	ince	6 Counti	6 Country and ZIP or foreign postal code			1	12 State or p	rovince	13 C	ountry and ZIP or	foreign postal code	
Dalton		GA		US 30	US 30720				GA		US	30720		
Part II Em	ployee Off	er of Cove	rage	·	Employee's Age on J				Plan Star	rt Month (er	nter 2-digit	2-digit number): 01		
All 12 Months Jan Feb					Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2D	2D										
17 ZIP Code														

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

Cat. No. 60705M

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Carmina Pineda 404 DAVIDSON DR DALTON, GA 30720

Form	095-	-C
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17 ZIP Code

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

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

2023 Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Carmina Pineda XXX-XX-6584 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 404 DAVIDSON DR 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ DALTON US 30720 Dalton GA US 30720 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)

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

Cat. No. 60705M

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Instructions for Recipient (continued)

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

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

Part III. Covered Individuals, Lines 18–30

Shayla L Posey 385 LIBERTY DR DALTON, GA 30721

OMB No. 1545-2251

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

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

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Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ		middle initial,	last name)	2 Socia	al security numbe	er (SSN)	7 Name of emp	ployer			8 En	nployer identifica	tion number (EIN)		
Shayla		L Pose	∋y		XXX-XX-4	261	Profession	al Eye Asso		581148820					
3 Street address (i	including apartr	ment no.)		'			9 Street addre	ss (including roor	n or suite no.)		10 Cd	10 Contact telephone number			
385 LIBERTY	DR						1111 Profe	essional Blvd	1			706226	2020		
4 City or town		5 State or pro	ovince	6 Count	6 Country and ZIP or foreign postal code				12 State or pr	rovince	13 Co	untry and ZIP or	oreign postal code		
DALTON		GA		US 30	0721		Dalton		GA		US	US 30720			
Part II Emp	oloyee Off	er of Cov	erage		Employee	's Age on .	January 1		Plan Star	rt Month (er	nter 2-digit r	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1H	1H	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)										2D	2D	2D	2D		
17 ZIP Code									N- 00705M				1005 C (2000)		

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Marco Ramos 147 Toria Trace Dalton, GA 30721

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

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OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	oyer Memb	er (Emplo	yer)			
1 Name of employ	vee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	mployer identific	ation number (EIN)		
Marco		Ramo)S		XXX-XX-9	216	Profession	al Eye Asso	ciates, Inc.			581148	8820		
3 Street address (i	including apartr	nent no.)		<u>'</u>			9 Street addre	ss (including roor	m or suite no.)		10 C	10 Contact telephone number			
147 Toria Trace							1111 Professional Blvd					7062262020			
4 City or town							e 11 City or town 12 State or province				13 Cd	ountry and ZIP or	foreign postal code		
Dalton		GA		US 30	0721		Dalton		GA		US	US 30720			
Part II Employee Offer of Coverage Employee's Age							January 1 Plan Start Month (ent				nter 2-digit	2-digit number): 01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													2B		
17 ZIP Code			A. N. W.										1005 0		

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Cat. No. 60705M

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

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Sarah Reed 128 Cousin Drive NE DALTON, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

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

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

2023

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Part I Empl	loyee						Α	pplicable La	arge Empl	oyer Memb	er (Empl	oyer)			
1 Name of employee	e (first name, m	iddle initial, las	t name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	oloyer			8 E	mployer identific	ation number (EIN)		
Sarah		Reed			XXX-XX-70	067	Professiona	al Eye Asso		58114	8820				
3 Street address (inc	cluding apartme	ent no.)					9 Street addres	ss (including roor	n or suite no.)		10 C	10 Contact telephone number			
128 Cousin Drive NE							1111 Profe	ssional Blvd	1			7062262020			
4 City or town 5 State or province 6 Country and ZIP or foreign postal country						gn postal code	e 11 City or town 12 State or province				13 C	ountry and ZIP or	foreign postal code		
DALTON GA US 30721							Dalton GA					US 30720			
Part II Employee Offer of Coverage Employee's Age										nter 2-digit	2-digit number): 01				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2D	2D	2D										
17 ZIP Code													1005.0		

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

Cat. No. 60705M

Instructions for Recipient

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

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Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Briana Reyes 2270 BOWERS RD NE DALTON, GA 30721

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Employee

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

CORRECTED

VOID

OMB No. 1545-2251

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

Applicable Large Employer Member (Employer)

