Danielle Marie Benge 4386 W 625 S West Point, UT 84015

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OMB No. 1545-2251

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

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

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Part I Em	ployee									Ap	plicable La	arge Emplo	yer Membe	er (E	mploy	er)	
1 Name of employ	ee (first name,	middl	e initial, last	t name)		2 Social	security num	ber (SSN)	7	7 Name of emp	loyer				8 Emp	loyer identificat	tion number (EIN)
Danielle		Μ	Benge				XXX-XX-	4997	E	Badlands Gear Co. LLC					861380511		
3 Street address (	including aparti	ment r	10.)						9	9 Street address	s (including roon	n or suite no.)			10 Cont	tact telephone	number
4386 W 625 S	5								9	9865 South 500 West 7065713405				3405			
4 City or town		<b>5</b> Sta	te or provin	nce		6 Country	and ZIP or fo	reign postal cod	e <b>1</b>	11 City or town 12 State or province			13 Coun	try and ZIP or fo	oreign postal code		
West Point		UT				US 840	)15		5	Sandy		UT			US 84	4070	
Part II Emp	ployee Off	er o	f Cover	age			Employe	e's Age or	e on January 1 Plan Start Month (enter 2-digit number):				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)	\$	\$		\$	\$		\$	\$		\$	\$	\$	\$	\$		\$	\$
<b>16</b> 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

Form 1095-C (2024)

# **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. 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. 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 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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- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
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- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|18 Danielle XXX-XX-4997 M Benge  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $|\times|$ X  $|\times|$  $\times$ 19 Madison XXX-XX-1807 Benge  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|20 Caleb Benge XXX-XX-8847 21 22 23 24 25 26 27 28 29 30

Page 4

Form 1095-C (2024)

#### 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

Curtis Bryner 6444 South Solar View Way West Jordan, UT 84081

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Depar	tment	of the	Trea	sury			
Internal Revenue Service							

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2024

Internal Revenue Se	rvice		GO to www	w.irs.gov/Forn	n1095C for in	structions ar	ia the latest in	itormation.						
Part I Emp	loyee						Aı	pplicable L	arge Emplo	yer Memb	er (Emplo	oyer)		
1 Name of employ	ee (first name, m	iddle initial, las	t name)	2 Social	security number	r (SSN)	7 Name of emp	oloyer			8 E	mployer identifica	ation number (EIN)	
Curtis		Bryner			XXX-XX-84	129	Badlands Gear Co. LLC					861380511		
3 Street address (i	ncluding apartme	ent no.)		•			9 Street addres	ss (including roor	n or suite no.)		<b>10</b> C	Contact telephone	number	
6444 South S	olar View W	'ay					9865 South	500 West				706571	3405	
4 City or town	5	State or provin	nce	6 Country	and ZIP or foreig	gn postal code	11 City or town		12 State or pro	ovince	<b>13</b> C	ountry and ZIP or	foreign postal code	
West Jordan	lι	JT		US 84	081		Sandy			US	84070			
Part II Emp	loyee Offe	r of Cover	age		Employee'	s Age on .	January 1		Plan Star	t Month (e	nter 2-digit	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1H	1H	1H	1H	1H	1H	1H	1H	1H	
15 Employee Required Contribution (see nstructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)					2A	2A	2A	2A	2A	2A	2A	2A	2A	
<b>17</b> ZIP Code													1005.0	

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Cat. No. 60705M

Form 1095-C (2024)

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

Pa	Covered Individuals If Employer provided self-insure				on for e	each 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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Page 4

Form 1095-C (2024)

#### Instructions for Recipient (continued)

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

Brendan B Call 144 Peachtree Dr Centerville, UT 84014

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OMB No. 1545-2251

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2024

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Part I Emp	ployee							Α	pplicable La	arge Emplo	yer Memb	er (Emp	loye	er)	
1 Name of employ	ee (first name,	middle	initial, las	t name)	2 Socia	I security numb	er (SSN)	7 Name of em	ployer			8	Emple	oyer identificati	on number (EIN)
Brendan		В	Call			XXX-XX-7	877	Badlands (	Gear Co. LL0	C			861380511		
3 Street address (i	including apartr	ment no	o.)					9 Street addre	ss (including roon	n or suite no.)		10	Conta	act telephone n	umber
144 Peachtre	e Dr							9865 South 500 West						7065713	405
4 City or town		5 State	e or provir	nce	6 Countr	y and ZIP or fore	eign postal code	11 City or town 12 State or province				13	Count	try and ZIP or fo	reign postal code
Centerville		UT			US 84	014		Sandy			U	S 84	1070		
Part II Emp	ployee Off	er of	Cover	age		Employee	's Age on .	January 1		Plan Star	<b>t Month</b> (en	ter 2-dig	it nur	mber):	01
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Cat. No. 60705M

