PAMELA ABERNATHY 202 Woodland Circle Calhoun, GA 30701

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

2023

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

Internal Revenue Ser	vice	Go to www.irs.gov/Form1095C for instructions and the latest information.											4			
Part I Emp	loyee						A	pplicable L	arge Empl	loyer Memb	er (En	nploye	er)			
1 Name of employe	ee (first name, m	niddle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ıployer				8 Empl	loyer identifica	ation number (EIN)		
PAMELA		ABER	NATHY		XXX-XX-4	942	Associates	Associates in Orthopedics and Sports Medicine PC					581388690			
3 Street address (in	ncluding apartm	ent no.)		•			9 Street addre	ess (including roo	m or suite no.)			10 Cont	act telephone	number		
202 Woodland Circle								essional Blvo	t				706226	5533		
4 City or town	5	State or provi	nce	6 Count	ry and ZIP or fore	ign postal code	11 City or town	11 City or town 12 State or province 13				13 Country and ZIP or foreign postal of				
Calhoun		GΑ		US 30	0701		Dalton GA L				US 30720-2588					
Part II Emp	loyee Offe	r of Cover	rage	•	Employee	's Age on	January 1	lanuary 1 Plan Start Month (enter 2-digit						number): 01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	C	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1	IA	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
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 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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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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Alison L Ausmus 1080 Estate Drive Dalton, GA 30721

Form	095	5-C
Departm	ent of the	Treasury
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OMB No. 1545-2251

CORRECTED

2023

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APRIL R BAGGETT 167 Atkins Way Dalton, GA 30721

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APRIL		R	BAGG	ETT		XXX-X	X-2843	3 .	Associates	in Orthoped	lics and Spo	rts Medicin	e PC	C 581388690			
3 Street address (including apartr	nent n	0.)		•				9 Street addre	ss (including roon	n or suite no.)		10 (10 Contact telephone number			
167 Atkins Wa	67 Atkins Way								1104 Profe	ssional Blvd				70622	55533		
4 City or town		5 Sta	te or provii	nce	6 C	6 Country and ZIP or foreign postal code			11 City or town		12 State or pro	vince	13 (Country and ZIP or	r foreign postal code		
Dalton GA US 30721								Dalton		GA		US	30720-258	8			
Part II Employee Offer of Coverage Employee's Age or							Age on J	January 1 Plan Start Month (enter 2-c					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.

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.

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

Jenna L Blevins 4010 Woodline Drive Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

RRECTED 20

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	m1095C for in	structions a	nd the latest in	nformation.						
Part I Emp	loyee						Α	pplicable La	arge Emplo	yer Membe	er (Em	ploye	er)	
1 Name of employe	ee (first name, m	iddle initial, las	t name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer			8	8 Emplo	oyer identificat	ion number (EIN)
Jenna		Blevins	S		XXX-XX-18	389	Associates in Orthopedics and Sports Medicine PC						5813886	590
3 Street address (in	ncluding apartme	ent no.)			9 Street addre	ss (including roor	n or suite no.)		1	10 Contact telephone number				
4010 Woodline	1104 Professional Blvd					7062265533								
4 City or town	5	State or provin	nce	6 Countr	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince	1:	13 Country and ZIP or foreign postal code		
Dalton		721		Dalton		GA		lι	JS 30	720-2588				
Part II Emp	loyee Offe	r of Cover	age		Employee'	s Age on	January 1		Plan Star	t Month (en	ter 2-di	digit number): 01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oc	ct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	11	4	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	2/	4	2A	2A
17 ZIP Code									N. 00705M					1005 € (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.
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
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- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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

Kirsten R Boggs 1142 Highway 411 SE Fairmount, GA 30139

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Employer-Provided Health Insurance Offer and Coverage

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.

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oloyee Offe	er of Cover	rage		Employee'	s Age on	January 1		Plan Star	rt Month (er	nter 2-	digit nu	mber):	01
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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.

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- **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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- 1W. Reserved for future use.
- 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	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 M BROOME 483 Foster Drive Ringgold, GA 30736

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Employer-Provided Health Insurance Offer and Coverage

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	m 1095C for in	structions ar	ia the latest in	normation.							
Part I Emp	oloyee						A	pplicable L	arge Emplo	yer Memb	er (En	ploye	er)		
1 Name of employ	ee (first name, i	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer				8 Emplo	oyer identifica	tion number (EIN)	
AMANDA		M BROC	OME		XXX-XX-6	520	Associates	in Orthopeo	lics and Sp	orts Medicir	ne PC		581388	690	
3 Street address (i	ncluding apartn	nent no.)					9 Street address	ss (including roor	n or suite no.)			10 Contact telephone number			
483 Foster Dr	483 Foster Drive								1104 Professional Blvd						
4 City or town	:	5 State or prov	ince	6 Count	6 Country and ZIP or foreign postal code			11 City or town		12 State or province			13 Country and ZIP or foreign postal co		
Ringgold	GA		0736	6 Dalton GA						US 30720-2588					
	oloyee Offe	er of Cove	rage	•	Employee'	s Age on c	January 1		Plan Star	t Month (er	nter 2-d	digit number): 01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	0	ct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	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)		2A	2A	2A	2A										
17 ZIP Code														1005.0	

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

Cat. No. 60705M

Instructions for Recipient

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

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

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



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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

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

- **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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- **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.

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

Jacey L Callahan 2055 Riverdale Rd NE Dalton, GA 30721

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

OMB No. 1545-2251

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Internal Revenue Ser	rvice		Go to www	irs.gov/For	<i>m10</i> 95C for in	structions ar	id the latest ii	ntormation.						
Part I Emp	oloyee						Α	pplicable La	arge Emplo	yer Memb	er (En	nploy	er)	
1 Name of employ	ee (first name, i	middle initial, las	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	ployer				8 Emp	loyer identifica	tion number (EIN)
Jacey		L Callah	nan		XXX-XX-3	500	Associates in Orthopedics and Sports Medicine PC					581388690		
3 Street address (in	ncluding apartn	nent no.)					9 Street addre	ss (including roon	n or suite no.)			10 Cont	tact telephone	number
2055 Riverdal	e Rd NE						1104 Profe	ssional Blvd					706226	5533
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 pr	rovince		13 Coun	itry and ZIP or f	oreign postal code
Dalton		GA		US 30	721		Dalton		GA			US 30	0720-2588	}
Part II Emp	oloyee Offe	er of Cove	rage		Employee ³	s Age on c	January 1		Plan Star	t Month (er	nter 2-c	digit nu	ımber):	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 Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2D							
17 ZIP Code									No. 60705M					1095-C (2022)

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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

April N Callaway 5451 Blair Road Cohutta, GA 30710

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Employer-Provided Health Insurance Offer and Coverage

OMB No. 1545-2251

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Internal Revenue Sei	rvice		GO TO WW	w.irs.gov/For	m 1095C for in	structions a	na the latest ir	ntormation.				- 1		
Part I Emp	oloyee						Α	pplicable L	arge Emplo	oyer Membe	r (Em	nploye	er)	
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security number	r (SSN)	7 Name of emp	ployer				8 Empl	oyer identificat	ion number (EIN)
April		N Callav	way		XXX-XX-91	20	Associates in Orthopedics and Sports Medicine PC				e PC	581388690		
3 Street address (in	ncluding apartr	ment no.)					9 Street address (including room or suite no.)					10 Contact telephone number		
5451 Blair Roa	ad						1104 Profe	essional Blvd	I				7062265	533
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince		13 Count	ry and ZIP or fo	reign postal code
Cohutta		GA		US 30	0710		Dalton GA U			US 30720-2588				
Part II Emp	loyee Off	er of Cove	rage	·	Employee'	s Age on	January 1		Plan Star	rt Month (ent	er 2-d	ligit nuı	mber):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	0	ct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1H	1H	1H	1H	1H	1H	1H	1	Н	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	2	Α	2A	2A
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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).
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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

Sheila Carlo-Juarez 1408 Rosewood Circle, Apt 44 Dalton, GA 30720

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.

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VOID

OMB No. 1545-2251

2023

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) Sheila Carlo-Juarez XXX-XX-7950 Associates in Orthopedics and Sports Medicine PC 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1408 Rosewood Circle Apt 44 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code Dalton GA US 30720 Dalton GA US 30720-2588 **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 1H required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2A 2A 2B 2A 2A 2A 2A 2A 2A 2A code, if applicable) 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.
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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.
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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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- **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.

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

Andrew G Carlone MD 9217 Rocky Cove Drive Chattanooga, TN 37421

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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

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

Internal Revenue Ser	vice		Go to ww	w.irs.gov/For	<i>m10</i> 95C for in	nstructions a	and the latest i	information.					4	
Part I Emp	loyee							Applicable L	arge Empl	loyer Memb	er (En	nploye	er)	
1 Name of employ	ee (first name, n	niddle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	nployer				8 Empl	oyer identifica	ition number (EIN)
Andrew	(G Carlor	ne MD		XXX-XX-6	600	Associates	Associates in Orthopedics and Sports Medicine PC						8690
3 Street address (i	ncluding apartm	nent no.)		•			9 Street addre	ess (including roo	m or suite no.)			10 Contact telephone number		
9217 Rocky C	ove Drive						1104 Profe	essional Blv	t				706226	5533
4 City or town 5 State or province					ry and ZIP or fore	ign postal code	11 City or town	1	12 State or p	orovince		13 Count	ry and ZIP or t	oreign postal code
Chattanooga	-	TN		US 37	7421		Dalton		GA			US 30	720-2588	}
Part II Emp	loyee Offe	r of Cover	rage	•	Employee	's Age on	January 1		Plan Sta	rt Month (e	nter 2-c	digit number): 01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	C	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1	ΙA	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code									No. 60705M					1095-С (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.

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

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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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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

GABRIELA CARO 3220 Leona Drive Rocky Face, GA 30740

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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. 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) Associates in Orthopedics and Sports Medicine PC **GABRIELA CARO** XXX-XX-0534 581388690 9 Street address (including room or suite no.) 3 Street address (including apartment no.) 10 Contact telephone number 3220 Leona Drive 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code Rocky Face GA US 30740 Dalton GA US 30720-2588 **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

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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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- **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	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.

Part III. Covered Individuals, Lines 18–30

Adriana B Chavarria 116 Southern Circle 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.

