Greg C Brock 1714 Westchester Drive Dalton, GA 30720

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

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OMB No. 1545-2251

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

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Part I Emp	loyee						Ap	plicable La	arge Employer Member (Employer)					
1 Name of employe	ee (first name, i	middle initial, last	: name)	2 Social s	security number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)	
Greg		C Brock			XXX-XX-168	30	Premier Yarı	n Dyers, Ind	C.			580831676		
3 Street address (in		9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	ımber						
1714 Westche	ester Drive						128 East Ge	orge Street	t			77077336	595	
4 City or town	,	5 State or provin	ce	6 Country a	and ZIP or foreigr	n postal code 1	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code	
Dalton		GA		US 307	20		Adairsville		GA		US 30	103		
Part II Emp	loyee Offe	er of Covera	age	E	Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$ 120.00	\$ 120.00 \$	120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00\$	\$ 120.00	\$ 120.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code													005 0	

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

Cat. No. 60705M

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).
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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
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- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
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- 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.

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Page 3 Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times |X||X| \times X |X| $|\times|$ |X|С 18 **Brock** XXX-XX-1680 Greg \times \times \times \times \times \times |X| $|\times|$ X $|\times|$ \times **Brock** XXX-XX-1993 19 Angela \times \times \times \times \times \times \times |X||X||X||X||X|Sydney XXX-XX-2356 **Brock** 21 22 23 24 25 26 27 28 29

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

Allen T Dover 45 Manning Mill Way Adairsville, GA 30103

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OMB No. 1545-2251

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Part I Emp	loyee							Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name,	middle	initial, last n	name)	2 Social s	ecurity number	(SSN)	7 Name of employer				8 Emplo	yer identification	n number (EIN)	
Allen		T	Dover		>	XX-XX-259	90	Premier Yarn Dyers, Inc.					580831676		
3 Street address (in	ncluding apartr	ment no	o.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number		
45 Manning M	lill Way							128 East Ge	eorge Street	t			77077336	95	
4 City or town		5 State	or province	е	6 Country a	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Countr	y and ZIP or for	eign postal code	
Adairsville		GΑ			US 301	03		Adairsville		GA		US 30	103		
Part II Emp	loyee Off	er of	Coverag	ge	E	mployee's	Age on J	anuary 1		Plan Start	: Month (ent	er 2-digit nur	nber):	01	
	All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)			1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$	120.00 \$	\$ 120.00\$	120.00	\$ 120.00	\$ 120.00)\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
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- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	irt III Co	overed Ind Employer pr	ividuals ovided self-ins	sured coverage, check th	ne box and enter th	e information	on for e	each inc	lividual	enrolle					employe	e. 🗵		
	(a) Nai First nai	me of covered me, middle init	individual(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
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Ronnie W Harris 23 Mill Creek SE Cartersville, GA 30120

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

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OMB No. 1545-2251

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Part I Emp	oloyee							Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)		
1 Name of employ	ee (first name,	middle	initial, last r	name)	2 Social s	ecurity number	(SSN)	7 Name of emple	oyer			8 Emplo	yer identificatio	n number (EIN)	
Ronnie		W	Harris		>	XX-XX-745	55	Premier Yarn Dyers, Inc.					580831676		
3 Street address (i	ncluding apartr	ment n	o.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number		
23 Mill Creek	SE							128 East Ge	eorge Street	t			77077336	95	
4 City or town		5 Stat	te or provinc	е	6 Country a	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Count	y and ZIP or fore	eign postal code	
Cartersville		GΑ			US 301	20		Adairsville		GA		US 30	103		
Part II Emp	oloyee Off	er of	Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	01	
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Cat. No. 60705M

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

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

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

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

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)

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

Maria Carmen Molina Cisneros 278 Mac Johnson Road NW Lot 54 Cartersville, GA 30121