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (c) DOB (if SSN or other (e) Months of coverage (d) Covered (a) Name of covered individual(s) (b) SSN or other TIN First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $|\times|$ |X|Call 18 Brendan В XXX-XX-7877  $\times$  $|\times|$  $\times$ 19 Finley Call XXX-XX-7470  $\times$  $\times$  $\times$ |X|Angela Call XXX-XX-0017 |X||X||X||X|Call 21 Ronan 0 XXX-XX-5473 22 23 24 25 26 27 28 29 30

Page 4

Form 1095-C (2024)

#### 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.

**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

Ashley D Coffman 6845 East 105th Street Tulsa, OK 74133

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

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OMB No. 1545-2251

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

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

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Part I Emp	oloyee									Applicable Large Employer Member (Employer)												
1 Name of employ	vee (first name,	middl	e initial, las	t name)		2 Social	secu	ırity number	r (SSN)	7	7 Name of employer							8 Emp	8 Employer identification number (EIN)			
Ashley		D	Coffma	an		XXX-XX-8452				Badlands Gear Co. LLC							861380511					
3 Street address (i	3 Street address (including apartment no.)										9 Street addres	s (ir	ncluding room	or suite	no.)			<b>10</b> Con	10 Contact telephone number			
6845 East 10!	6845 East 105th Street										9865 South	50	00 West						7065713405			
4 City or town 5 State or province					6 Country	6 Country and ZIP or foreign postal code			1.	11 City or town			12 State or province				13 Cour	13 Country and ZIP or foreign postal code				
Tulsa OK					US 74133				5	Sandy			UT				US 8	US 84070				
Part II Employee Offer of Coverage								Employee's Age on Jan			anuary 1			Plan Start Month (enter 2-				2-digit nı	umbe	01		
	All 12 Months	6	Jan	Feb		Mar		Apr	May		June		July	Aı	Jg	Sept		Oct		Nov	Dec	
14 Offer of Coverage (enter required code)			1A	1A		1A		1A	1A		1A		1A	1	A	1H		1H		1H	1H	
15 Employee Required Contribution (see instructions)	\$	\$		\$	\$		\$		\$		\$	\$		\$		\$	\$		\$		\$	
<b>16</b> Section 4980H Safe Harbor and Other Relief (enter code, if applicable)																2A		2A		2A	2A	
17 ZIP Code																						

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

Cat. No. 60705M

# **Instructions for Recipient**

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. 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. 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 your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



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

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

### Part I. Employee

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

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

## Part I. Applicable Large Employer Member (Employer)

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

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

### Part II. Employer Offer of Coverage, Lines 14-17

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$ |X||X| $\times$ X 18 D Coffman XXX-XX-8452 Ashley  $\times$  $\times$  $\times$ X |X| $|\times|$  $\times$ X 19 **TYLER** Κ **COFFMAN** XXX-XX-0080  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X|**JEFFREY COFFMAN** W XXX-XX-2350 X |X||X||X| $\times$ |X||X|X BLAKE 21 W **COFFMAN** XXX-XX-6094 22 23 24 25 26 27 28 29 30

Page 4

Form 1095-C (2024)

#### 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

Zachary A Crawford 504 E 8575 S Sandy, UT 84070

Form	10	<b>95</b> -	·U
Depart	ment c	f the Tre	asury
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OMB No. 1545-2251