VOID

	OMB No. 1545-2251
CORRECTED	2023

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

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Part I Emp	oloyee	•					A	pplicable L	arge Empl	oyer Memb	er (Er	nploy	er)			
1 Name of employ	ee (first name	, middle initial, la	st name)	2 Soci	al security numbe	er (SSN)	7 Name of employer						8 Employer identification number (EIN)			
Adriana		B Chav	arria		XXX-XX-0	408	Associates in Orthopedics and Sports Medicine Po						C 581388690			
3 Street address (i	including apar	tment no.)					9 Street addre	9 Street address (including room or suite no.)					10 Contact telephone number			
116 Southern	Circle						1104 Profe	essional Blvo	t			7062265533				
4 City or town		5 State or prov	vince	6 Count	try and ZIP or fore	ign postal code	11 City or town	1	12 State or p	rovince		13 Country and ZIP or foreign postal code				
Chatsworth GA US 30705							Dalton		GA			US 30	0720-2588			
Part II Emp	oloyee Of	fer of Cove	rage	·	Employee	's Age on	January 1		Plan Sta	rt Month (er	nter 2-	digit nu	ımber):	01		
	All 12 Month	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									No. COZOEM					1005 C (2000		

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Brittany Corbin 5731 Smyrna Church Road Chatsworth, GA 30705

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VOID	OMB No. 1545-2251
X CORRECTED	2023

Internal Revenue Se	ervice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest in	itormation.						
Part I Emp	ployee						Aı	pplicable L	arge Emplo	yer Membe	er (Em	ployer)		
1 Name of employ	ee (first name, r	middle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer			1	8 Employe	er identifica	tion number (EIN)
Brittany		Corbin	า		XXX-XX-90	002	Associates in Orthopedics and Sports Medicine PC					581388690		
3 Street address (i	including apartn	nent no.)					9 Street addres	ss (including roor	n or suite no.)		1	0 Contact	telephone	number
5731 Smyrna	Church Ro	ad					1104 Profe	ssional Blvd					7062265	5533
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 pr	rovince	1	3 Country	and ZIP or f	oreign postal code
Chatsworth		GA		US 30	705		Dalton		GA		Įι	JS 307	20-2588	
Part II Emp	ployee Offe	er of Cove	rage		Employee'	s Age on c	January 1		Plan Star	t Month (en	ter 2-di	git numl	oer):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oc	ct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1/	4	1A	1A
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17 ZIP Code														1005 0

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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	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

Sydney T Davis 2105 McCamish Rd NE Dalton, GA 30721

OMB No. 1545-2251

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

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

Do not attach to your tax return. Keep for your records. 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) Sydney Т Davis XXX-XX-7873 Associates in Orthopedics and Sports Medicine PC 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 2105 McCamish Rd NE 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code Dalton GA US 30721 Dalton GA US 30720-2588 **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 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 code, if applicable) 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.

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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.

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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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- **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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	(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

TESHA R DUNN 40 Booger Branch Spur Crandall, GA 30711

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.

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CORRECTED	2023

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 Membe	er (Er	nploye	er)	
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security number	r (SSN)	7 Name of emp	ployer				8 Emp	loyer identifica	tion number (EIN)
TESHA		R DUNN	J		XXX-XX-43	322	Associates	in Orthoped	lics and Spo	orts Medicin	e PC		581388	690
3 Street address (i	ncluding apart	ment no.)		'			9 Street addres	ss (including roor	n or suite no.)			10 Cont	act telephone	number
40 Booger Bra	anch Spur						1104 Profe	essional Blvd					7062265	5533
4 City or town	•	5 State or provi	ince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince		13 Coun	try and ZIP or fo	oreign postal code
Crandall		GA		US 30)711		Dalton		GA			US 30	0720-2588	
Part II Emp	loyee Off	er of Cove	rage		Employee'	s Age on	January 1		Plan Star	t Month (en	ter 2-	digit nu	ımber):	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									No. 60705M					1095-C (2022

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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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Part III. Covered Individuals, Lines 18–30

Tonja L Ensley 1755 Trickum Road Rocky Face, GA 30740

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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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Part I Em	ployee						Aı	oplicable La	arge Emplo	yer Memb	er (En	nploye	er)	
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Socia	I security number	r (SSN)	7 Name of emp	oloyer				8 Empl	oyer identifica	tion number (EIN)
Tonja		L Ensley	У		XXX-XX-62	206	Associates in Orthopedics and Sports Medicine PC					581388690		
3 Street address (including apart	ment no.)		•			9 Street addres	ss (including roon	n or suite no.)			10 Cont	act telephone	number
1755 Trickum	Road						1104 Profe	ssional Blvd					706226	5533
4 City or town 5 State or province			6 Country	y and ZIP or forei	gn postal code	de 11 City or town 12 State or province 1			13 Country and ZIP or foreign postal code					
Rocky Face GA				US 30	740		Dalton		GA			US 30720-2588		
Part II Em	ployee Off	er of Cover	rage		Employee'	s Age on	January 1		Plan Star	t Month (er	nter 2-c	ligit nu	mber):	01
	All 12 Months	3 Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	С)ct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1H	1H	1H	1H	1H	1H	1H	1H	1	Н	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	2	2A	2A	2A
17 ZIP Code														

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Cat. No. 60705M

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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).

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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- **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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Par	art 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

Morgan Fowler 1301 Witherow Bridge Road 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.

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

OMB No. 1545-2251

internal Revenue Sei	rvice		GO LO WW	w.iis.gov/roi	11110950 101 111	isti uctions a	ina the latest ii	normation.							
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Er	nploy	er)		
1 Name of employ	ee (first name, r	middle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of emp	ployer				8 Emp	loyer identifica	tion number (EIN)	
Morgan		Fowle	r		XXX-XX-28	865	Associates	Associates in Orthopedics and Sports Medicine Po					581388690		
3 Street address (in	ncluding apartm	nent no.)		•			9 Street addre	ss (including roor	m or suite no.)			10 Cont	tact telephone	number	
1301 Witherov	w Bridge Ro	oad					1104 Profe	essional Blvd	i				706226	5533	
4 City or town				6 Count	ry and ZIP or forei	ign postal code	de 11 City or town 12 State or province			13 Country and ZIP or foreign postal code					
Dalton		GA		US 30	0721		Dalton		GA			US 30	0720-2588		
Part II Emp	oloyee Offe	er of Cover	rage		Employee	's Age on	January 1		Plan Sta	rt Month (ei	nter 2-	digit nu	ımber):	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.



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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.

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Par	art 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

Magali Fraire 641 W Nance Springs Rd SW Dalton, GA 30721

Form	109:	5-C					
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Internal Devenue Convice							

Employer-Provided Health Insurance Offer and Coverage

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VOID

	OMB No. 1545-2251
CORRECTED	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 Sei	rvice		GO to www	/.irs.gov/For	m 1095C for in	structions a	na tne latest ir	ntormation.				- 1					
Part I Employee								Applicable Large Employer Member (Employer)									
1 Name of employee (first name, middle initial, last name) 2 Social security number (SSN)					r (SSN)	7 Name of emp	ployer		8 Employer identification number (EIN)								
Magali Fraire					XXX-XX-9755			Associates in Orthopedics and Sports Medicine PC						581388690			
3 Street address (including apartment no.)								9 Street address (including room or suite no.)						10 Contact telephone number			
641 W Nance	Springs Rd	ISW			1104 Professional Blvd						7062265533						
4 City or town 5 State or province				6 Count	6 Country and ZIP or foreign postal code				12 State or p	rovince		13 Country and ZIP or foreign postal code					
Dalton GA				US 30	US 30721				GA			US 30720-2588					
Part II Employee Offer of Coverage					Employee'	s Age on	January 1		Plan Sta	rt Month (en	ter 2-c	digit nu	mber):	01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	C	Oct	Nov	Dec			
14 Offer of Coverage (enter required code)		1H	1H	1H	1A	1A	1A	1A	1A	1A	1	IA	1A	1A			
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$			
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2D													
17 ZIP Code														1005.0			

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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

JAMES FRIX 290 McAfee Circle NE Ranger, GA 30734

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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	rvice		Go to ww	structions a	nd the latest ir	nformation.										
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Er	mployer)				
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 Emp	loyer identifica	tion number (EIN)		
JAMES		FRIX			XXX-XX-58	316	Associates in Orthopedics and Sports Medicine PC						581388690			
3 Street address (including apartment no.)							9 Street addres	ss (including roo	m or suite no.)			10 Contact telephone number				
290 McAfee C	Circle NE						1104 Profe	essional Blvd	i				706226	5533		
4 City or town	5	State or provi	nce	6 Countr	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince		13 Cour	try and ZIP or t	oreign postal code		
Ranger		GΑ		US 30	734		Dalton		GA			US 30	0720-2588	}		
Part II Emp	oloyee Offe	r of Cover	age	i	Employee'	s Age on	January 1		Plan Sta	rt Month (er	nter 2-	digit nu	ımber):	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		IA	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code														100E C (000		

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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- 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.

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

Tanya Garcia 304 Nicholas Drive Resaca, GA 30735

OMB No. 1545-2251

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Employer-Provided Health Insurance Offer and Coverage

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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	<i>m10</i> 95C for in	structions ar	id the latest in	nformation.							
Part I Emp	oloyee						A	pplicable L	arge Emplo	yer Memb	er (Em	ploye	r)		
1 Name of employ	vee (first name, m	niddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer				8 Emplo	yer identifica	tion number (EIN)	
Tanya		Garcia	a		XXX-XX-47	736	Associates in Orthopedics and Sports Medicine PC						581388	690	
3 Street address (i	3 Street address (including apartment no.)							ss (including roor	n or suite no.)			10 Contact telephone number			
304 Nicholas	Drive						1104 Profe	ssional Blvd	1				706226	5533	
4 City or town	5	State or prov	ince	6 Counti	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince	1	13 Countr	y and ZIP or f	oreign postal code	
Resaca		GΑ		US 30	735		Dalton		GA			US 30	720-2588		
Part II Employee Offer of Coverage Employee's Age of							lanuary 1		Plan Star	t Month (en	ter 2-d	igit number): 01			
	All 12 Months	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.	Α	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	9	3	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			A at Nation on											1005 C (2000	

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

Cat. No. 60705M

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

Cailee Glover 75 Brushtown Road Crandall, GA 30711

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. 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 (Er	nploy	er)	
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 Emp	loyer identifica	ation number (EIN)
Cailee		Glove	r		XXX-XX-3	421	Associates	Associates in Orthopedics and Sports Medicine PC					581388	3690
3 Street address (i	including apart	ment no.)					9 Street addre	ss (including roor	n or suite no.)			10 Con	tact telephone	number
75 Brushtown	Road						1104 Profe	essional Blvd	I				706226	5533
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	rovince		13 Cour	ntry and ZIP or	foreign postal code
Crandall		GA		US 30)711		Dalton		GA			US 3	0720-2588	3
Part II Emp	oloyee Off	er of Cove	rage		Employee	's Age on .	January 1		Plan Star	rt Month (e	nter 2-	digit nu	ımber):	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	2A	2A	2D					
17 ZIP Code	<u> </u>								N- 00705M					1005 C (2000)

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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).
- 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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- **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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- **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.