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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						Ap	r)							
1 Name of employe	ee (first name, i	middle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	on number (EIN)		
Maria Carmen		Molina	Cisneros		XX-XX-037	75	Premier Yarı	n Dyers, Ind	C.			5808316	76		
3 Street address (in	ncluding apartn	nent no.)				!	9 Street address	(including room	or suite no.)		10 Contac	10 Contact telephone number			
278 Mac John	son Road	NW Lot 54					128 East Ge	orge Street	t		7707733695				
4 City or town		5 State or provin	се	6 Country and ZIP or foreign postal code			11 City or town		12 State or pro	vince	13 Country	y and ZIP or for	eign postal code		
Cartersville		GA		US 301	21		Adairsville		GA		US 30 ²	103			
Part II Emp	loyee Offe	er of Covera	age	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit num	nber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1H		
15 Employee Required Contribution (see instructions)	\$	\$ 120.00	\$ 120.00\$	120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00\$	3 120.00	\$		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2A		
17 ZIP Code													005 0 222		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. 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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- **1F**. Minimum essential coverage NOT providing minimum value offered to you, or you and your spouse or dependent(s), or you, your spouse, and dependent(s).
- **1G.** You were NOT a full-time employee for any month of the calendar year but were enrolled in self-insured employer-sponsored coverage for one or more months of the calendar year. This code will be entered in the *All 12 Months* box or in the separate monthly boxes for all 12 calendar months on line 14
- **1H.** No offer of coverage (you were NOT offered any health coverage or you were offered coverage that is NOT minimum essential coverage).
- 11. Reserved for future use.
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- **1N.** Individual coverage HRA offered to you, spouse, and dependent(s) with affordability determined by using employee's primary residence ZIP code.
- **10.** Individual coverage HRA offered to you only using the employee's primary employment site ZIP code affordability safe harbor.
- **1P.** Individual coverage HRA offered to you and dependent(s) (not spouse) using the employee's primary employment site ZIP code affordability safe harbor.
- **1Q.** Individual coverage HRA offered to you, spouse, and dependent(s) using the employee's primary employment site ZIP code affordability safe harbor.
- **1R.** Individual coverage HRA that is NOT affordable offered to you; employee and spouse or dependent(s); or employee, spouse, and dependents.
- 1S. Individual coverage HRA offered to an individual who was not a full-time employee.
- **1T.** Individual coverage HRA offered to employee and spouse (no dependents) with affordability determined using employee's primary residence ZIP code.
- **1U.** Individual coverage HRA offered to employee and spouse (no dependents) using employee's primary employment site ZIP code affordability safe harbor.
- 1V. Reserved for future use.
- 1W. Reserved for future use.
- 1X. Reserved for future use.
- 1Y. Reserved for future use.
- 1Z. Reserved for future use.

Pa	If Employ			d coverage, check th			on for e	ach inc	lividual	enrolle					employe	e. 🗵		-
	(a) Name of co	overed in	dividual(s)	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months						Months				0.		_
	T iist name, mid		, iast fiame		Tilv is flot available)	all 12 months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
18	Maria Carmer		Molina Cisner	XXX-XX-0375			\times	\times	\times	\times	\times	\boxtimes	\times	\boxtimes	\boxtimes	\times	\times	
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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

Juan R Murillo 18 Burnett Ferry Road SW Rome, GA 30165

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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 Service Go to www.irs.gov/Form1095C for instruction							d the latest inf	ormation.							
Part I Emp	oloyee						Ар	plicable La	rge Emplo	yer Membe	r (Employe	<u>r)</u>			
1 Name of employ	/ee (first name, ı	niddle initial, las	st name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identification	n number (EIN)		
Juan		R Murillo)		XXX-XX-32	35	Premier Yarı	n Dyers, Ind		5808316	76				
3 Street address (i	including apartn	nent no.)		•			9 Street address	(including room	or suite no.)		10 Contac	10 Contact telephone number			
18 Burnett Fe	rry Road S	W					128 East Ge	orge Street	t			7707733695			
4 City or town		5 State or provi	ince	6 Country	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Country	13 Country and ZIP or foreign postal co			
Rome		GA		US 301	65		Adairsville		GA		US 30 ²	103			
Part II Emp	oloyee Offe	er of Cover	rage	E	Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit num	nber):	01		
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1H	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00\$	120.00	\$ 120.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2D	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													005 0		

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

Cat. No. 60705M

Instructions for Recipient

You are receiving this Form 1095-C because your employer is an Applicable Large Employer subject to the employer shared responsibility provisions in the Affordable Care Act. This Form 1095-C includes information about the health insurance coverage offered to you by your employer. Form 1095-C, Part II, includes information about the coverage, if any, your employer offered to you and your spouse and dependent(s). If you purchased health insurance coverage through the Health Insurance Marketplace and wish to claim the premium tax credit, this information will assist you in determining whether you are eligible. 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).