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

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

2024

Internal Revenue Se	rvice		Go to www	v.irs.gov/For	<i>m10</i> 95C for in	structions ar	nd the latest ir	nformation.							
Part I Emp	oloyee						Α	pplicable L	arge Empl	loyer Meml	per (Emplo	yer)			
1 Name of employ	vee (first name, i	middle initial, la	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	ployer			8 Em	nployer identific	ation number (EIN)		
Zachary		A Crawf	ord		XXX-XX-9	546	Badlands (	Gear Co. LL		861380511					
3 Street address (i	including apartn	nent no.)		'			9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number			
504 E 8575 S							9865 South	า 500 West				7065713405			
4 City or town 5 State or province					6 Country and ZIP or foreign postal code				12 State or p	orovince	<b>13</b> Co	13 Country and ZIP or foreign postal code			
Sandy	Sandy UT						Sandy		UT		US	84070			
Part II Emp	oloyee Offe	er of Cove	rage	,	Employee <sup>3</sup>	's Age on c	January 1		Plan Sta	rt Month (e	nter 2-digit r	-digit number): C			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			A di National										1005 0		

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

Cat. No. 60705M

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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. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|18 Zachary Crawford XXX-XX-9546 Α  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X| $|\times|$ X  $|\times|$  $\times$ 19 Penelope Crawford XXX-XX-5084  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|Kelsey Crawford XXX-XX-5966 21 22 23 24 25 26 27 28 29 30

Page 4

Form 1095-C (2024)

#### 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

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OMB No. 1545-2251

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

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

2024

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Part I Emp	oloyee						Α	pplicable L	arge Emplo	oyer Memb	er (Emplo	yer)			
1 Name of employ	ee (first name, n	niddle initial, la	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	oloyer			8 E	mployer identific	ation number (EIN)		
Campbell		J Etulaiı	n		XXX-XX-86	533	Badlands (	Gear Co. LL		861380511					
3 Street address (i	ncluding apartm	nent no.)		'			9 Street addre	ss (including roor	n or suite no.)		<b>10</b> C	10 Contact telephone number			
9472 S 220 E							9865 South	າ 500 West				7065713405			
4 City or town 5 State or province					6 Country and ZIP or foreign postal code				12 State or p	rovince	<b>13</b> Co	13 Country and ZIP or foreign postal code			
Sandy	ndy UT US 84070						Sandy					US 84070			
Part II Emp	oloyee Offe	er of Cove	rage		Employee'	ployee's Age on January 1 Plan Start Month (enter					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													1005.0		

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

Cat. No. 60705M

# **Instructions for Recipient**

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

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

### Part I. Employee

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

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

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

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

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

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. $\succeq$		
	(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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Form 1095-C (2024)

#### Instructions for Recipient (continued)

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

**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

Donald M Gubler 1135 N 910 E Orem, UT 84097

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## **Employer-Provided Health Insurance Offer and Coverage**

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OMB No. 1545-2251

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

2024

Internal Revenue Se	rvice		GO to WWV	v.irs.gov/For	m 1095C for in	istructions ar	ia the latest li	ntormation.					
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Memb	per (Emplo	yer)	
1 Name of employ	ree (first name, i	middle initial, la	st name)	2 Socia	l security numbe	er (SSN)	7 Name of em	ployer			8 Em	ployer identific	ation number (EIN)
Donald		M Guble	er		XXX-XX-3!	586	Badlands Gear Co. LLC					861380	0511
3 Street address (i	ncluding apartn	nent no.)		•			9 Street address (including room or suite no.)				<b>10</b> Co	ntact telephone	number
1135 N 910 E							9865 South	n 500 West				706571	3405
4 City or town	ţ	5 State or prov	rince	6 Countr	y and ZIP or forei	ign postal code	11 City or town		12 State or p	province	<b>13</b> Co	untry and ZIP or	foreign postal code
Orem		UT		US 84	097		Sandy		UT		US	34070	
Part II Emp	oloyee Offe	er of Cove	rage	'	Employee	's Age on c			Plan Sta	rt Month (e	nter 2-digit r	iumber):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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)													2A
17 ZIP Code													1005.0

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Cat. No. 60705M

Form 1095-C (2024)

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

Pa	Irt III Covere			ed coverage, check th	e box and enter th	e informatio	on for e	each inc	dividual	enrolle	d in cov	/erage,	includir	ng the e	employe	e. 🗵		
	(a) Name of co	overed in	dividual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other	(d) Covered												
	First name, mid	idie initia	i, iast name		TIN is not available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
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Page 4

Form 1095-C (2024)