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

Dolores Gonzalez 179 Lasabre Blvd Chatsworth, GA 30705

Form	10)95 .	-C
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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	rvice		Go to www	v.irs.gov/Foi	m1095C for ins	structions an	is and the latest information. $\square \subseteq \square$									
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Emplo	yer)				
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Socia	al security number	(SSN)	7 Name of em	ployer			8 Er	nployer identifica	ation number (EIN)			
Dolores		Gonza	alez		XXX-XX-28	351	Associates	in Orthope	dics and Spo	orts Medicir	ne PC	S 581388690				
3 Street address (i	including aparti	ment no.)					9 Street addre	ess (including roo	n or suite no.)		10 Cd	10 Contact telephone number				
179 Lasabre I	Blvd						1104 Profe	essional Blvd	I			7062265533				
4 City or town		5 State or provi	nce	6 Count	ry and ZIP or foreig	n postal code	11 City or town	ı	13 Co	13 Country and ZIP or foreign postal cod						
Chatsworth		GA		US 30	0705		Dalton		GA		US	30720-2588	3			
Part II Emp	oloyee Off	er of Cover	age		Employee's	s Age on J	lanuary 1		Plan Star	t Month (er	iter 2-digit i	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																

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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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

David A Goss Jr 2671 Crow Valley Road NW Dalton, GA 30720

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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 Ser	vice		Go to www	v.irs.gov/For	<i>m10</i> 95C for in	structions a	nd the latest in	nformation.								
Part I Emp	loyee						Α	pplicable L	arge Emplo	oyer Membe	er (Em	ploye	r)			
1 Name of employ	ee (first name, m	iddle initial, las	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer				8 Emplo	yer identifica	tion number (EIN)		
David	4	Goss	Jr		XXX-XX-32	269	Associates	in Orthoped	dics and Sp	orts Medicin	e PC		581388	690		
3 Street address (in	ncluding apartme	ent no.)		•			9 Street addre	ss (including roor	n or suite no.)			10 Conta	ct telephone	number		
2671 Crow Va	lley Road N	IW					1104 Profe	essional Blvd	I				706226	5533		
4 City or town 5 State or province 6 Country and ZIP or foreign post						gn postal code	11 City or town 12 State or province 13					13 Countr	y and ZIP or f	oreign postal code		
Dalton GA US 30720							Dalton	Dalton GA US						ı		
Part II Employee Offer of Coverage Employee's Age							January 1		Plan Star	rt Month (en	ter 2-d	2-digit number): 01				
	All 12 Months	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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	9	5	\$		
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

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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

ROY L GRAY Jr 331 Lake Dr SE Calhoun, GA 30701

OMB No. 1545-2251

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17 ZIP Code

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

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nternal Revenue Ser	vice		Go to www.	irs.gov/Fort	m1095C for ins	structions an	d the latest in	formation.		Z0 Z 0					
Part I Emp	loyee						A	pplicable L	arge Emplo	yer Membe	er (Em	nploye	er)		
1 Name of employe	ee (first name,	middle initial, last	t name)	2 Social	l security number	(SSN)	7 Name of emp	oloyer				8 Empl	oyer identification	on number (EIN	
ROY		L GRAY	Jr		XXX-XX-90	88	Associates	in Orthopeo	dics and Spo	orts Medicin	e PC		5813886	90	
3 Street address (in	cluding apartr	nent no.)		'			9 Street addres	ss (including roo	m or suite no.)			10 Cont	act telephone n	umber	
331 Lake Dr S	Ε						1104 Profe	ssional Blvo	k				7062265	533	
4 City or town							11 City or town		12 State or pro	ovince		13 Country and ZIP or foreign postal co			
Calhoun		GA		US 30	701		Dalton		GA			US 30720-2588			
Part II Emp	loyee Off	er of Cover	age		Employee's	s Age on J	lanuary 1		Plan Star	t Month (en	ligit nu	01			
	All 12 Months Jan Feb Mar Apr May						June	July	Aug	Sept	0)ct	Nov	Dec	
4 Offer of Coverage (enter equired code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1	Α	1A	1A	
5 Employee Required Contribution (see Instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$	
6 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

VOID

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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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Page 4

Form 1095-C (2023)

Instructions for Recipient (continued)

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Brandy D Hall 220 Dogwood Dr 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

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OMB No. 1545-2251

2023

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) Associates in Orthopedics and Sports Medicine PC Brandv D Hall XXX-XX-4220 581388690 9 Street address (including room or suite no.) 3 Street address (including apartment no.) 10 Contact telephone number 220 Dogwood Dr 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code GΑ Chatsworth US 30705 Dalton GA US 30720-2588 **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

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KATLYN C HAMMONTREE 893 Beaverdale Rd Crandall, GA 30711

Form 1095- C
Department of the Treasury
Internal Davisaria Camilas

Employer-Provided Health Insurance Offer and Coverage

OMB No. 1545-2251

ORRECTED 202

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Internal Revenue Se	ervice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest in	itormation.							
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KATLYN		C HAMI	MONTREE		XXX-XX-2	373	Associates in Orthopedics and Sports Medicine Po					C 581388690			
3 Street address (including apartn	nent no.)		•			9 Street address	ss (including roor	n or suite no.)			10 Conta	act telephone	number	
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Part II Emp	ployee Offe	er of Cove	rage		Employee ³	s Age on c	January 1		Plan Star	rt Month (en	ter 2-c	ligit nu	mber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	0	oct .	Nov	Dec	
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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.
- 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

Kayla L Harrison 148 Sahara Lane Chatsworth, GA 30705

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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	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 (Em	ploye	r)			
1 Name of employ	/ee (first name, m	iddle initial, la	ıst name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer				8 Emplo	oyer identifica	tion number (EIN)		
Kayla		_ Harris	son		XXX-XX-14	416	Associates in Orthopedics and Sports Medicine P						PC 581388690			
3 Street address (i	including apartme	ent no.)		'			9 Street address	ss (including roor	n or suite no.)			10 Conta	ct telephone	number		
148 Sahara L	ane						1104 Profe	ssional Blvd	1				706226	5533		
4 City or town 5 State or province 6 Country and ZIP or foreign postal						gn postal code	11 City or town 12 State or province 13					13 Count	ry and ZIP or f	oreign postal code		
Chatsworth		3A		US 30	705		Dalton		GA			US 30	720-2588			
Part II Emp	oloyee Offe	r of Cove	rage		Employee ²	s Age on c	January 1		Plan Star	t Month (en	ter 2-d	igit nur	nber):	01		
	All 12 Months	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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code			A at Nation as											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.



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Part I. Applicable Large Employer Member (Employer)

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

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

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

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

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

RHONDA L HARRISON 552 Hamilton Way 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

VOID

OMB No. 1545-2251

2023

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) **RHONDA** HARRISON XXX-XX-3812 Associates in Orthopedics and Sports Medicine PC 581388690 9 Street address (including room or suite no.) 3 Street address (including apartment no.) 10 Contact telephone number 552 Hamilton Way 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code Chatsworth GA US 30705 Dalton GA US 30720-2588 **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

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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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Part III. Covered Individuals, Lines 18–30

Misty D Hawkins 1751 Riverdale Rd NE Dalton, GA 30721

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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	v.irs.gov/For	<i>m10</i> 95C for in	structions a	nd the latest in	nformation.					4			
Part I Emp	loyee						Α	pplicable L	arge Emplo	oyer Memb	er (En	nploye	er)			
1 Name of employ	ee (first name, m	niddle initial, las	t name)	2 Socia	l security numbe	er (SSN)	7 Name of em	ployer				8 Empl	oyer identifica	tion number (EIN)		
Misty	[) Hawkii	ns		XXX-XX-6	539	Associates	Associates in Orthopedics and Sports Medicine PC						690		
3 Street address (in	ncluding apartm	ent no.)		•			9 Street addre	ess (including roor	n or suite no.)			10 Contact telephone number				
1751 Riverdal	e Rd NE						1104 Profe	essional Blvd	I				706226	5533		
4 City or town 5 State or province					y and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince		13 Count	ry and ZIP or f	oreign postal code		
Dalton GA US 3072							Dalton GA US					US 30	US 30720-2588			
Part II Emp	loyee Offe	r of Cover	age		Employee ³	's Age on	January 1		Plan Star	rt Month (en	ter 2-d	digit number): 01				
	All 12 Months	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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$		
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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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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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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- **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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- 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	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

Kaitlyn M Herrera 2524 Dug Gap Rd 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

Internal Revenue Se	ervice			Go to www	.irs.gov/Fo	rm1095C for ins	structions a	nd the latest i	information.							
Part I Emp	oloyee							_ A	Applicable L	arge Emplo	yer Memb	er (Emp	loyer)			
1 Name of employ	ee (first name,	middle in	itial, last	name)	2 Soci	al security number	(SSN)	7 Name of em	nployer			8	8 Employer identification number (EIN			
Kaitlyn		M H	lerrera	ì		XXX-XX-41	09	Associates	s in Orthope	ne PC	C 581388690					
3 Street address (i	including apartr	ment no.)			•			9 Street addre	ess (including roo	10	10 Contact telephone number					
2524 Dug Ga	p Rd							1104 Profe	essional Blvo		7062265533					
4 City or town 5 State or province					6 Count	try and ZIP or foreig	n postal code	11 City or town	1	12 State or pr	ovince	13	Country and ZIP	or foreign postal code		
<u>Dalton</u> GA					US 30	0720		Dalton		GA		U:	US 30720-2588			
Part II Employee Offer of Coverage Employee's Age on							s Age on .	January 1		Plan Star	t Month (e	nter 2-digi	git number): 01			
	All 12 Months	J	an	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1	ΙΗ	1H	1H	1H	1H	1H	1H	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2	2 A	2A	2A	2A	2A	2A	2D							
17 ZIP Code																

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

Ashley N Hooper 1064 Ben Hill Road 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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VOID

OMB No. 1545-2251

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) Hooper Ashlev Ν XXX-XX-6616 Associates in Orthopedics and Sports Medicine PC 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1064 Ben Hill Road 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code Dalton GA US 30721 Dalton GA US 30720-2588 **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 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 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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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

Sabrina S Jarvis 2035 Bowers Road NE Dalton, GA 30721

OMB No. 1545-2251

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Employer-Provided Health Insurance Offer and Coverage

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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	v.irs.gov/roi	minosoc ioi iii	Structions a	ina the latest i	mormation.					_ ~			
Part I Emp	oloyee						A	pplicable L	arge Emplo	yer Membe	er (Er	nploy	er)			
1 Name of employ	ree (first name, r	niddle initial, la	ast name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ıployer				8 Emp	loyer identificat	ion number (EIN)		
Sabrina		S Jarvis	S		XXX-XX-4	456	Associates in Orthopedics and Sports Medicine P						581388690			
3 Street address (i	ncluding apartn	nent no.)					9 Street addre	ess (including roo	m or suite no.)			10 Cont	act telephone r	number		
2035 Bowers	Road NE						1104 Profe	essional Blvd	ł				7062265	533		
4 City or town		5 State or prov	vince	6 Count	ry and ZIP or forei	gn postal code	11 City or town	1	12 State or pro	ovince		13 Coun	try and ZIP or fo	reign postal code		
Dalton		GA		US 30	0721		Dalton		GA			US 30	0720-2588			
Part II Emp	oloyee Offe	er of Cove	rage		Employee	's Age on	January 1		Plan Star	t Month (en	ter 2-d	digit nu	ımber):	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 € (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).
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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.
- 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

Alexandria J Johnson 225 Allen Road Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

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	m 1095C for in	istructions ar	ia the latest ii	ntormation.				- 1				
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Er	nploy	er)			
1 Name of employ	ee (first name, n	niddle initial, la	ast name)	2 Socia	al security numbe	er (SSN)	7 Name of emp	ployer				8 Emp	loyer identifica	ation number (EIN)		
Alexandria		J Johns	son		XXX-XX-6	802	Associates in Orthopedics and Sports Medicine PC						581388690			
3 Street address (i	ncluding apartm	ent no.)		<u>'</u>			9 Street addre	ss (including roor	n or suite no.)			10 Con	tact telephone	number		
225 Allen Roa	ıd						1104 Profe	essional Blvd	I				706226	5533		
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	rovince		13 Cour	ntry and ZIP or	foreign postal code		
Chatsworth	(GA		US 30	0705		Dalton		GA			US 3	0720-2588	3		
Part II Emp	loyee Offe	r of Cove	rage	•	Employee	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-	digit nu	ımber):	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 Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code														1005-C (2022		

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Cat. No. 60705M

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee.																
	(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 L Johnson 242 Daisy Lane Chatsworth, GA 30705

OMB No. 1545-2251

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Employer-Provided Health Insurance Offer and Coverage

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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	ervice		Go to www	ırs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest in	nformation.								
Part I Emp	ployee						Aı	pplicable L	arge Emplo	oyer Memb	er (En	nploye	er)			
1 Name of employ	ee (first name, n	niddle initial, la	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer				8 Emplo	oyer identifica	tion number (EIN)		
Heather		L Johns	son		XXX-XX-32	200	Associates	in Orthopeo	dics and Sp	orts Medicin	ne PC	581388690				
3 Street address (i	including apartm	ent no.)					9 Street address (including room or suite no.)						10 Contact telephone number			
242 Daisy Lar	ne						1104 Professional Blvd					7062265533				
4 City or town	5	State or prov	vince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince		13 Count	ry and ZIP or f	oreign postal code		
Chatsworth	(GA		US 30	705		Dalton		GA			US 30	720-2588	1		
Part II Employee Offer of Coverage Employee's Age of						s Age on c	January 1 Plan Start Month (enter 2-dig				ligit nur	01				
	All 12 Months	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	Α	1A	1A		
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code														1005 0 2000		

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Cat. No. 60705M

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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.
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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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- **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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- 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.