1 Name of employee (first name, middle initial, last name)				2 Socia	, , , , , , ,			7 Name of employer					8 Employer identification number (EIN)			
Briana		Reyes			XXX-XX-77	725	Professiona	al Eye Asso	ciates, Inc.			581148	3820			
3 Street address (i	including apartr	nent no.)					9 Street addres	s (including roon	n or suite no.)		10 Co	ntact telephone	number			
2270 BOWER	RS RD NE						1111 Profes	ssional Blvd				706226	2020			
4 City or town		5 State or provi	nce	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince	13 Co.	13 Country and ZIP or foreign postal code				
DALTON		GA		US 30	0721		Dalton		GA		US 3	US 30720				
Part II Emp	oloyee Off	er of Cover	age	•	Employee'	s Age on c	January 1		Plan Star	t Month (en	iter 2-digit n	umber):	01			
	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec						
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code												1005.0				

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

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

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- **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).
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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Par	Covered Individuals 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 individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Ashley Richards 32 Legion Street Apt B7 Adairsville, GA 30103

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

VOID

OMB No. 1545-2251

Internal Revenue Se	ervice		Go to www	.irs.gov/Fo	rm1095C for i	nstructions a	nd the latest i	nformation.		Z E E O					
Part I Em	oloyee						Α	Applicable I	arge Emp	loyer Meml	per (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Soc	ial security numb	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)		
Ashley		Richa	ırds		XXX-XX-9	302	Profession	nal Eye Asso	ociates, Inc			581148820			
3 Street address (including apart	ment no.)		'			9 Street addre	ess (including roo	om or suite no.)		10 C	10 Contact telephone number			
32 Legion Str	eet Apt B7						1111 Profe	essional Blv	d			7062262020			
4 City or town	•	5 State or prov	vince	6 Coun	try and ZIP or fore	eign postal code	11 City or town	1	12 State or	province	13 Co	ountry and ZIP or	foreign postal code		
Adairsville GA US 30103							Dalton GA					30720			
Part II Employee Offer of Coverage Employee's Age							January 1		Plan Sta	art Month (e	nter 2-digit	number):	01		
	All 12 Months Jan Feb Mar A						June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1H	1H	1H	1H	1H	1H	1H	1H	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	2A	2A	2A	2A		
17 ZIP Code													1005 0		

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

Cat. No. 60705M

Instructions for Recipient

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

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Part III. Covered Individuals, Lines 18–30

Alondra Rivera 3085 Kenwood Drive Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Ser	vice		Go to www	.irs.gov/Fori	<i>m10</i> 95C for in	structions ar	nd the latest in								
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Meml	ber (Emplo	yer)			
1 Name of employ	ee (first name, m	niddle initial, las	st name)	2 Socia	l security numbe	er (SSN)	7 Name of emp	ployer			8 Em	nployer identific	ation number (EIN)		
Alondra		Rivera	1		XXX-XX-40	010	Profession	al Eye Asso	ciates, Inc.			58114	8820		
3 Street address (in	ncluding apartme	ent no.)					9 Street addre	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
3085 Kenwoo	d Drive						1111 Professional Blvd					7062262020			
4 City or town	5	State or provi	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town 12 State or province 13					untry and ZIP or	foreign postal code		
Dalton		GΑ		US 30	720		Dalton GA U					30720			
Part II Employee Offer of Coverage Employee's Age							January 1		Plan Sta	rt Month (e	nter 2-digit r	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D	2D	2D	2D								
17 ZIP Code			A at Nation										1005 C (222		

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

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Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
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- **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).
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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Part III. Covered Individuals, Lines 18–30

Elizabeth Rodriguez 437 Arrowhead Dr NE Dalton, GA 30721

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

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OMB No. 1545-2251

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Internal Revenue Se	rvice		Go to www	w.irs.gov/For	m1095C for ins	structions an	d the latest in	formation.		Z020					
Part I Emp	oloyee						A	oplicable L	arge Emplo	yer Memb	er (Employ	/er)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security number	(SSN)	7 Name of emp	oloyer			8 Em	ployer identifica	ation number (EIN)		
Elizabeth		Rodri			XXX-XX-31	73	Professiona	al Eye Asso	ciates, Inc.			581148	3820		
3 Street address (i	ncluding apartr	ment no.)	.	'			9 Street addres	ss (including roo	m or suite no.)		10 Co	10 Contact telephone number			
437 Arrowhea	nd Dr NE						1111 Profe	ssional Blvo	i			706226	2020		
4 City or town		5 State or prov	vince	6 Count	ry and ZIP or foreig	n postal code	11 City or town		12 State or pro	ovince	13 Cou	13 Country and ZIP or foreign postal coo			
Dalton		GA		US 30)721		Dalton		GA		US 3	US 30720			
Part II Emp	oloyee Off	er of Cove	rage	!	Employee's	s Age on J	January 1 Plan Start Month			t Month (er	nter 2-digit n	umber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1H	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		
17 ZIP Code															