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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)

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

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

Part III. Covered Individuals, Lines 18–30

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

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Employer-Provided Health Insurance Offer and Coverage

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OMB No. 1545-2251

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

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

2024

Internal Revenue Sei	vice		Go to www.irs	s.gov/Form	1095C for ins	tructions and	a the latest into	ormation.							
Part I Emp	loyee						Ap	plicable La	r (Employe	r)					
1 Name of employ	ee (first name, m	iddle initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)		
Maria	. E	E Perez-S	Soto	>	XXX-XX-81 ⁻	10	Premier Yarı	n Dyers, Ind		5808316	76				
3 Street address (i	ncluding apartme	ent no.)		_			9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number			
6 Dellwood Dr	· NW						128 East Ge	orge Street				7707733695			
4 City or town	5	State or province	ce	6 Country and ZIP or foreign postal code			11 City or town		12 State or pro	vince	13 Countr	13 Country and ZIP or foreign posta			
Rome	0	3A		US 301	65		Adairsville		GA		US 30	103			
Part II Emp	loyee Offer	r of Covera	age	E	Employee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	01			
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
15 Employee Required Contribution (see instructions)	\$	\$ 120.00	\$ 120.00\$	120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00\$	120.00	\$ 120.00		
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H		
17 ZIP Code													205.0		

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

Cat. No. 60705M

Instructions for Recipient

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

Pa	Covered Individuals If Employer provided self-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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Part III. Covered Individuals, Lines 18–30

Jessica H Pinion 38 Bishop Road NW Cartersville, GA 30121

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

CORRECTED

VOID

OMB No. 1545-2251

Treasury

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

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

DRRECTED 2024

Internal Revenue Ser	rvice		Go to www.i	rs.gov/Form	1095C for inst	tructions and	d the latest inf	ormation.						
Part I Emp	oloyee						Ар	plicable La	r (Employe	r)				
1 Name of employ	ee (first name, m	niddle initial, last	name)	2 Social s	ecurity number ((SSN)	7 Name of emple	oyer			8 Emplo	8 Employer identification number (EIN)		
Jessica	H	H Pinion		>	(XX-XX-540	00	Premier Yarn Dyers, Inc.					580831676		
3 Street address (in	ncluding apartm	ent no.)		•			,					10 Contact telephone number		
38 Bishop Roa	ad NW						128 East George Street					7707733695		
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreign							13 Country and ZIP or foreign postal code		
Cartersville		GA		US 301	21							US 30103		
Part II Emp	oloyee Offe	r of Covera	ige		mployee's	Age on J							01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$ 120.00	\$ 120.00\$	3 120.00 i	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	120.00	\$ 120.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	
17 ZIP Code			A Nation										00E C (200	

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

Cat. No. 60705M

Form 1095-C (2024)

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- 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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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Terry W Pruitt 26 Dana Way NW Cartersville, GA 30121

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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 www.	irs.gov/Forn	n 1095C for ins	structions and	a the latest into	ormation.						
Part I Emp	oloyee							Apı	plicable La	rge Emplo	yer Membe	r (Employe	er)		
1 Name of employ	ee (first name,	middle	e initial, last	name)	2 Social	security number	(SSN)	7 Name of emplo	oyer			8 Emp	loyer identification	n number (EIN)	
Terry		W	Pruitt			XXX-XX-35	40	Premier Yarı	n Dyers, Ind	3 .			580831676		
3 Street address (including apartment no.)							9 Street address	(including room	or suite no.)		10 Cont	10 Contact telephone number			
26 Dana Way NW						128 East George Street					7707733695				
4 City or town 5 State or province 6 Country and ZIP or foreign po					n postal code	11 City or town		12 State or pro	vince	13 Coun	try and ZIP or for	eign postal code			
Cartersville		GΑ			US 30	121	1.	Adairsville GA					0103		
Part II Emp	oloyee Off	er of	Covera	ige		Employee's	s Age on J						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)			1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	
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16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code															

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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.
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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 Cove			ured coverage, check th	e box and enter th	e information	on for e	ach inc	lividual	enrolle					employe	ee. 🗵		
		of covered in middle initia	ndividual(s) al, last name	(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) May	Months June	of covera July	ge Aug	Sept	Oct	Nov	Dec
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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