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														
18												Aug	Sept	Oct	Nov	Dec
19																
20																
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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

MICHAEL J JOHNSON 141 Tara Drive SE Calhoun, GA 30701

OMB No. 1545-2251

Form	10)95 .	-C
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Employer-Provided Health Insurance Offer and Coverage

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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	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 (En	nploye	er)		
1 Name of employ	/ee (first name, m	iddle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer				8 Empl	oyer identifica	tion number (EIN)	
MICHAEL		JOHN	ISON		XXX-XX-79	979	Associates	in Orthopeo	dics and Spe	orts Medicin	ne PC	581388690			
3 Street address (i	including apartme	ent no.)					9 Street address (including room or suite no.) 10					10 Contact telephone number			
141 Tara Driv	e SE						1104 Professional Blvd					7062265533			
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 Count	ry and ZIP or t	oreign postal code	
Calhoun		3A		US 30	701		Dalton		GA			US 30	720-2588	}	
Part II Emp	oloyee Offe	r of Cove	rage		Employee'	s Age on c	January 1		Plan Star	t Month (en	iter 2-d	ligit nuı	mber):	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	Α	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											100F 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.

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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN														
18												Aug	Sept	Oct	Nov	Dec
19																
20																
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Part III. Covered Individuals, Lines 18–30

Lauren N Jonason PO Box 168 Eton, GA 30724

OMB No. 1545-2251

Form 1095-	
Department of the Treas	ury

Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

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) Lauren Ν Jonason XXX-XX-0010 Associates in Orthopedics and Sports Medicine PC 581388690 9 Street address (including room or suite no.) 3 Street address (including apartment no.) 10 Contact telephone number PO Box 168 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code Eton GA US 30724 Dalton GA US 30720-2588 **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 1H 1H 1H 1H 1H 1H 1H 1A 1A 1A 1A 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2A 2A 2A 2A 2A 2D 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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	(a) Name of covered individual(s) First name, middle initial, last name	(b) SSN or other TIN														
18												Aug	Sept	Oct	Nov	Dec
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Part III. Covered Individuals, Lines 18–30

Samantha P Kincaid 62 Brookwalk Drive 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. Go to www irs gov/Form1095C for instructions and the latest information

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OMB No. 1545-2251

Department of the Treasury nternal Revenue Service Go to www.irs.gov/Form1095C for instructions an

Internal Revenue Se	ervice		Go to www	v.irs.gov/Fo	<i>rm10</i> 95C for in	structions ar	s and the latest information.							20 20		
Part I Em	ployee						Α	pplicable L	nploy	er)						
1 Name of employ	ee (first name,	middle initial, I	ast name)	2 Soci	al security numbe	er (SSN)	7 Name of em	ployer				8 Emp	loyer identifica	ation number (EIN)		
Samantha		P Kinca	aid		8-XXX	K-XX-8832 Associates in Orthopedics and Sports Medicine PC							581388690			
3 Street address (9 Street addre	ss (including roo	m or suite no.)			10 Contact telephone number									
62 Brookwalk Drive							1104 Profe	essional Blv	b				7062265533			
4 City or town 5 State or province 6 Country and ZIP or foreign postal co						ign postal code	11 City or town		12 State or	orovince		13 Coun	try and ZIP or t	foreign postal code		
Chatsworth GA US 30705							Dalton GA US					US 30	0720-2588	}		
Part II Em	ployee Off	er of Cove	erage	•	Employee	's Age on .	January 1		Plan Sta	rt Month (e	nter 2-	digit nu	ligit 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														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.

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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.

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

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

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

JAMES E LASHLEY 708 Tee Top Dr Cohutta, GA 30710

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Employer-Provided Health Insurance Offer and Coverage

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 WW	w.irs.gov/Foi	m 1095C for in	structions ar	ia the latest in	normation.				- 1				
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	yer Memb	er (En	nploye	er)			
1 Name of employ	ee (first name,	middle initial,	last name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer				8 Empl	oyer identifica	tion number (EIN)		
JAMES		E LAS	HLEY		XXX-XX-79	962	Associates in Orthopedics and Sports Medicine PC						581388	690		
3 Street address (i	including apartr	ment no.)		•			9 Street addres	ss (including roor	n or suite no.)			10 Contact telephone number				
708 Tee Top I			1104 Profe	ssional Blvd				7062265533								
4 City or town 5 State or province 6 Country and ZIP or to						gn postal code	11 City or town		12 State or pr	rovince		13 Country and ZIP or foreign postal code				
Cohutta GA US 30710							Dalton GA						US 30720-2588			
Part II Emp	oloyee Offe	er of Cov	erage	•	Employee	s Age on c	January 1		Plan Star	t Month (er	nter 2-c	digit number): 01				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	C	Oct	Nov	Dec		
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																
17 ZIP Code				<u>l</u>										1005.0		

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Cat. No. 60705M

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Part III. Covered Individuals, Lines 18–30

Heidi Y Lazo 275 Valley Road Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

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.

20**23**

Internal Revenue Sei	rvice		GO to WWW	structions ar	ia the latest ir	ntormation.									
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (En	nploye	r)		
1 Name of employ	ee (first name, r	niddle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	ployer				8 Emplo	yer identifica	tion number (EIN)	
Heidi		Y Lazo			XXX-XX-26	635	Associates in Orthopedics and Sports Medicine PC						581388	690	
3 Street address (i	ncluding apartm	nent no.)					9 Street addre	ss (including roor	n or suite no.)			10 Contact telephone number			
275 Valley Ro	ad			1104 Profe	ssional Blvd				7062265533						
4 City or town 5 State or province 6 Country and ZIP or foreign postal or							11 City or town		12 State or p	province		13 Countr	y and ZIP or f	oreign postal code	
Chatsworth GA US 30705							Dalton		GA			US 30	720-2588	}	
Part II Employee Offer of Coverage US 30/05 Employee's Age							January 1		Plan Sta	rt Month (e	nter 2-d	digit number): 01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	0	oct	Nov	Dec	
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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

Asia M Long PO Box 373 Eton, GA 30724

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Part I

Employee

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

VOID

OMB No. 1545-2251

Treasury
Service

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

Applicable Large Employer Member (Employer)
e of employer
ciates in Orthopedics and Sports Medicine PC
t address (including room or suits no.)

10 Contact telephone number

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 identification			ion number (EIN)
Asia		M Long			XXX-XX-4	546	Associates	in Orthope	dics and Spo	orts Medicin	ie PC		5813886	590
3 Street address (including apart	ment no.)					9 Street addre	ss (including roo	m or suite no.)			10 Cont	act telephone r	number
PO Box 373							1104 Profe	essional Blvo	i				7062265	533
4 City or town		5 State or prov	ince	6 Counti	ry and ZIP or forei	ign postal code	11 City or town		12 State or pr	ovince	13 Country and ZIP or foreign p			reign postal code
Eton		GA		US 30	724		Dalton GA					US 30720-2588		
Part II Employee Offer of Coverage Er						's Age on	January 1		Plan Star	t Month (en	iter 2-c	digit nu	mber):	01
All 12 Months Jan Feb Mar Apr May					June	July	Aug	Sept	С	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	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														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.

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	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

Denisse D Lope 346 North Lakeshore Drive Tunnel Hill, GA 30755

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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	rvice		Go to www	irs.gov/For	<i>m10</i> 95C for in:	structions ar	nd the latest in	itormation.						
Part I Emp	oloyee						A	pplicable L	arge Emplo	yer Memb	er (Em	ploye	r)	
1 Name of employ	ee (first name, r	middle initial, la	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer				8 Emplo	oyer identifica	ation number (EIN)
Denisse		D Lope			XXX-XX-99	922	Associates in Orthopedics and Sports Medicine P					C 581388690		
3 Street address (i	ncluding apartn	nent no.)					9 Street addres	ss (including roor	n or suite no.)		1	10 Contact telephone number		
346 North Lak	eshore Dri	ve					1104 Profes	ssional Blvd				7062265533		
4 City or town	4 City or town 5 State or province 6 Country and ZIP or foreign						11 City or town		12 State or pr	ovince	1	3 Count	ry and ZIP or	foreign postal code
Tunnel Hill		GA		US 30)755		Dalton		GA		ι	JS 30	720-2588	3
Part II Employee Offer of Coverage Employee's Age o							January 1		Plan Star	t Month (er	ter 2-di	git nur	mber):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oc	ct	Nov	Dec
14 Offer of Coverage (enter required code)		1H	1H	1H	1H	1H	1H	1H	1H	1H	11	4	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	2A	2A	2/	Д	2D	
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).
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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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- 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	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

Elizabeth Lopez 121 Frontier Trail NW, Apt B Dalton, GA 30721

Form 1095- C
Department of the Treasury
Internal Davisaria Camilas

Employer-Provided Health Insurance Offer and Coverage

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

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

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VOID

OMB No. 1545-2251

2023

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Part I Emp	loyee						Aı	oplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employe	ee (first name,	middle initial, las	t name)	2 Social	security number	(SSN)	7 Name of emp	oloyer			8 Ei	mployer identit	ication number (EIN)	
Elizabeth		Lopez			XXX-XX-70	39	Associates	in Orthope	dics and Spo	orts Medicin	e PC	PC 581388690		
3 Street address (in	ncluding apartr	ment no.)					9 Street address (including room or suite no.)					10 Contact telephone number		
121 Frontier T	rail NW Ap	ot B					1104 Profe	ssional Blvo	t			70622	265533	
4 City or town		5 State or provir	nce	6 Country	and ZIP or foreig	n postal code	11 City or town		12 State or pr	ovince	13 Co	ountry and ZIP	or foreign postal code	
Dalton	GA US 30721						Dalton		GA		US	30720-25	38	
Part II Employee Offer of Coverage Employee's Age of							lanuary 1		Plan Star	t Month (en	ter 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	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 7IP Codo														

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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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.