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Cat. No. 60705M

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Elsa Rodriguez 452 Plemons Road Crandall, GA 30711

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

CORRECTED

VOID

OMB No. 1545-2251

2023

Go to www.irs.gov/Form1095C for instructions and the latest information. Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Elsa Rodriauez XXX-XX-3625 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 452 Plemons Road 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ Crandall US 30711 Dalton GA US 30720 **Employee Offer of Coverage** Employee's Age on January 1 Plan Start Month (enter 2-digit number): Part II 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1H required code) 1H 1H 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2D 2A 2A 2A 2A 2A 2A 2D 2B 2A 2A code, if applicable) 2A 17 ZIP Code

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

Cat. No. 60705M

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- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
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- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
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- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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

Part III. Covered Individuals, Lines 18–30

Maria G Rodriguez 824 Shugart Rd Apt C2 Dalton, GA 30720

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

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OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Mem	ber (Emplo	oyer)		
1 Name of employ	ree (first name,	middle initial, la	ast name)	2 Soci	al security numb	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)	
Maria		G Rodri	guez		XXX-XX-2	161	Professional Eye Associates, Inc.					581148820		
3 Street address (i	ncluding apartr	ment no.)	•				9 Street addre	ess (including roo	10 C	10 Contact telephone number				
824 Shugart F	Rd Apt C2						1111 Profe	essional Blvd	d			706226	2020	
4 City or town		5 State or prov	vince	6 Count	try and ZIP or fore	ign postal code	11 City or town		12 State or	province	13 Co	ountry and ZIP or	foreign postal code	
Dalton		GA		US 30	0720		Dalton		GA		US	30720		
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	art Month (e	enter 2-digit	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code			n Act Notice of						N- 00705M				1005 C (2000	

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Blanca A Salas 699 Daris Drive Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

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

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

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Internal Revenue Se	ervice		Go	to www.irs	s.gov/Forn	<i>n10</i> 95C for in:	structions an	id the latest in	tormation.							
Part I Emp	ployee							Ap	pplicable La	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	/ee (first name, i	middle initia	al, last name)		2 Social	security number	r (SSN)	7 Name of emp	loyer			8 En	nployer identifica	ation number (EIN)		
Blanca		A Sa	las			XXX-XX-07	777	Professional Eye Associates, Inc.					581148820			
3 Street address (i	including apartn	nent no.)						9 Street address (including room or suite no.) 1					10 Contact telephone number			
699 Daris Driv	ve							1111 Profes	ssional Blvd				706226	2020		
						11 City or town		12 State or pr	ovince	13 Co	untry and ZIP or	foreign postal code				
Dalton		GA			US 30	721		Dalton GA				US	US 30720			
Part II Emp	ployee Offe	er of Co	verage			Employee'	s Age on J	lanuary 1		Plan Star	t Month (er	nter 2-digit ı	number):	01		
	All 12 Months	Jar	n F	eb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code														1005 0 2000		

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

Cat. No. 60705M

Instructions for Recipient

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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Jessica Sanchez 79 Keith Ave Chatsworth, GA 30705

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

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OMB No. 1545-2251

nternal Revenue Service Go to www.irs.gov/Form1095C for instruction								nd the latest i	nformation.							
Part I Emp	ployee							A	Applicable L	arge Emplo	yer Memb	er (Emplo	mployer)			
1 Name of employ	yee (first name,	middle ini	tial, last	name)	2 Soci	ial security number	r (SSN)	7 Name of em	ployer			8 Er	mployer identific	ation number (EIN)		
Jessica		S	anche	eZ		XXX-XX-97	' 35	Profession	nal Eye Asso	ciates, Inc.			581148820			
3 Street address (including apartr	ment no.)						9 Street addre	ess (including roo	10 C	10 Contact telephone number					
79 Keith Ave								1111 Profe	essional Blvo		7062262020					
4 City or town 5 State or province 6 Country and ZIP or foreign postal coordinates and ZIP or foreign postal					gn postal code	11 City or town 12 State or province					ountry and ZIP or	foreign postal code				
Chatsworth GA US 30705						Dalton GA					30720					
Part II Employee Offer of Coverage Employee's Age or							s Age on .									
	All 12 Months	i Ja	an	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1,	A	1A	1A	1A	1A	1A	1H	1H	1H	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		
17 ZIP Code																

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

Cat. No. 60705M

Instructions for Recipient

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In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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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.