#### Instructions for Recipient (continued)

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

Kendra Jones 11209 N 132nd E Ave Owasso, OK 74055

Form <b>1095-</b> C
Department of the Treasury
Internal Revenue Service

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

VOID

OMB No. 1545-2251

Internal Revenue Se	rvice		GO tO WW	/w.irs.gov/Fo	rm 1095C for in	structions a	nd the latest i	information.					
Part I Emp	oloyee						A	Applicable L	arge Emplo	yer Memb	er (Employ	yer)	
1 Name of employ	vee (first name,	middle initial, la	ast name)	2 Soci	al security numbe	er (SSN)	7 Name of em	nployer			8 Em	ployer identifica	tion number (EIN)
Kendra		Jones	S		XXX-XX-10	085	Badlands	Gear Co. LL	.C			861380	)511
3 Street address (including apartment no.)					9 Street addre	ess (including roc	m or suite no.)		<b>10</b> Co	ntact telephone	number		
11209 N 132r	nd E Ave						9865 Sout	h 500 West				706571	3405
4 City or town		5 State or prov	vince	6 Count	try and ZIP or forei	gn postal code	11 City or town	1	12 State or pr	ovince	<b>13</b> Cou	untry and ZIP or t	oreign postal code
Owasso		OK		US 7	4055		Sandy		UT		US 8	34070	
Part II Emp	oloyee Offe	er of Cove	rage	•	Employee'	's Age on	January 1		Plan Star	t Month (ei	nter 2-digit n	umber):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
<b>14</b> Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
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Cat. No. 60705M

Form 1095-C (2024)

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

30

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|18 Kendra XXX-XX-1085 Jones  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 Kaidyn Ρ Allen XXX-XX-4069  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X||X|٧ 20 **RYAN JONES** XXX-XX-6512 X |X||X||X| $\times$ |X||X|X |X||X||X||X|Makenzie J Allen XXX-XX-3948 22 23 24 25 26 27 28 29

Page 4

Form 1095-C (2024)

#### 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.

**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

Christopher Self Lambert 743 Pinnacle Ln Saratoga Springs, UT 84045

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

VOID

OMB No. 1545-2251

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

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Part I Emp	oloyee						Α	pplicable L	arge Emp	loyer Mem	ber (Emplo	oyer)	
1 Name of employ	vee (first name,	middle initial, la	ast name)	2 Soci	al security numb	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)
Christopher		S Lamb	ert		XXX-XX-8	611	Badlands (	Gear Co. LL	С			861380	0511
3 Street address (i	including apart	ment no.)					9 Street address (including room or suite no.)				<b>10</b> C	ontact telephone	number
743 Pinnacle	Ln						9865 Soutl	h 500 West				706571	3405
4 City or town		5 State or prov	vince	6 Count	try and ZIP or fore	ign postal code	11 City or town	ı	12 State or	province	<b>13</b> C	ountry and ZIP or	foreign postal code
Saratoga Spri	ings	UT		US 8	4045		Sandy		UT		US	84070	
Part II Emp	oloyee Off	er of Cove	rage		Employee	's Age on <b>.</b>	January 1		Plan Sta	rt Month (e	enter 2-digit	number):	01
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)													
17 ZIP Code									N- 00705M				1005 C (000 t)

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



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

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

#### Part I. Employee

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

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

#### Part I. Applicable Large Employer Member (Employer)

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

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

#### Part II. Employer Offer of Coverage, Lines 14-17

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered all 12 months First name, middle initial, last name TIN is not available) Jan Feb Apr May June July Aug Sept Oct Mar Nov Dec  $\times$  $\times$  $\times$ |X| $\times$ |X| $\times$  $\times$  $\times$ X  $\times$ S XXX-XX-8611 Christopher Lambert  $\times$ X X |X| $|\times|$  $\times$ |X|X  $|\times|$ |X||X|Eliza XXX-XX-5625 19 Lambert  $\times$  $\times$  $\times$  $\times$ |X||X||X|X |X||X| $\times$  $|\times|$ **MICHELLE** LAMBERT XXX-XX-8061  $\times$ |X||X||X| $\times$ |X||X|X  $\times$ |X||X||X|MADELYN Ε LAMBERT XXX-XX-9276  $\times$  $\times$  $\times$  $\times$ X |X|X |X| $\times$ |X|22 **CALVIN** W **LAMBERT** XXX-XX-4987  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ X  $\times$  $\times$  $\times$ **ZOEY** M LAMBERT XXX-XX-0492 24 25 26 27 28 29 30