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

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

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	(e) Months of coverage Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec											
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Barbara I Loveless 10653 Hwy 411 South Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

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

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) Barbara Loveless XXX-XX-3857 Associates in Orthopedics and Sports Medicine PC 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 10653 Hwy 411 South 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code GΑ Chatsworth US 30705 Dalton GA US 30720-2588 **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 1A 1A 1H 1H 1H 1H 1A 1A 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 code, if applicable) 2A 17 ZIP Code

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Monica Lugo 949 Dawnville Rd NE Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

OMB No. 1545-2251

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ORRECTED 2023

Internal Revenue Se	ervice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest in	itormation.							
Part I Emp	ployee						Aı	pplicable L	arge Emplo	oyer Memb	er (En	nploye	er)		
1 Name of employ	/ee (first name, i	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer				8 Empl	oyer identifica	tion number (EIN)	
Monica		Lugo			XXX-XX-50	025	Associates in Orthopedics and Sports Medicine PC					581388690			
3 Street address (i	including apartn	nent no.)		9 Street address (including room or suite no.) 10 Co							10 Contact telephone number				
949 Dawnville	Rd NE						1104 Profe	ssional Blvd	I				706226	5533	
4 City or town	:	5 State or prov	ince	6 Counti	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince		13 Count	try and ZIP or f	oreign postal code	
Dalton		GA		US 30	721		Dalton		GA			US 30	720-2588		
Part II Emp	ployee Offe	er of Cove	rage		Employee'	s Age on c	January 1		Plan Star	rt Month (en	ter 2-c	ligit nu	mber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	С	oct .	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)															
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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

Mackenzie A Mastin 635 Mount View Drive Tunnel Hill, GA 30755

Form	10	95 -	·U
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Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

○ CORRECTED

2023

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

Iternal 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.

internal Revenue Sei	rvice		GO TO WWW	.ii s.gov/roii	11110950 101 111	structions ar	iu tile latest il	normation.						
Part I Emp	oloyee						Aı	pplicable La	arge Emplo	yer Membe	r (Emp	oloyer)		
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	oloyer			8	Employer identific	ation number (EIN)	
Mackenzie		A Masti	n		XXX-XX-89	991	Associates in Orthopedics and Sports Medicine Po					581388690		
3 Street address (in	ncluding apartr	ment no.)		<u>'</u>			9 Street addres	ss (including roon	n or suite no.)		10	O Contact telephone	number	
635 Mount Vie	ew Drive						1104 Profe	ssional Blvd				706226	5533	
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 pro	ovince	13	3 Country and ZIP or	foreign postal code	
Tunnel Hill		GA		US 30	755		Dalton		GA		U	JS 30720-2588	3	
Part II Emp	loyee Off	er of Cove	rage	,	Employee'	s Age on c	January 1		Plan Star	t Month (ent	er 2-dig	git number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	t 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									No. 60705M				1095-C (2023)	

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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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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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).
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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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- **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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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
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- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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

Martha L McClure 355 Lower Dug Gap Rd SW Dalton, GA 30720

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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Internal Revenue Se	rvice		Go to www	v.irs.gov/Fo	<i>m10</i> 95C for ir	nstructions a	nd the latest i	information.							
Part I Emp	oloyee						A	Applicable I	arge Empl	oyer Memb	er (En	ploye	er)		
1 Name of employ	vee (first name, i	middle initial, la	ıst name)	2 Socia	al security numbe	er (SSN)	7 Name of em	nployer				8 Empl	oyer identifica	ation number (EIN)	
Martha		L McClu	ure		XXX-XX-6	111	Associates in Orthopedics and Sports Medicine PC						581388690		
3 Street address (i	including apartn	nent no.)					9 Street addre	ess (including roo	om or suite no.)			10 Contact telephone number			
355 Lower Du	ig Gap Rd	SW					1104 Profe	essional Blv	d				7062265533		
4 City or town		5 State or prov	rince	6 Count	ry and ZIP or fore	ign postal code	11 City or town	1	12 State or p	province		13 Count	ry and ZIP or f	foreign postal code	
Dalton GA US 30720						Dalton		GA			US 30	720-2588	3		
Part II Employee Offer of Coverage Employee's Age						's Age on	January 1		Plan Sta	rt Month (e	nter 2-c	ligit nu	git number): 01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	С	ct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	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														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-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

Chelsea T McKenzie 932 Hardwick Circle 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

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						Aı	pplicable La	arge Emplo	yer Memb	er (En	nploye	er)		
1 Name of employ	/ee (first name, r	niddle initial,	last name)	2 Socia	al security numbe	er (SSN)	7 Name of emp	oloyer				8 Empl	oyer identifica	ation number (EIN)	
Chelsea		T McK	Cenzie		XXX-XX-5	125	Associates	in Orthopeo	lics and Spo	orts Medicir	ne PC		581388	3690	
3 Street address (i	including apartm	nent no.)					9 Street addres	ss (including roor	n or suite no.)			10 Contact telephone number			
932 Hardwick	Circle						1104 Profes	ssional Blvd				7062265533			
4 City or town	į	5 State or pr	rovince	6 Count	ry and ZIP or forei	ZIP or foreign postal code 11 City or town 12 State or province					13 Coun	try and ZIP or f	foreign postal code		
Dalton		GA		US 30	720		Dalton								
Part II Employee Offer of Coverage Employee's Age of						's Age on .	January 1		Plan Star	t Month (er	nter 2-	digit nu	mber):	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	1	IA	1A	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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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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- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
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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.
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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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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

Autumn D Meadows 178 Thornton Road S Chatsworth, GA 30705

Form	095	5-C
Departm	ent of the	Treasury
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17 ZIP Code

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 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) Autumn D Meadows XXX-XX-0236 Associates in Orthopedics and Sports Medicine PC 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 178 Thornton Road S 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code GΑ Chatsworth US 30705 Dalton GA US 30720-2588 **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 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2A 2A 2A 2A 2A 2A 2A 2A 2A 2D code, if applicable) 2A

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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Part III. Covered Individuals, Lines 18–30

Aracely Mojica 665 Furnace Creek Rd LaFayette, GA 30728

Form 1095- C
Department of the Treasury
Internal Davisaria Camilas

17 ZIP Code

Employer-Provided Health Insurance Offer and Coverage

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

	OMB No. 1545-2251
X CORRECTED	2023

VOID

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) Associates in Orthopedics and Sports Medicine PC Aracely Moiica XXX-XX-5034 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 665 Furnace Creek Rd 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code GΑ LaFayette US 30728 Dalton GA US 30720-2588 **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 1H 1H 1H 1H 1H 1H 1H 1H 1A 1A 1A 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2A 2A 2A 2A 2A 2A 2D code, if applicable) 2A

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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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Part III. Covered Individuals, Lines 18–30

Jimena Morales 432 Sheridan Ave 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. Reep for your records.	
to www.irs.gov/Form1095C for instructions and the latest informati	^

Department of the I Internal Revenue Se			Go to www.i	rs.gov/Fo	rm1095C for in	structions a	nd the latest i	nformation.		<u></u>	11120122) 2 3		
Part I Emp	ployee						A	Applicable L	arge Empl	oyer Meml	er (Emp	loyer)			
1 Name of employ	yee (first name, r	middle initial, la	st name)	2 Soci	al security numbe	er (SSN)	7 Name of em	ployer			8	Employer identific	ation number (EIN)		
Jimena		Moral	es		XXX-XX-88	394	Associates	s in Orthope	dics and Sp	orts Medici	ne PC	PC 581388690			
3 Street address (including apartment no.)						9 Street addre	ess (including roc	om or suite no.)		10	10 Contact telephone number				
432 Sheridan Ave						1104 Profe	essional Blv	d			706226	5533			
4 City or town 5 State or province 6 Country and ZIP or foreign postal co			gn postal code	11 City or town	1	12 State or p	province	13	13 Country and ZIP or foreign postal code						
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Part II Emp	ployee Offe	er of Cove	rage	*	Employee	's Age on	January 1		Plan Sta	rt Month (e	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	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)		2A	2A	2A	2D			2B	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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- 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	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

Emily M Myers 1711 Hwy 52 Alt Chatsworth, GA 30705

OMB N. 4545 005

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Employer-Provided Health Insurance Offer and Coverage

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

	OMB No. 1545-2251
CORRECTED	2023

VOID

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) Associates in Orthopedics and Sports Medicine PC Emilv М Mvers XXX-XX-6252 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1104 Professional Blvd 7062265533 1711 Hwy 52 Alt 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 30720-2588 **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 1H 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2D code, if applicable) 17 ZIP Code

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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															
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Joy Nelson 353 Oakman Dr Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

RRECTED 20

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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 a	nd the latest i	ntormation.							
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Membe	er (En	nploy	er)		
1 Name of employ	vee (first name, n	niddle initial, las	t name)	2 Socia	l security numbe	r (SSN)	7 Name of em	ployer				8 Emp	loyer identificat	ion number (EIN)	
Joy		Nelsor	1		XXX-XX-38	315	Associates	in Orthoped	dics and Spo	orts Medicin	e PC		581388	690	
3 Street address (i	3 Street address (including apartment no.)						9 Street addre	ess (including roor	n or suite no.)			10 Contact telephone number			
353 Oakman	Dr						1104 Profe	essional Blvd	I				7062265	533	
4 City or town	5	State or provin	nce	6 Countr	y and ZIP or forei	gn postal code	11 City or town	l	12 State or pr	ovince		13 Coun	itry and ZIP or fo	oreign postal code	
Chatsworth	(GA		US 30	705		Dalton		GA			US 30	0720-2588		
Part II Emp	oloyee Offe	r of Cover	age		Employee'	s Age on	January 1		Plan Star	t Month (en	ter 2-c	ligit nu	ımber):	01	
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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	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

Taylor M Newsom 2821 Haywood Avenue Chattanooga, TN 37415

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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 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) Associates in Orthopedics and Sports Medicine PC Taylor М Newsom XXX-XX-9236 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 2821 Haywood Avenue 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code Chattanooga TN US 37415 Dalton GA US 30720-2588 **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 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).

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.
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- 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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Part III. Covered Individuals, Lines 18–30

LINDA NICHOLS 34 Singer Trail 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.

CORRECT

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

OMB No. 1545-2251

CORRECTED

2023

Internal Revenue Sei	rvice		GO tO WW	w.irs.gov/roi	11110950 101 11	istructions a	ina the latest i	mormation.				- 1	_ ~	
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	er (Er	nploy	er)	
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 Emp	loyer identifica	tion number (EIN)
LINDA		NICH	OLS		XXX-XX-7	961	Associates	in Orthope	dics and Sp	orts Medici	ne PC		581388	690
3 Street address (i	ncluding apartr	ment no.)		•			9 Street addre	ess (including roo	m or suite no.)			10 Cont	act telephone	number
34 Singer Trai	il						1104 Profe	essional Blvd	k				7062265	5533
4 City or town		5 State or prov	rince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or p	province		13 Coun	try and ZIP or fo	oreign postal code
Ringgold		GA		US 30	0736		Dalton		GA			US 30	0720-2588	
Part II Emp	oloyee Off	er of Cove	rage		Employee	's Age on	January 1		Plan Sta	rt Month (e	nter 2-	digit nu	mber):	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									Na COZOFM					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.
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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
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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

Danya T Nieto 413 Griggs 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.