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

Part I. Applicable Large Employer Member (Employer)

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Meghan Saylors 179 Jamerson Way Cohutta, GA 30710

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Meml	oer (Emplo	yer)			
1 Name of employ	ee (first name, r	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 Er	nployer identific	ation number (EIN)		
Meghan		Saylo	rs		XXX-XX-6	370	Profession	al Eye Asso	ciates, Inc.			581148820			
3 Street address (i	ncluding apartm	nent no.)					9 Street addre	ss (including roo	10 Co	10 Contact telephone number					
179 Jamersor	า Way						1111 Professional Blvd					7062262020			
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or p	province	13 Co	ountry and ZIP or	foreign postal code		
Cohutta	-	GA		US 30	0710		Dalton		GA		US	30720			
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	irt Month (e	nter 2-digit	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			And Madica and										1005 C (222		

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Erika Simmons 212 Haywood Valley Rd Armuchee, GA 30105

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Intern	al Ray	anua 9	Sarvic	2

Employee

3 Street address (including apartment no.)

212 Haywood Valley Rd

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

Part I

Erika

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

OMB No. 1545-2251

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

XXX-XX-6039

2 Social security number (SSN)

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

2023 Applicable Large Employer Member (Employer) 8 Employer identification number (EIN) Professional Eye Associates, Inc. 581148820 9 Street address (including room or suite no.) 10 Contact telephone number 7062262020

4 City or town	5	State or provin	ice	6 Country	and ZIP or foreig	n postal code	11 City or town		12 State or pro	ovince	13 Cour	ntry and ZIP or fo	reign postal code
Armuchee		GA		US 301	105		Dalton		GA		US 3	0720	
Part II Em	ployee Offe	r of Covera	age		Employee's	s Age on J	lanuary 1		Plan Start	t Month (ent	ter 2-digit nu	umber):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H		Ψ	1.			*	•	Ψ	7	Τ	т	_ '	
Safe Harbor and Other Relief (enter code, if applicable)		•		2B	2A	2A	2A	2A	2A	2A	2A	2A	2A

7 Name of employer

1111 Professional Blvd

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

Simmons

Cat. No. 60705M

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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Nautica'Leah K Sitton 431 Mountain View Circle Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

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

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

2023

Internal Revenue Ser	vice		GO to www.	ırs.gov/Fori	m 1095C for in	structions ar	na the latest li	ntormation.						
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Meml	per (Emplo	yer)		
1 Name of employe	ee (first name, m	niddle initial, las	st name)	2 Socia	l security numbe	er (SSN)	7 Name of em	ployer			8 Em	nployer identific	ation number (EIN)	
Nautica'Leah		K Sitton			XXX-XX-18	357	Professional Eye Associates, Inc.					581148820		
3 Street address (in	ncluding apartm	ent no.)					9 Street address (including room or suite no.)					10 Contact telephone number		
431 Mountain	View Circle)					1111 Profe	ssional Blvd	k			706226	2020	
4 City or town	5	State or provi	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	province	13 Co	untry and ZIP or	foreign postal code	
Chatsworth		GΑ		US 30	705		Dalton GA				US :	US 30720		
Part II Emp	loyee Offe	r of Cover	rage	'	Employee ³	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-digit r	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2D	2D								
17 ZIP Code													1005.0	

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

Cat. No. 60705M

Instructions for Recipient

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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Kelia Smith 305 Ridgecrest Dr Lafayette, GA 30728

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

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

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

2023 Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Kelia Smith XXX-XX-1685 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 305 Ridgecrest Dr 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ Lafayette US 30728 Dalton GA US 30720 **Employee Offer of Coverage** Part II Employee's Age on January 1 Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1A 1A 1A 1H 1H 1H 1H 1H 1A 1H 1H required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2B 2A 2A 2A 2A 2A 2A code, if applicable) 17 ZIP Code

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Cat. No. 60705M

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Erin Stockwell 214 Roy Way Dalton, GA 30720

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

CORRECTED

OMB No. 1545-2251

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Internal Revenue Service Go to www.irs.gov/Form1095C for instructions and the latest information.															
Part I Emp	oloyee						A	oplicable L	arge Emplo	yer Memb	er (Emplo	/er)			
1 Name of employ	ee (first name,	middle initial, las	t name)	2 Socia	I security number	(SSN)	7 Name of emp	oloyer			8 Em	ployer identifica	tion number (EIN)		
Erin		Stocky	vell		XXX-XX-9741			Professional Eye Associates, Inc.					581148820		
3 Street address (i	including apartr	ment no.)					9 Street address (including room or suite no.) 10 C				10 Co	O Contact telephone number			
214 Roy Way	,						1111 Profe	ssional Blvd	ł			7062262	2020		
4 City or town 5 State or province 6 Country and ZIP or foreign postal c						n postal code	11 City or town		12 State or pro	ovince	13 Co.	intry and ZIP or f	oreign postal code		
Dalton	Iton GA US 30720						Dalton		GA		US :	US 30720			
Part II Employee Offer of Coverage Employee's Age							January 1 Plan Start Month (enter 2-d			nter 2-digit n	digit number): 01				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1H		
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17 ZIP Code															