Page 4

Form 1095-C (2024)

#### 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.

**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

Okcha Mikkelson 6928 Kings Estate Dr West Valley City, UT 84128

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

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

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Part I Emp	loyee						Α	pplicable L	arge Emplo	yer Memb	oer (Er	nploy	er)	
1 Name of employ	ee (first name,	middle initial, las	st name)	2 Socia	l security numbe	er (SSN)	7 Name of emp	ployer		8 Employer identification number (EIN)				
Okcha		Mikkel	Ison		XXX-XX-3	753	Badlands (	Gear Co. LL		861380511				
3 Street address (i	ncluding apartr	ment no.)			9 Street addre	ss (including roor	n or suite no.)			10 Contact telephone number				
6928 Kings Es	state Dr						9865 South	n 500 West					706571	3405
4 City or town	6 Countr	y and ZIP or fore	gn postal code	11 City or town		12 State or pr	rovince		13 Country and ZIP or foreign postal code					
West Valley C	ity	UT		US 84	US 84128				UT			US 84070		
Part II Emp	loyee Off	er of Cover	rage		<b>Employee</b>	's Age on	January 1	January 1 Plan Start Month (enter				digit nı	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	(	Oct	Nov	Dec
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A		1A	1A	1A
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		\$	\$
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code														1005 0 222

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.

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. $\succeq$		
	(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
18												Aug	Зерг			
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Form 1095-C (2024)

#### 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

Jeffrey Moore 800 E Union Street Broken Arrow, OK 74011

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

CORRECTED

VOID

OMB No. 1545-2251

2024

Internal Revenue Se	rvice		Go to www	/.irs.gov/Foi	rm 1095C for ins	structions ar	id the latest i	ntormation.							
Part I Emp	oloyee						Α	pplicable L	arge Emplo	yer Memb	er (Employ	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 Em	ployer identifica	tion number (EIN)				
Jeffrey		Moore			XXX-XX-9147			Gear Co. LL		861380511					
3 Street address (i	ncluding apartr	ment no.)					9 Street addre	ess (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number			
800 E Union Street								h 500 West				7065713405			
4 City or town 5 State or province					try and ZIP or foreig	n postal code	11 City or town		12 State or pr	ovince	<b>13</b> Cou	13 Country and ZIP or foreign postal code			
Broken Arrow		OK		US 74	4011		Sandy		UT		US 8	US 84070			
Part II Emp	oloyee Off	er of Cover	age	•	Employee's	s Age on c	January 1		Plan Star	<b>t Month</b> (er	nter 2-digit n	-digit number): 01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		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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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.

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

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

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

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

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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.
- **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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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
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- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- 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. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$  $\times$ |X||X| $\times$ X |X| $|\times|$ |X|18 XXX-XX-9147 **Jeffrey** Moore  $\times$  $\times$ X |X| $|\times|$  $\times$ |X|X  $|\times|$  $\times$ |X|19 LARYN **MOORE** XXX-XX-7877  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X| $\times$ MOORE 20 RYAN XXX-XX-7287 X |X||X||X| $\times$ |X||X|X |X||X||X|X 21 **JUDITH MOORE** XXX-XX-2087 22 23 24 25 26 27 28 29 30

Page 4

Form 1095-C (2024)

#### 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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Dominick Murphy 2100 E Walker Lane Salt Lake City, UT 84117

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

VOID

OMB No. 1545-2251

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

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Part I Emp	loyee						Α	pplicable L	arge Emp	loyer Meml	ber (Emplo	yer)			
1 Name of employ	ee (first name, r	middle initial, la	st name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer	8 E	mployer identific	ation number (EIN)				
Dominick		Murph	ny		XXX-XX-3	325	Badlands (	Gear Co. LL		861380511					
3 Street address (in	ncluding apartn	nent no.)					9 Street addre	ess (including roo	m or suite no.)		<b>10</b> C	10 Contact telephone number			
2100 E Walke	r Lane						9865 South	h 500 West				7065713405			
4 City or town	;	5 State or prov	ince	6 Count	ry and ZIP or fore	ign postal code	11 City or town		12 State or p	province	<b>13</b> Co	13 Country and ZIP or foreign postal code			
Salt Lake City		UT		US 84	US 84117				UT		US	US 84070			
Part II Emp	loyee Offe	er of Cove	rage		<b>Employee</b>	's Age on .	January 1		Plan Sta	irt Month (e	onth (enter 2-digit number):				
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			A at Nation										1005 C (222)		

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

Cat. No. 60705M

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

Pa	Covered Individuals If Employer provided self-insure				on for e	each inc	lividual	enrolle					employe	e. $\succeq$		
	(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
18												Aug	Зерг			
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Form 1095-C (2024)

#### Instructions for Recipient (continued)

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

Nathan Edward Remington 492 W Miller Way Farmington, UT 84025

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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.