VOID

OMB No. 1545-2251

Internal Revenue Se	ervice		Go to ww	w.irs.gov/Fo	<i>rm10</i> 95C for in	structions a	and the latest information.								
Part I Em	ployee						Applicable Large Employer Member (Empl								
1 Name of employ	yee (first name,	middle initial, I	ast name)	2 Soci	ial security numbe	r (SSN)	7 Name of employer					8 Employer identification number (EIN			
Danya		T Nieto)		XXX-XX-61	112	Associates	s in Orthope	dics and Spo	orts Medici	ne PC	581388690			
3 Street address	(including apartr	ment no.)					9 Street address (including room or suite no.)					10 Contact telephone number			
413 Griggs D	rive						1104 Professional Blvd					7062265533			
4 City or town		5 State or pro	vince	6 Coun	6 Country and ZIP or foreign postal code			1	12 State or pr	12 State or province			or foreign postal code		
Dalton		GA		US 3	Dalton GA			GA		US	30720-25	88			
Part II Employee Offer of Coverage Employee's Age of						's Age on	January 1 Plan Start Month (enter 2			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	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.

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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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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

JOHN NORMAN 1818 Wood Valley Dr Dalton, GA 30720

OMB No. 1545-2251

Form	109:	5-C
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Employer-Provided Health Insurance Offer and Coverage

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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) Associates in Orthopedics and Sports Medicine PC **JOHN** NORMAN XXX-XX-1956 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1818 Wood Valley Dr 1104 Professional Blvd 7062265533 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 30720-2588 **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 May June July Sept Nov 14 Offer of Coverage (enter 1A 1A 1A 1A 1A 1A 1A required code) 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.



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Part III. Covered Individuals, Lines 18–30

Isabel Nunez 1005 Winnwood Drive Dalton, GA 30721

Form	1	095-C	
		ent of the Treasury	,

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 Ser	rvice		Go to www	irs.gov/Fort	m1095C for ins	structions an	id the latest in	formation.							
Part I Emp	loyee						A	oplicable L	arge Emplo	yer Memb	er (Emplo	yer)			
1 Name of employe	ee (first name,	middle initial, las	t name)	2 Socia	I security number	(SSN)	7 Name of emp	loyer	8 En	Employer identification number (EIN)					
Isabel		Nunez			XXX-XX-54	35	Associates in Orthopedics and Sports Medicine PC					581388690			
3 Street address (in	ncluding apartr	ment no.)		•			9 Street address (including room or suite no.) 10 0					Contact telephone number			
1005 Winnwoo	od Drive						1104 Professional Blvd					7062265533			
4 City or town		5 State or provin	ice	6 Countr	6 Country and ZIP or foreign postal code				12 State or pr	ovince	13 Co	Country and ZIP or foreign postal cod			
Dalton		GA		US 30	US 30721				GA		US	30720-2588			
Part II Employee Offer of Coverage Employee's Age							January 1 Plan Start Month (ente			ter 2-digit ı	r 2-digit number): 01				
						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															

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Cat. No. 60705M

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Joseph Ogden 85 Swinging Bridge Lane Ringgold, GA 30736

OMB No. 1545-2251

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Employer-Provided Health Insurance Offer and Coverage

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CORRECTED 2023

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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) Associates in Orthopedics and Sports Medicine PC Joseph Oaden XXX-XX-3188 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 85 Swinging Bridge Lane 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code GΑ Ringgold US 30736 Dalton GA US 30720-2588 **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

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.

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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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- **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.
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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					Oct Nov [
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Gracie M Ogle 361 Wilson Loop Cohutta, GA 30710

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

Internal Revenue Se	rvice		GO to www	v.irs.gov/For	m 1095C for in	structions ar	na the latest in	itormation.								
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	yer Memb	er (Em	ploye	er)			
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer				8 Empl	oyer identifica	tion number (EIN)		
Gracie		M Ogle			XXX-XX-13	368	Associates in Orthopedics and Sports Medicine PC						581388690			
3 Street address (i	including apartr	ment no.)					9 Street addres	ss (including roor	m or suite no.)			10 Contact telephone number				
361 Wilson Lo	361 Wilson Loop							ssional Blvd	i			7062265533				
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 Count	ry and ZIP or f	oreign postal code		
Cohutta GA					30710 Dalton				GA			US 30720-2588				
Part II Employee Offer of Coverage Employee's Age							January 1		Plan Star	t Month (er	nter 2-d	digit number): 01				
	All 12 Months	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	1H	1H	1H	1	Н	1H	1H		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$		
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Samantha L Patrick 1737 Quinton Rd Rocky Face, GA 30740

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○ CORRECTED

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OMB No. 1545-2251

Department of the Treasury
Internal Revenue Service

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Internal Revenue Se	rvice		Go to ww	w.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest in	nformation.		4					
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	yer Memb	er (Em	ploye	er)		
1 Name of employ	vee (first name, i	middle initial,	last name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer				8 Emplo	oyer identifica	tion number (EIN)	
Samantha		L Patri	ick		XXX-XX-3	XXX-XX-3553 Associates in Orthopedics and Sports Medicine PC						581388690			
3 Street address (i	including apartn	nent no.)					9 Street addres	ss (including roor	n or suite no.)			10 Contact telephone number			
1737 Quinton	1737 Quinton Rd							ssional Blvd				7062265533			
4 City or town 5 State or province					ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	rovince		13 Count	ry and ZIP or t	oreign postal code	
					0740		Dalton		GA			US 30	720-2588	}	
						s Age on c	January 1		Plan Star	t Month (en	ter 2-d	igit nur	mber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	0	ct	Nov	Dec	
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17 ZIP Code									N. 00705M					1005 C (2000)	

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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.

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					Oct Nov [
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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

ALLISON L PEEK 301 Cardinal Lane 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. 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) Associates in Orthopedics and Sports Medicine PC ALLISON PEEK XXX-XX-3707 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1104 Professional Blvd 7062265533 301 Cardinal Lane 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 US 30721 GA Dalton GA US 30720-2588 Dalton Part II **Employee Offer of Coverage 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

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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- 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	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

Aubrie M Price 652 Jim Petty Rd 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.

	OMB No. 1545-2251
CORRECTED	2023

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

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Part I Emp	oloyee						A	pplicable La	arge Emplo	yer Membe	er (Emp	loyer)	
1 Name of employ	ee (first name,	middle initial, la	ast name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	oloyer			8	Employer identifica	tion number (EIN)
Aubrie		M Price			XXX-XX-4	428	Associates	in Orthopeo	lics and Spo	orts Medicin	e PC	581388	690
3 Street address (i	including apart	ment no.)		•			9 Street addres	ss (including roor	n or suite no.)		10	Contact telephone	number
652 Jim Petty	Rd						1104 Profe	ssional Blvd				706226	5533
4 City or town		5 State or prov	/ince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pro	ovince	13	Country and ZIP or t	oreign postal code
Crandall		GA		US 30	0711		Dalton		GA		U	S 30720-2588	
Part II Emp	oloyee Off	er of Cove	rage		Employee ³	's Age on c	January 1		Plan Star	t Month (en	ter 2-dig	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	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
17 ZIP Code													1005 0

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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.

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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	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

Donna Ratcliff 898 Busted Rock Road Old Fort, TN 37362

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Employer-Provided Health Insurance Offer and Coverage

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

○ CORRECTED

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OMB No. 1545-2251

2023

Internal Revenue Service Go to www.irs.gov/Form1095C for instructions and the latest information.) 2 3					
Part I Emp	oloyee						A	pplicable L	arge Emplo	yer Memb	er (Empl	oyer)		
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Soci	ial security number	r (SSN)	7 Name of em	ıployer			8 E	mployer identific	ation number (EIN)	
Donna		Ratclif	f		XXX-XX-74	194	Associates	s in Orthope	dics and Spo	orts Medicii	ne PC	581388690		
3 Street address (i	including apartr	ment no.)					9 Street addre	ess (including roc	m or suite no.)		10 (Contact telephone number		
898 Busted R	ock Road						1104 Profe	essional Blv	b			706226	55533	
4 City or town		5 State or provi	ince	6 Count	try and ZIP or forei	gn postal code	11 City or town		12 State or pr	12 State or province		13 Country and ZIP or foreign post		
Old Fort TN US 37362						Dalton GA U					S 30720-2588			
Part II Employee Offer of Coverage Employee's A						s Age on .	January 1 Plan Start Month (enter 2-dig					igit 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

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Part I. Applicable Large Employer Member (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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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	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

DALE N REED 25 TURRENTINE DR Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

OMB No. 1545-2251

TED 202

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

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

Internal Revenue Sei	rvice		GO TO WW	/w.irs.gov/Foi	miugoc for in	istructions a	and the latest i	ntormation.						
Part I Emp	oloyee						A	pplicable L	arge Emp	loyer Memb	er (Er	nploy	er)	
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 Emp	loyer identifica	tion number (EIN)
DALE		N REED)		XXX-XX-6	349	Associates	in Orthope	dics and Sp	oorts Medici	ne PC		581388	690
3 Street address (in	ncluding apartm	nent no.)					9 Street addre	ess (including roo	m or suite no.)			10 Cont	tact telephone	number
25 TURRENT	INE DR						1104 Profe	essional Blvo	b				706226	5533
4 City or town	5	5 State or prov	rince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or p	province		13 Cour	itry and ZIP or f	oreign postal code
Dalton	-	GA		US 30	0720		Dalton		GA			US 30	0720-2588	}
Part II Emp	loyee Offe	er of Cove	rage		Employee	's Age on	January 1		Plan Sta	rt Month (e	nter 2-	digit nu	ımber):	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														1095-C (2022

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

Bethany C Reese 304 Asbury Drive Chattanooga, TN 37411

Form 1095	- C
Department of the Ti	reasury
Internal Revenue Ser	vice

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

OMB No. 1545-2251

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

internal Revenue Sei	vice		GO TO WW	w.ii s.gov/roi	11110950 101 111	1511 46110115 6	iliu tile latest li	mormation.						
Part I Emp	loyee						Α	pplicable L	arge Empl	oyer Memb	er (Er	nploy	er)	
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 Emp	loyer identifica	tion number (EIN)
Bethany		C Reese)		XXX-XX-7	408	Associates	in Orthoped	dics and Sp	orts Medicir	ne PC		581388	690
3 Street address (in	ncluding apartn	nent no.)		•			9 Street addre	ess (including roor	n or suite no.)			10 Cont	act telephone	number
304 Asbury Di	rive						1104 Profe	essional Blvd	I				7062265	5533
4 City or town		5 State or provi	ince	6 Count	ry and ZIP or forei	ign postal code	11 City or town		12 State or p	rovince		13 Cour	itry and ZIP or f	oreign postal code
Chattanooga		TN		US 37	7411		Dalton		GA			US 30	0720-2588	
Part II Emp	loyee Offe	er of Cove	rage	·	Employee	's Age on	January 1		Plan Star	rt Month (er	nter 2-	digit nu	ımber):	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														1005 C (2000)

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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-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	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

Cristian G Reyes-Gatica 1884 South Boyd Drive Rocky Face, GA 37040

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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
○ CORRECTED	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) Associates in Orthopedics and Sports Medicine PC Cristian G Reves-Gatica XXX-XX-7804 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1884 South Boyd Drive 1104 Professional Blvd 7062265533 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 Rocky Face US 37040 Dalton GA US 30720-2588 **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 1H 1H 1A 1A 1A 1A 1A 1A 1H required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 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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Lines 1-6. Part I, lines 1 through 6, reports information about you, the employee.