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- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Claudia Vasquez 1536 Margaret Circle SE Dalton, GA 30721

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

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OMB No. 1545-2251

internal Revenue Se	ervice		GO LO WV	vw.irs.gov/ru	111110936 101	mstructions a	is and the latest information.										
Part I Emp	ployee						Applicable Large Employer Member (Employer)										
1 Name of employ	ee (first name,	middle initial,	last name)	2 Soc	cial security nun	nber (SSN)	7 Name of em	ployer			8 E	mployer ide	ntification number (EIN)				
Claudia		Vaso	quez		XXX-XX	-8692	Profession	al Eye Asso	ciates, Inc.			581	1148820				
3 Street address (i	including apartr	ment no.)					9 Street addre	ss (including roo	10 C	10 Contact telephone number							
1536 Margare	et Circle SE	<u> </u>					1111 Profe	essional Blvo		7062262020							
4 City or town		5 State or pr	ovince	6 Cour	ntry and ZIP or fo	oreign postal code	11 City or town		12 State or pr	rovince	13 C	13 Country and ZIP or foreign postal code					
Dalton		GA		US 3	30721		Dalton	Dalton GA			US 30720						
Part II Emp	erage	e's Age on	January 1 Plan Start Month (enter 2-c					-digit number): 01									
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	No	ov Dec				
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1.	A 1A				
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$				
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2D	2D	2D						
17 ZIP Code																	

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
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- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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

Part III. Covered Individuals, Lines 18–30

Lauren Vaughn 633 SUNNY LANE RINGGOLD, GA 30736

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

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OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	ployer			8 Er	nployer identifica	ation number (EIN)		
Lauren		Vaug	hn		XXX-XX-65	541	Profession	al Eye Asso	ciates, Inc.			581148820			
3 Street address (i	ncluding apart	ment no.)					9 Street addre	ss (including roo	10 Cd	10 Contact telephone number					
633 SUNNY L	.ANE						1111 Profe	ssional Blvd	i			7062262020			
4 City or town		5 State or prov	vince	6 Countr	y and ZIP or forei	gn postal code	11 City or town 12 State or province				13 Co	13 Country and ZIP or foreign postal code			
RINGGOLD GA US 30736							Dalton GA US 30720								
Part II Employee Offer of Coverage Employee's Age							January 1		Plan Star	t Month (er	nter 2-digit ı	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1H	1H	1H	1H	1H	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	2A		
17 ZIP Code		l Dadaskia	A A Matica						No. 60705M				1095-C (2023)		

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

Cat. No. 60705M

Instructions for Recipient

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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.

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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

Part III. Covered Individuals, Lines 18–30

Amber Veal 108 Roberts Drive Dalton, GA 30721

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

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OMB No. 1545-2251

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

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Part I Emp	loyee						Applicable Large Employer Member (Employer)									
1 Name of employ	ee (first name,	middle initial, las	t name)	2 Soci	al security number	(SSN)	7 Name of emp	loyer			8 Em	8 Employer identification number (EIN)				
Amber		Veal			XXX-XX-36	89	Professiona	I Eye Asso		581148820						
3 Street address (i	ncluding apartr	nent no.)		_			9 Street addres	s (including roo	m or suite no.)		10 Co	10 Contact telephone number				
108 Roberts D	rive						1111 Profes	ssional Blvc	k			706226	2020			
4 City or town		5 State or proving	nce	6 Count	try and ZIP or foreig	n postal code	11 City or town 12 State or province				13 Co	untry and ZIP or	foreign postal code			
Dalton		GA		US 30	30721 Dalton GA L					US :	US 30720					
Part II Employee Offer of Coverage Employee's Age							January 1		Plan Sta	rt Month (er	nter 2-digit r	number):	01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	1H	1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$	\$	}	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2D	2D	2D	2D					
17 ZIP Code													1005 0 200			

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Brandi M Voyles-YOUELL 153 Stancil Rd Cohutta, GA 30710