2024

Internal Revenue Se	rvice		GO TO WWW	.irs.gov/Fori	m 1095C for in	structions ar	na the latest ir	ntormation.				`		
Part I Emp	oloyee						Α	pplicable L	arge Empl	oyer Meml	per (Emplo	yer)		
1 Name of employ	ee (first name, n	middle initial, la	st name)	2 Socia	I security numbe	r (SSN)	7 Name of emp	ployer			8 Em	nployer identific	ation number (EIN)	
Nathan		E Remir	ngton		XXX-XX-47	730	Badlands Gear Co. LLC					861380511		
3 Street address (i	ncluding apartm	nent no.)					9 Street addre	ss (including roo	m or suite no.)		<b>10</b> Co	10 Contact telephone number		
492 W Miller \	Way						9865 South	n 500 West				706571	3405	
4 City or town	5	State or prov	ince	6 Countr	y and ZIP or forei	gn postal code	11 City or town		12 State or p	province	<b>13</b> Co	untry and ZIP or	foreign postal code	
Farmington		UT		US 84	025		Sandy			US	US 84070			
Part II Emp	oloyee Offe	er of Cove	rage	'	Employee'	s Age on			Plan Sta	rt Month (e	nter 2-digit r	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
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17 ZIP Code													1005.0	

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Cat. No. 60705M

Form 1095-C (2024)

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

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

### Part I. Applicable Large Employer Member (Employer)

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

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

### Part II. Employer Offer of Coverage, Lines 14-17

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

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

Pa	art III Cove If Emp	red Indi	<b>viduals</b> ovided self-insure	ed coverage, check th	e box and enter th	e information	on for e	each inc	lividual	enrolle					employe	ee. 🗵		
	(a) Name of First name.	of covered in	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera	ge Aug	Sept	Oct	Nov	Dec
18	Nathan	E	Remington	XXX-XX-4730			X	X	×	X	×	X	X	X	Ж	X	X	X
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Form 1095-C (2024)

### 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.

**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

Blake VanTussenbrook 597 Crestwood Rd Kaysville, UT 84037

Form	<b>7</b> U	<i>)</i> 95	)-U
			Treasury
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# Employer-Provided Health Insurance Offer and Coverage Do not attach to your tax return. Keep for your records.

VOID

OMB No. 1545-2251

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

internal Revenue Sei	rvice		GO LO WWW	s.gov/roi	11110930 101 11	isti uctions ai	iu tile latest li	mormation.							
Part I Emp	loyee						Α	pplicable L	arge Emp	loyer Meml	er (Emplo	yer)			
1 Name of employ	ee (first name,	middle initial, la	ıst name)	2 Socia	al security numbe	er (SSN)	7 Name of em	ployer			8 E	mployer identific	ation number (EIN)		
Blake		VanT	ussenbrook		XXX-XX-6	139	Badlands Gear Co. LLC					861380511			
3 Street address (in	ncluding apartr	nent no.)		•			9 Street addre	ess (including roo	m or suite no.)		<b>10</b> C	10 Contact telephone number			
597 Crestwoo	d Rd						9865 South	h 500 West				706571	3405		
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	<b>13</b> Co	ountry and ZIP or	foreign postal code		
Kaysville		UT		US 84	1037		Sandy		UT		US	84070			
Part II Emp	loyee Off	er of Cove	rage		Employee	's Age on .	January 1		Plan Sta	irt Month (e	nter 2-digit	number):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A		
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)															
17 ZIP Code			A a t Nation										1005 C (200		

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

Cat. No. 60705M

Form 1095-C (2024)