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

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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.
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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	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										Oct	t Nov Dec		
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Part III. Covered Individuals, Lines 18–30

SAMATHA R ROBERTS 6557 HWY 225 South Chatsworth, GA 30705

OMB No. 1545-2251

2023

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Employer-Provided Health Insurance Offer and Coverage

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

CORRECTED 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) **SAMATHA** R ROBERTS XXX-XX-1639 Associates in Orthopedics and Sports Medicine PC 581388690 9 Street address (including room or suite no.) 3 Street address (including apartment no.) 10 Contact telephone number 6557 HWY 225 South 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code GΑ Chatsworth US 30705 Dalton GA US 30720-2588 **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

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Part III. Covered Individuals, Lines 18–30

Frida Rodriguez 126 South Adelia Dr Dalton, GA 30721

OMB No. 1545-2251

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Employer-Provided Health Insurance Offer and Coverage

CORRECTED

VOID

2023

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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) Frida Rodriauez XXX-XX-6099 Associates in Orthopedics and Sports Medicine PC 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1104 Professional Blvd 7062265533 126 South Adelia Dr 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code GΑ Dalton US 30721 Dalton GA US 30720-2588 **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 1H 1H 1H 1A 1H 1A 1A 1A 1A 1A 1A 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2D 2A 2A code, if applicable) 2A 17 ZIP Code

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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).
- 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

Ana J Romero 813 Red Clay, Apt 1 Dalton, GA 30721

OMB No. 1545-2251

Form	1(<u>09</u>	 5 -	·C
Depar	tmer	nt of th	ne Tre	asury
Interna	al Re	Weni i	Serv	ice

Employer-Provided Health Insurance Offer and Coverage

Do not attach to your tax return. Keep for your records.	X CORRECTE
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	oyer Memb	er (Er	nploye	er)		
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer				8 Emp	loyer identificat	tion number (EIN)	
Ana		J Rome	ro		XXX-XX-38	395	Associates in Orthopedics and Sports Medicine Po						581388	690	
3 Street address (i	ncluding apart	ment no.)		•			9 Street addre	ss (including roor	n or suite no.)			10 Contact telephone number			
813 Red Clay	Apt 1						1104 Profe	essional Blvd				7062265533			
4 City or town 5 State or province 6 Country and ZIP or foreign postal coordinates to the country and ZIP or foreign postal country and ZI						gn postal code	11 City or town		12 State or p	rovince		13 Coun	try and ZIP or fo	oreign postal code	
Dalton		GA		US 30	721		Dalton GA				US 30720-2588				
Part II Emp	oloyee Off	er of Cove	rage	<u>'</u>	Employee ³	s Age on	January 1		Plan Star	rt Month (er	nter 2-	digit nu	mber):	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															

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

Cat. No. 60705M

VOID

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)

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

ANNA A Ruddell 3685 Kingsport Drive Dalton, GA 30721

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Intoun.	al Day			_

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 www	.irs.gov/For	<i>m10</i> 95C for ins	structions ar	nd the latest i								
Part I Em	ployee							A	Applicable L	arge Emplo	yer Memb	er (Emplo	oyer)			
1 Name of employ	yee (first name,	middle in	itial, last	name)	2 Socia	al security number	r (SSN)	7 Name of em	ployer			8 E	mployer identifica	ation number (EIN)		
ANNA		A R	Ruddell	l		XXX-XX-18	342	Associates	s in Orthope	dics and Spo	orts Medicir	ie PC	581388690			
3 Street address (including apartr	ment no.)			•			9 Street addre	ess (including roo	m or suite no.)		10 C	10 Contact telephone number			
3685 Kingspo	ort Drive							1104 Profe	essional Blv	d			7062265533			
4 City or town		5 State of	or provinc	се	6 Counti	ry and ZIP or forei	gn postal code	11 City or town	1	12 State or pr	ovince	13 C	13 Country and ZIP or foreign postal code			
Dalton GA US 30721							Dalton		GA		US	US 30720-2588				
Part II Employee Offer of Coverage Employee's Age							s Age on .	January 1		ter 2-digit	number):	01				
	All 12 Months Jan Feb Mar					Apr	May	June	July	July Aug Sept		Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1	Α	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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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

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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
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- 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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- 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.

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

TRACI SAYLORS 417 McAfee Circle Ranger, GA 30734

OMB No. 1545-2251

Form	10	95	- 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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VOID

Go to www.irs.gov/Form1095C for instructions and the latest information. Applicable Large Employer Member (Employer) Employee Part I 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Associates in Orthopedics and Sports Medicine PC **TRACI SAYLORS** XXX-XX-5669 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 417 McAfee Circle 1104 Professional Blvd 7062265533 13 Country and ZIP or foreign postal code 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province

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Ranger				US 30	734		Dalton		GA		US 3	US 30720-2588			
Part II Emp	oloyee Offe	r of Cover	age		Employee'	s Age on J	lanuary 1		Plan Star	t Month (en	ter 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	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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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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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, Lines 18–30

Stephanie Scott 1020 Haven Drive Dalton, GA 30721

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Employer-Provided Health Insurance Offer and Coverage

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.

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Part I Emp	oloyee						A	pplicable L	arge Empl	oyer Memb	er (Er	nploy	er)		
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 Emp	loyer identifica	tion number (EIN)	
Stephanie		Scott			XXX-XX-6	158	Associates	Associates in Orthopedics and Sports Medicine PC 5							
3 Street address (i	ncluding apartn	nent no.)		•			9 Street addre	ess (including roo	m or suite no.)			10 Contact telephone number			
1020 Haven D	Orive						1104 Profe	essional Blvd	ł				7062265	5533	
4 City or town	:	5 State or prov	rince	6 Count	ry and ZIP or fore	ign postal code	11 City or town	ı	12 State or p	province		13 Coun	try and ZIP or fo	oreign postal code	
Dalton		GA		US 30	0721		Dalton		GA			US 30	0720-2588		
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee	's Age on	January 1		Plan Sta	rt Month (e	nter 2-	digit nu	mber):	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									No. COZOEM					1005 C (2000	

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Page 4

Form 1095-C (2023)

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Britani F Silvers 880 Norton Bridge Road Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

OMB No. 1545-2251

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vee (first name, i	middle initial, las	st name)	2 Socia	l security number	r (SSN)	7 Name of emp	ployer				8 Emp	loyer identificat	ion number (EIN)	
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ridge Road						1104 Profe	ssional Blvd					7062265	5533	
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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.
- 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

Kenlee J Slaton 621 Pine Oaks Drive 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.

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OMB No. 1545-2251

Internal Revenue Se	ervice		GO LO WII	w.irs.gov/ro	111110936 101 1	nstructions at	iu tile latest i	mormation.							
Part I Em	ployee						Α	Applicable L	arge Empl	oyer Memb	er (Em	ploye	er)		
1 Name of employ	yee (first name,	middle initial,	last name)	2 Soci	al security numb	oer (SSN)	7 Name of em	nployer				8 Empl	loyer identificati	ion number (EIN)	
Kenlee		J Slate	n		XXX-XX-6	5993	Associates	s in Orthoped	dics and Sp	orts Medicin	e PC		5813886	590	
3 Street address (including apart	ment no.)		•			9 Street addre	9 Street address (including room or suite no.)						umber	
621 Pine Oak	ks Drive						1104 Profe	essional Blvd	i				7062265	533	
4 City or town		5 State or pro	ovince	6 Count	try and ZIP or for	eign postal code	11 City or town	1	12 State or p	12 State or province			13 Country and ZIP or foreign postal co		
Tunnel Hill		GA		US 30	0755		Dalton GA				US 30720-2588				
Part II Em	ployee Off	er of Cove	erage		Employee	ployee's Age on January 1 Plan Start Month (enter 2-						-digit number): 01			
	All 12 Months Jan Feb					May	June	July	Aug	Sept	0	Oct Nov		Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	100			1.	A	1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													2B	2A	
17 ZIP Code	7 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.
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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

Bonnie E Sluder 394 Piney Hill Rd Chatsworth, GA 30705

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Employer-Provided Health Insurance Offer and Coverage

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	m1095C for in	istructions ar	nd the latest ir	ntormation.							
Part I Emp	oloyee						Α	pplicable La	arge Emplo	yer Memb	er (En	nploy	er)		
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of emp	oloyer				8 Emp	loyer identifica	tion number (EIN)	
Bonnie		E Slude	r		XXX-XX-40	015	Associates	in Orthopeo	lics and Spo	orts Medicii	ne PC		581388	690	
3 Street address (i	ncluding apartn	nent no.)					9 Street addres	ss (including roor	n or suite no.)			10 Contact telephone number			
394 Piney Hill	Rd						1104 Profe	ssional Blvd					706226	5533	
4 City or town	:	5 State or prov	rince	6 Count	ry and ZIP or forei	ign postal code	11 City or town		12 State or pr	rovince		13 Country and ZIP or foreign postal code			
Chatsworth		GA		US 30	705		Dalton		GA			US 30	0720-2588		
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee	's Age on .	January 1		Plan Star	t Month (e	nter 2-c	digit nu	mber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	C	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1H	1H	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)		2A	2D												
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.

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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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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).
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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

MISTY N SMALL 502 PEDEN RD Crandall, GA 30711

OMB No. 1545-2251

2023

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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.