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

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OMB No. 1545-2251

2023

Internal Revenue Se	rvice		Go to ww	w.irs.gov/For	rm1095C for in:	structions ar	nd the latest in	nformation.							
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, I	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of em	oloyer			8 Er	nployer identifi	cation number (EIN)		
Brandi		M Voyle	es-YOUELL		XXX-XX-00	006	Profession	al Eye Asso	ciates, Inc.			58114	8820		
3 Street address (i	ncluding apartr	ment no.)		•			9 Street addre	ss (including roo	m or suite no.)		10 Co	ontact telephor	e number		
153 Stancil Ro	d						1111 Profe	ssional Blv	b			70622	62020		
4 City or town		5 State or pro	vince	6 Count	ry and ZIP or foreig	gn postal code	11 City or town		12 State or pr	ovince	13 Co	untry and ZIP o	r foreign postal code		
Cohutta		GA		US 30	0710		Dalton GA					US 30720			
Part II Emp	Employee Offer of Coverage Employee's Age of						January 1 Plan Start Month (er				nter 2-digit	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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Cat. No. 60705M

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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Donna Walker 271 DOVER ROAD RESACA, GA 30735

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Employer-Provided Health Insurance Offer and Coverage

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VOID

OMB No. 1545-2251

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

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

Internal Revenue Sei	vice		GO TO WN	/w.irs.gov/Foi	miugoc for in	istructions a	and the latest i	ntormation.					
Part I Emp	loyee						A	pplicable L	arge Empl	oyer Memb	er (Emp	oloyer)	
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8	Employer identifica	ation number (EIN)
Donna		Walke	er		XXX-XX-2	800	Profession	al Eye Asso	ciates, Inc.			581148	3820
3 Street address (in	ncluding apartr	ment no.)		'			9 Street addre	ess (including roo	m or suite no.)		10	O Contact telephone	number
271 DOVER F	ROAD						1111 Profe	essional Blv	t			706226	2020
4 City or town		5 State or prov	rince	6 Count	ry and ZIP or fore	ign postal code	11 City or town	l	12 State or p	orovince	13	3 Country and ZIP or	foreign postal code
RESACA		GA		US 30	0735		Dalton		GA		lι	JS 30720	
Part II Emp	loyee Off	er of Cove	rage	!	Employee	's Age on	January 1		Plan Sta	rt Month (e	nter 2-dig	git number):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oc	t Nov	Dec
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code									No. 60705M				1005-C (2022

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Cat. No. 60705M

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- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Ashlyn Walls 159 Beedie Jones Road Chatsworth, GA 30705

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

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OMB No. 1545-2251

2023

nternal Revenue Ser	vice		Go to www	.irs.gov/Fort	m1095C for ins	structions ar	d the latest in	formation.							
Part I Emp	loyee						A	oplicable L	arge Emplo	yer Memb	er (Employ	mployer)			
1 Name of employe	ee (first name,	middle initial, las	t name)	2 Social	l security number	(SSN)	7 Name of emp	oloyer			8 Em	ployer identifica	tion number (EIN)		
Ashlyn		Walls			XXX-XX-86	94	Professiona	al Eye Asso	ciates, Inc.			581148	820		
3 Street address (in	ncluding apartr	ment no.)					9 Street addres	ss (including roo	m or suite no.)		10 Cor	ntact telephone	number		
159 Beedie Jo	nes Road						1111 Profe	ssional Blvo	ł			706226	2020		
4 City or town		5 State or provin	ice	6 Country	y and ZIP or foreig	n postal code	11 City or town		12 State or pro	ovince	13 Cou	13 Country and ZIP or foreign postal cod			
Chatsworth		GA		US 30	705		Dalton		GA		US 3	US 30720			
Part II Employee Offer of Coverage Employee's Age or							January 1 Plan Start Month (ente					2-digit number): 0			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see nstructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code															

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other (d) Covered (e) Months of coverage															
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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

Part III. Covered Individuals, Lines 18–30

Claudia Weckman 315 Pine Grove Dr N Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

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

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

Internal Revenue Se	rvice		GO tO WWW	.irs.gov/For	m 1095C for in	istructions ar	na the latest i	ntormation.				`			
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name, m	niddle initial, la	ast name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 En	nployer identifica	ation number (EIN)		
Claudia		Weck	man		XXX-XX-1	827	Professional Eye Associates, Inc.					581148820			
3 Street address (i	ncluding apartm	ent no.)		· ·			9 Street addre	ess (including roo	m or suite no.)		10 Cd	10 Contact telephone number			
315 Pine Grov	ve Dr N						1111 Profe	essional Blvd	k			7062262020			
4 City or town	5	State or prov	vince	6 Count	6 Country and ZIP or foreign postal code			ı	12 State or pr	rovince	13 Co	untry and ZIP or	foreign postal code		
Dalton							Dalton GA				US	US 30720			
Part II Emp	oloyee Offe	r of Cove	rage	Employee	's Age on	January 1		Plan Star	rt Month (er	nter 2-digit ı	number):	01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1H	1H	1H	1H	1H	1H	1H	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	2A	2A	2A		
17 ZIP Code									No 60705M				1005-C (2022)		