### **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. 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. 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 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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- 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. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered TIN is not available) First name, middle initial, last name all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec  $\times$  $\times$  $\times$ |X| $\times$ |X| $\times$ X  $\times$  $|\times|$ |X|18 Blake VanTussenbro XXX-XX-6139  $\times$  $\times$ X |X| $|\times|$ |X|X  $|\times|$  $\times$ |X|19 **AUDRA** VANTUSSEN XXX-XX-5371  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$  $\times$ |X||X||X||X| $|\times|$ В VANTUSSEN **MAGNUS** XXX-XX-6461 X |X||X||X| $\times$ |X||X|X |X||X||X||X|VANTUSSEN 21 **BIRDY** Н XXX-XX-0220 22 23 24 25 26 27 28 29 30

Form 1095-C (2024)

### 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

Tyler Wolf 163 W 1430 N Tooele, UT 84074

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

VOID

OMB No. 1545-2251

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

Internal Revenue Se	ervice		GO TO WWV	/.irs.gov/For	m 1095C for in	structions ar	ia the latest in	tormation.						
Part I Emp	oloyee						A	oplicable L	arge Emplo	yer Memb	er (Emplo	yer)		
1 Name of employ	/ee (first name, ı	middle initial, la	ıst name)	2 Socia	l security numbe	r (SSN)	7 Name of emp	loyer			8 En	nployer identifica	ation number (EIN)	
Tyler		Wolf			XXX-XX-74	488	Badlands Gear Co. LLC					861380511		
3 Street address (i	including apartn	nent no.)		•			9 Street address	s (including roor	n or suite no.)		<b>10</b> Cd	10 Contact telephone number		
163 W 1430 N	V						9865 South	500 West				706571	3405	
4 City or town 5 State or province 6 Country and ZIP or foreign postal of					gn postal code	11 City or town		12 State or pr	rovince	<b>13</b> Co	untry and ZIP or	foreign postal code		
Tooele		UT		US 84	074		Sandy UT			US	US 84070			
Part II Emp	oloyee Offe	er of Cove	rage		Employee <sup>3</sup>	s Age on c	January 1		Plan Star	t Month (e	nter 2-digit ı	number):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	1A	
15 Employee Required Contribution (see instructions)	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	\$	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)														
17 ZIP Code													1005.0	

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

Cat. No. 60705M

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Pa	Covered Individuals If Employer provided self-insure				on for e	each 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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Form 1095-C (2024)

### 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

Joslyn Wright 6537 South Tanner Lane Salt Lake City, UT 84121

Form	1	U	9	5	-C					
Department of the Treasury										

# **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		ao to ww	w.ii s.gov/i oi	11110930 101 111	sti uctions ai	ilu tile latest il	mormation.								
Part I Employee							Applicable Large Employer Member (Employer)									
Name of employee (first name, middle initial, last name)				2 Socia	2 Social security number (SSN)			ployer	<b>8</b> Er	8 Employer identification number (EIN)						
Joslyn Wright					XXX-XX-3851			Gear Co. LLO		861380511						
3 Street address (including apartment no.)							9 Street addre	ess (including roor	<b>10</b> Cd	10 Contact telephone number						
6537 South Tanner Lane							9865 Soutl	h 500 West		7065713405						
4 City or town 5 State or province			6 Count	6 Country and ZIP or foreign postal code				12 State or pro	ovince	<b>13</b> Co	13 Country and ZIP or foreign postal code					
Salt Lake City UT				US 84	US 84121				UT		US	US 84070				
Part II Employee Offer of Coverage Employ					Employee'	nployee's Age on January 1			Plan Star	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. 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. 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 your employer provided you or a family member health coverage through an insured health plan or in another manner, you may receive information about the coverage separately on Form 1095-B, Health Coverage. Similarly, if you or a family member obtained minimum essential coverage from another source, such as a government-sponsored program, an individual market plan, or miscellaneous coverage designated by the Department of Health and Human Services, you may receive information about that coverage on Form 1095-B. If you or a family member enrolled in a qualified health plan through a Health Insurance Marketplace, the Health Insurance Marketplace will report information about that coverage on Form 1095-A, Health Insurance Marketplace Statement.



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

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

### Part I. Employee

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

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

### Part I. Applicable Large Employer Member (Employer)

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

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

### Part II. Employer Offer of Coverage, Lines 14-17

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

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

Pa	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 of cover		age Aug Sep		Oct	Nov	Dec
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Form 1095-C (2024)

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