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) **MISTY** Ν SMALL XXX-XX-6343 Associates in Orthopedics and Sports Medicine PC 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 502 PEDEN RD 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code Crandall GA US 30711 Dalton GA US 30720-2588 **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 1H 1H 1H 1H 1A 1A 1A 1A required code) 15 Employee Required Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2A 2A 2A 2A 2A 2A 2D code, if applicable) 2A 17 ZIP Code

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

Cat. No. 60705M

VOID

Instructions for Recipient

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- 1Y. Reserved for future use.
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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	(e) Months of coverage Feb Mar Apr May June July Aug Sept Oct Nov I										Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Kristine A Smith 895 E Summit Drive, Unit 18 Dalton, GA 30721

Form	10)95 .	-C
		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 Ser	vice		Go to www	.irs.gov/Forr	m1095C for ins	structions ar	nd the latest in	nformation.								
Part I Emp	loyee					·	Α	pplicable L	er (Emplo	yer)						
1 Name of employe	ee (first name,	middle initial, las	t name)	2 Social	l security number	(SSN)	7 Name of emp	oloyer			8 Er	nployer identif	ication number (EIN)			
Kristine		A Smith			XXX-XX-98	371	Associates	in Orthope	ne PC	581388690						
3 Street address (in	ncluding apartr	ment no.)					9 Street addres	ss (including roo	10 Cd	Contact telephone number						
895 E Summit	Drive Unit	t 18					1104 Profe	ssional Blv		7062265533						
4 City or town		5 State or provin	nce	6 Country	6 Country and ZIP or foreign postal code				12 State or pr	ovince	13 Co	ountry and ZIP or foreign postal code				
Dalton		GA		US 30	US 30721				GA		US	30720-2588				
Part II Emp	Part II Employee Offer of Coverage Employee's Ag						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

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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	(e) Months of coverage Feb Mar Apr May June July Aug Sept Oct Nov I										Dec
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Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Regina Storey 217 Dublin Drive SE Calhoun, GA 30701

Form 1095- C
Department of the Treasury
Internal Davisaria Camilas

17 ZIP Code

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) Associates in Orthopedics and Sports Medicine PC Regina Storev XXX-XX-1933 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 217 Dublin Drive SE 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code GΑ Calhoun US 30701 Dalton GA US 30720-2588 **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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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

Maria G Tardie 633 Richardson Street Dalton, GA 30720

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Employer-Provided Health Insurance Offer and Coverage

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 (Er	nploy	er)	
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of emp	ployer				8 Emp	loyer identificat	tion number (EIN)
Maria		G Tardie	<u> </u>		XXX-XX-20)17	Associates	in Orthoped	dics and Sp	orts Medicir	ne PC		581388	690
3 Street address (i	ncluding apart	ment no.)					9 Street addre	ss (including roor	n or suite no.)			10 Con	tact telephone	number
633 Richardso	on Street						1104 Profe	essional Blvd	I				7062265	5533
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or p	rovince		13 Cour	itry and ZIP or fo	oreign postal code
Dalton		GA		US 30	0720		Dalton		GA			US 30	0720-2588	
Part II Emp	oloyee Off	er of Cove	rage	•	Employee'	s Age on	January 1		Plan Star	rt Month (er	nter 2-	digit nu	ımber):	01
	All 12 Months	s 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)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2A	2A	2A	2A	2A	2A	2A	2A	2A	2	2 A	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

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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 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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- **1E.** Minimum essential coverage providing minimum value offered to you and minimum essential coverage offered to your dependent(s) and spouse.
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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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- 11. Reserved for future use.
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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) 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

Ashlyn H Thornton 208 Doubletree Drive Calhoun, GA 30701

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

OMB No. 1545-2251

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

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Part I Emp	oloyee						A	pplicable La	arge Emplo	yer Memb	er (Er	nploye	er)			
1 Name of employ	ee (first name,	middle initial, la	st name)	2 Socia	al security numbe	r (SSN)	7 Name of em	ployer				8 Emp	loyer identifica	tion number (EIN)		
Ashlyn		H Thorn	ton		XXX-XX-86	598	Associates in Orthopedics and Sports Medicine Po						581388690			
3 Street address (i	including apart	ment no.)					9 Street addre	ss (including roor	n or suite no.)			10 Cont	act telephone	number		
208 Doubletre	ee Drive						1104 Profe	ssional Blvd					706226	5533		
4 City or town		5 State or prov	ince	6 Count	ry and ZIP or forei	gn postal code	11 City or town		12 State or pr	ovince		13 Coun	try and ZIP or f	oreign postal code		
Calhoun		GA		US 30	US 30701			Dalton		GA			US 30720-2588			
Part II Emp	oloyee Off	er of Cove	rage	'	Employee'	s Age on	January 1		Plan Star	t Month (en	ter 2-	digit nu	ımber):	01		
	All 12 Month	s 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														1005 0 (2000		

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Cat. No. 60705M

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

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)

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Part III. Covered Individuals, Lines 18–30

THIERRY URBAIN 113 Davidson Dr Dalton, GA 30720

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.

VOID

Internal Revenue Se	rvice		GO TO WI	ww.irs.gov	/Form it	J95C for in	structions an	a the latest in	formation.								
Part I Emp	oloyee							Ap	pplicable La	arge Emplo	yer Membe	r (Em	ploye	er)			
1 Name of employ	ee (first name,	middle initial,	last name)	2	Social sec	curity number	r (SSN)	7 Name of emp	loyer			ε	B Empl	loyer identificat	ion number (EIN)		
THIERRY		URE	BAIN		X	XX-XX-72	256	Associates in Orthopedics and Sports Medicine PC 58							581388690		
3 Street address (including apartment no.)								9 Street addres	s (including roon	n or suite no.)		1	0 Cont	act telephone r	number		
113 Davidson	13 Davidson Dr							1104 Profes	ssional Blvd				7062265533				
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 pro	ovince	10	13 Country and ZIP or foreign postal code					
Dalton GA US 30720							Dalton		GA		lι	JS 30	0720-2588				
Part II Emp	oloyee Off	er of Cov	erage		Er	nployee'	s Age on J	lanuary 1		Plan Star	t Month (ent	ter 2-di	2-digit number): 01				
	All 12 Months	Jan	Feb	Ma	ar	Apr	May	June	July	Aug	Sept	Ос	t	Nov	Dec		
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15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$		\$	\$	\$	\$	\$	\$		\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																	
17 ZIP Code																	
															400E O		

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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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- **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.
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

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.

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

Lizabeth Valdez 679 Buck Blvd SE Calhoun, GA 30701

Form	10	95	-C
Depar	tment	of the T	reasury

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	m 1095C for in	structions ar	na the latest in	itormation.						
Part I Emp	oloyee						Aı	pplicable La	arge Emplo	yer Memb	er (En	nploye	er)	
1 Name of employ	/ee (first name, r	middle initial, la	ıst name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	oloyer				8 Empl	oyer identifica	tion number (EIN)
Lizabeth		Valde	z		XXX-XX-85	597	Associates in Orthopedics and Sports Medicine P					581388690		
3 Street address (i	including apartm	nent no.)		•			9 Street address (including room or suite no.)					10 Contact telephone number		
679 Buck Blvd	d SE						1104 Professional Blvd					7062265533		
4 City or town	į	5 State or prov	rince	6 Countr	6 Country and ZIP or foreign postal code		11 City or town		12 State or province			13 Country and ZIP or foreign postal code		
Calhoun GA US 30701						Dalton		GA			US 30720-2588			
Part II Employee Offer of Coverage Employee's Age of					s Age on c	January 1		Plan Star	t Month (er	nter 2-c	digit number): 01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	C	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	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														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.

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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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- 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	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

Yensy C Valle 4100 Sydney Circle 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

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	C Valle			XXX-XX-8332 Associates in Orthopedics and Sports Medicine					ie PC	PC 581388690				
ncluding apartr	ment no.)					9 Street address (including room or suite no.)					10 Contact telephone number			
Circle						1104 Professional Blvd					7062265533			
	5 State or provi	nce	6 Count	ry and ZIP or foreig	11 City or town		12 State or pr	ovince	13 Co	untry and ZIP o	r foreign postal code			
Dalton GA)721	Dalton		GA		US	30720-258	88			
Part II Employee Offer of Coverage Employee's Age						lanuary 1		Plan Star	t Month (en	ter 2-digit ı	digit number): 01			
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
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For Privacy Act and Paperwork Reduction Act Notice, see separate instructions.

Cat. No. 60705M

Instructions for Recipient

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- 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	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

KRISTIE A WHALEY 1059 Good Hope Rd 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.

CORRECTED

VOID

OMB No. 1545-2251

2023

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) **KRISTIE** Α WHALEY XXX-XX-1072 Associates in Orthopedics and Sports Medicine PC 581388690 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 1059 Good Hope Rd NE 1104 Professional Blvd 7062265533 11 City or town 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 12 State or province 13 Country and ZIP or foreign postal code Dalton GA US 30721 Dalton GA US 30720-2588 **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

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	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)

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Part III. Covered Individuals, Lines 18–30

Associates in Orthopedics and Sports Medicine PC 1104 Professional Blvd Dalton, GA 30720-2588

MICHAEL WILSON 390 Castle Road Dalton, GA 30720

OMB No. 1545-2251

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Departm	ent 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

Internal Revenue Se	rvice		Go to www	v.irs.gov/Fo	<i>m10</i> 95C for in	structions ar	nd the latest ir	nformation.					4			
Part I Emp	oloyee						Applicable Large Employer Member (Employer)						er)			
1 Name of employ	vee (first name, i	middle initial, la	ast name)	2 Socia	al security numbe	er (SSN)	7 Name of emp	oloyer				8 Empl	oyer identifica	tion number (EIN)		
MICHAEL		WILS	ON		XXX-XX-7	483	Associates in Orthopedics and Sports Medicine PC						581388690			
3 Street address (i	including apartn	ment no.)		<u>'</u>			9 Street addres	ss (including roo	m or suite no.)			10 Contact telephone number				
390 Castle Ro	390 Castle Road							ssional Blvd	I			7062265533				
4 City or town 5 State or province			6 Count	ry and ZIP or fore	gn postal code	11 City or town		12 State or p	rovince		13 Count	try and ZIP or	oreign postal code			
Dalton		GA US 30720					Dalton		GA			US 30	JS 30720-2588			
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee	's Age on c	January 1		Plan Star	rt Month (en	ter 2-c	ligit nu	mber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	С	oct	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									No. 60705M					1095-0 (2022)		

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

Cat. No. 60705M

Form **1095-C** (2023)

Instructions for Recipient

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

(continued on page 4)

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

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 13 covered individuals, additional copies of page 3 may be used.

Associates in Orthopedics and Sports Medicine PC 1104 Professional Blvd Dalton, GA 30720-2588

Stacy L Womac 4402 Panorama Dr 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.

Keep for your records.

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Go to v	vww.irs.gov/For	m1095C for	instructions and	the latest	information

CORRECTED 2023

Internal Revenue Se	ervice		Go to www	.irs.gov/For	<i>m10</i> 95C for in	structions an	id the latest in	itormation.							
Part I Emp	oloyee						Aı	pplicable L	arge Emplo	yer Memb	er (Em	ploye	r)		
1 Name of employ	/ee (first name, mi	ddle initial, la	st name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	oloyer				8 Emplo	yer identifica	tion number (EIN)	
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3 Street address (i	including apartme	nt no.)		'			9 Street address	ss (including roor	n or suite no.)			10 Conta	ct telephone	number	
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4 City or town	4 City or town 5 State or province					gn postal code	11 City or town		12 State or pr	ovince	1	13 Countr	y and ZIP or f	oreign postal code	
Cohutta GA					710		Dalton		GA			US 30	720-2588	}	
Part II Emp	oloyee Offer	of Cove	rage		Employee'	s Age on J	January 1		Plan Star	t Month (en	ter 2-d	igit nur	nber):	01	
	All 12 Months	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.	Α	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	9	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			A at Nation on											100F C (2000)	

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

Cat. No. 60705M

Form **1095-C** (2023)

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.

(continued on page 4)

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

Part III reports the name, SSN (or TIN for covered individuals other than the employee listed in Part I), and coverage information about each individual (including any full-time employee and non-full-time employee, and any employee's family members) covered under the employer's health plan, if the plan is "self-insured." A date of birth will be entered in column (c) only if an SSN (or TIN for covered individuals other than the employee listed in Part I) is not entered in column (b). Column (d) will be checked if the individual was covered for at least one day in every month of the year. For individuals who were covered for some but not all months, information will be entered in column (e) indicating the months for which these individuals were covered. If there are more than 13 covered individuals, additional copies of page 3 may be used.