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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Part I. Applicable Large Employer Member (Employer)

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

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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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

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Part III. Covered Individuals, Lines 18–30

Cheryl Welch 13123 Granada Way Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251 2023

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

Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Chervl Welch XXX-XX-5323 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 13123 Granada Way 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GA US 30720 Dalton GA US 30720 Dalton **Employee Offer of Coverage** Part II Employee's Age on January 1 Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A 1A 1A required code) 1A 1A 1A 1A 1A 1A 1A 1A 1A 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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

Cat. No. 60705M

Instructions for Recipient

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Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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- **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).
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Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Tiffany Wells 1208 Covie Dr Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

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OMB No. 1545-2251

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

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

2023

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1 Name of employ	ee (first name, i	middle initial, la	ıst name)	2 Soci	al security numb	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)	
Tiffany		Wells			XXX-XX-4	694	Professional Eye Associates, Inc.					581148820		
3 Street address (i	ncluding apartn	nent no.)					9 Street addre	ess (including roo	m or suite no.)		10 C	10 Contact telephone number		
1208 Covie D	r						1111 Profe	essional Blvd	d			7062262020		
4 City or town		5 State or prov	rince	6 Count	6 Country and ZIP or foreign postal code			ı	12 State or	province	13 C	ountry and ZIP or	foreign postal code	
Dalton GA US 30720						Dalton GA				US	US 30720			
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	art Month (e	enter 2-digit	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code			Act Notice of						N- 00705M				- 1005 C (2000	

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Adrianne A West 1918 Meadowbrooke Colony Dalton, GA 30720

Form 1095-C
Department of the Treasury
Internal Revenue Service

CORRECTED

VOID

OMB No. 1545-2251

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2023

Part I Employee Applicable Large Employer Member (Employer) 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Adrianne Α West XXX-XX-8237 Professional Eye Associates, Inc. 581148820 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1918 Meadowbrooke Colony 1111 Professional Blvd 7062262020 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code Dalton GA US 30720 Dalton GA US 30720 **Employee Offer of Coverage** Part II Employee's Age on January 1 Plan Start Month (enter 2-digit number): 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable) 17 ZIP Code

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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Leslie Wilkins 2840 Reed Rd Dalton, GA 30720

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OMB No. 1545-2251 2023

Do not attach to your tax return. Keep for your records. Go to www.irs.gov/Form1095C for instructions and the latest information. Applicable Large Employer Member (Employer) Part I Employee 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Leslie Wilkins XXX-XX-8982 Professional Eye Associates, Inc. 581148820

3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 2840 Reed Rd 1111 Professional Blvd 7062262020 6 Country and ZIP or foreign postal code 11 City or town 4 City or town 5 State or province 12 State or province 13 Country and ZIP or foreign postal code GΔ 115 30720 Dalton GΔ 115 30720 Dalton

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Part II Emp	oloyee Offe	r of Cove	rage		Employee's Age on January 1				Plan Start Month (enter 2-digit number):				01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code													
17 ZIP Code													

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

Cat. No. 60705M

Instructions for Recipient

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Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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Robi Wingrove 2611 Potts Rd RINGGOLD, GA 30736

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OMB No. 1545-2251

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

2023

Internal Revenue Sei	rvice		GO TO WWW	.irs.gov/For	m 1095C for in	structions ar	ia the latest ir	ntormation.						
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	per (Emplo	yer)		
1 Name of employ	ee (first name, m	niddle initial, la:	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	ployer			8 Em	ployer identific	ation number (EIN)	
Robi		Wingr	ove		XXX-XX-00	087	Professional Eye Associates, Inc.					581148820		
3 Street address (in	ncluding apartm	ent no.)		<u>'</u>			9 Street addre	ss (including roor	n or suite no.)		10 Co	10 Contact telephone number		
2611 Potts Ro	l						1111 Profe	ssional Blvc	I			7062262020		
4 City or town	5	State or prov	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince	13 Co	untry and ZIP or	foreign postal code	
RINGGOLD		GA		US 30	736		Dalton GA					US 30720		
Part II Emp	loyee Offe	r of Cove	rage	,	Employee ³	s Age on	January 1		Plan Sta	rt Month (e	nter 2-digit r	iumber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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Kaylee Worley 206 JoAnn Dr Calhoun, GA 30701

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OMB No. 1545-2251

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Internal Revenue Se	rvice		GO to WWW	/.irs.gov/For	m 1095C for in	structions ar	ia the latest in	itormation.							
Part I Emp	oloyee					Applicable Large Employer Member (Employer)									
1 Name of employ	/ee (first name, ı	middle initial, la	ıst name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer	8 Er	8 Employer identification number (EIN)					
Kaylee Worley XXX-XX-9566							Professiona	al Eye Asso	ciates, Inc.			581148820			
3 Street address (i	3 Street address (including apartment no.)								n or suite no.)		10 C	ontact telephone	number		
206 JoAnn Dr	-						1111 Profe	ssional Blvd				7062262020			
4 City or town		5 State or prov	rince	6 Counti	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	13 Cd	ountry and ZIP or	foreign postal code		
Calhoun		GA		US 30	701		Dalton GA				US	US 30720			
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee ³	s Age on .	January 1		Plan Star	t Month (er	nter 2-digit	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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- **1A.** Minimum essential coverage providing minimum value offered to you with an employee required contribution for self-only coverage equal to or less than 9.5% (as adjusted) of the 48 contiguous states single federal poverty line and minimum essential coverage offered to your spouse and dependent(s) (referred to here as a Qualifying Offer). This code may be used to report for specific months for which a Qualifying Offer was made, even if you did not receive a Qualifying Offer for all 12 months of the calendar year. For information on the adjustment of the 9.5%, visit IRS.gov.
- **1B.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage NOT offered to your spouse or dependent(s).
- **1C.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) but NOT your spouse.
- **1D**. Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your spouse but NOT your dependent(s).
- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
- **1J.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage NOT offered to your dependent(s).
- **1K.** Minimum essential coverage providing minimum value offered to you; minimum essential coverage conditionally offered to your spouse; and minimum essential coverage offered to your dependent(s).
- **1L.** Individual coverage health reimbursement arrangement (HRA) offered to you only with affordability determined by using employee's primary residence ZIP code.
- **1M.** Individual coverage HRA offered to you and dependent(s) (not spouse) with affordability determined by using employee's primary residence ZIP code.
- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Par	Covered Individuals 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 individual(s) First name, middle initial, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	rered (e) Months of coverage onths Jan Feb Mar Apr May June July Aug Sept Oct No											Dec
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Instructions for Recipient (continued)

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

Line 16. This code provides the IRS information to administer the employer shared responsibility provisions. Other than a code 2C, which reflects your enrollment in your employer's coverage, none of this information affects your eligibility for the premium tax credit. For more information about the employer shared responsibility provisions, visit IRS.gov.

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

Part III. Covered Individuals, Lines 18–30

Morgan Wright 364 Village Creek Drive Chatsworth, GA 30705

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Depar					easury

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

VOID

OMB No. 1545-2251

Internal Revenue Se			Go to www	irs.gov/For	ov/Form1095C for instructions and the latest information.								<u> </u>			
Part I Em	ployee						Applicable Large Employer Member (Employer)									
1 Name of employ	yee (first name,	middle initial, la	st name)	2 Socia	al security number	urity number (SSN) 7 Name of employer						8 Employer identification number (EIN)				
Morgan Wright					XXX-XX-97	42	Profession	nal Eye Asso		581148820						
3 Street address (including aparti	ment no.)		<u>'</u>			9 Street addre	ess (including roo	m or suite no.)		10 C	Contact telephone number				
364 Village C	reek Drive						1111 Profe	essional Blvd	t			7062262020				
			6 Count	ry and ZIP or foreig	n postal code	11 City or town	1	12 State or pre	12 State or province			13 Country and ZIP or foreign postal code				
Chatsworth GA					0705		Dalton		GA		US	US 30720				
Part II Em	ployee Off	er of Cove	rage	•	Employee's	s Age on .	January 1		Plan Star	t Month (er	nter 2-digit	2-digit number): (
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1A	1A	1A	1A	1A	1H	1H			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2D	2D	2D	2D						2B	2A			
17 ZIP Code																

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

Cat. No. 60705M

Instructions for Recipient

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

In addition, if you, or any other individual who is offered health coverage because of their relationship to you (referred to here as family members), enrolled in your employer's health plan and that plan is a type of plan referred to as a "self-insured" plan, Form 1095-C, Part III, provides information about you and your family members who had certain health coverage (referred to as "minimum essential coverage") for some or all months during the year. If you or your family members are eligible for certain types of minimum essential coverage, you may not be eligible for the premium tax credit.

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

Line 14. The codes listed below for line 14 describe the coverage that your employer offered to you and your spouse and dependent(s), if any. (If you received an offer of coverage through a multiemployer plan due to your membership in a union, that offer may not be shown on line 14.) The information on line 14 relates to eligibility for coverage subsidized by the premium tax credit for you, your spouse, and dependent(s). For more information about the premium tax credit, see Pub. 974.

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Form 1095-C (2023)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30