Kenneth G Quick 12 Bramblewood Drive Cartersville, GA 30120

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17 ZIP Code

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

CORRECTED

VOID

OMB No. 1545-2251

2024

Go to www.irs.gov/Form1095C for instructions and the latest information. Internal Revenue Service Applicable Large Employer Member (Employer) Part I **Employee** 2 Social security number (SSN) 7 Name of employer 8 Employer identification number (EIN) 1 Name of employee (first name, middle initial, last name) Kenneth G Quick XXX-XX-1307 Premier Yarn Dyers, Inc. 580831676 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 12 Bramblewood Drive 128 East George Street 7707733695 4 City or town 5 State or province 6 Country and ZIP or foreign postal code 11 City or town 12 State or province 13 Country and ZIP or foreign postal code GΑ Cartersville US 30120 Adairsville GA US 30103 **Employee Offer of Coverage Employee's Age on January 1** Plan Start Month (enter 2-digit number): Part II 01 All 12 Months Feb Mar Oct Dec Jan Apr May June July Sept Nov 14 Offer of Coverage (enter 1E required code) 15 Employee Required Contribution (see 120.00\$ 120.00 \$ 120.00 \$ 120.00 \$ 120.00 \$ 120.00\$ 120.00 \$ 120.00 \$ 120.00 \$ 120.00 \$ 120.00\$ 120.00 instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2C code, if applicable)

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

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

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

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

Jessey Guadalupe Resto 114 Cherry Street Rome, GA 30165

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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.

1 Name of employed Jessey 3 Street address (in 114 Cherry St 4 City or town Rome		middle initial, last G Resto	name)	2 Social s			Ар	plicable La	rge Employ	ver Membe	r (Employe	r)		
Jessey 3 Street address (ii 114 Cherry St 4 City or town Rome		1	name)	2 Social s			Applicable Large Employer Member (mployer)		
3 Street address (in 114 Cherry St 4 City or town Rome	ncluding apartn	G Posto		2 300lai 3	ecurity number ((SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)	
114 Cherry St 4 City or town Rome	ncluding apartn	U INCOLU		\	XXX-XX-0221 Premier Yarn Dyers, Inc.						580831676			
4 City or town Rome		nent no.)					9 Street address	(including room	or suite no.)		10 Conta	10 Contact telephone number		
Rome	reet						128 East George Street					7707733695		
		5 State or province	ce	6 Country a	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Countr	y and ZIP or fore	eign postal code	
		GA		US 301	US 30165				GA		US 30	103		
Part II Emp	loyee Offe	er of Covera	ige	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$ 120.00	\$ 120.00\$	120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00\$	\$ 120.00 <i>\$</i>	\$ 120.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	2H	
17 ZIP Code														

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Cat. No. 60705M

Instructions for Recipient

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

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- 1Y. Reserved for future use.
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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)

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

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Part III. Covered Individuals, Lines 18–30

Claudia Villanueva 5 Verbena Ave Rome, GA 30165

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Employer-Provided Health Insurance Offer and Coverage

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VOID

OMB No. 1545-2251

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

Go to $\emph{www.irs.gov/Form1095C}$ for instructions and the latest information.

2024

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including apartm	ent no.)		•	9 Street address (including room or suite no.)						10 Conta	10 Contact telephone number			
e						128 East Ge	eorge Street	t			77077336	95		
5	State or provinc	ce	6 Country a	6 Country and ZIP or foreign postal code				12 State or pro	vince	13 Count	13 Country and ZIP or foreign postal c			
	GA		US 3016	US 30165				GA		US 30	103			
oloyee Offe	r of Covera	ge	E	mployee's	Age on J	anuary 1		Plan Start	Month (ent	er 2-digit nur	nber):	01		
All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec		
	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E		
\$	\$ 120.00	\$ 120.00\$	120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00		
	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C		
i	ployee ree (first name, n ncluding apartm e 5 loloyee Offe	ployee ree (first name, middle initial, last Villanue Villanue S State or province GA Coloyee Offer of Covera All 12 Months Jan 1E \$ \$ 120.00	ployee ree (first name, middle initial, last name) Villanueva Villanueva State or province GA GA All 12 Months Jan Feb 1E 1E \$ 120.00 \$ 120.00 \$	ployee ree (first name, middle initial, last name) Villanueva Vil	Dioyee 2 Social security number 2 Social security number 2 Social security number 3 Social security number 3 Social security number 4 Social security number 5 State or province 6 Country and ZIP or foreign US 30165	Dioyee 2 Social security number (SSN) XXX-XX-7740 Villanueva XXX-XX-7740	Dioyee Tee (first name, middle initial, last name) Tee (first name, middle initial, last name) Villanueva Villanueva XXX-XX-7740 Premier Yar 128 East Ge 128 East Ge 128 East Ge 128 East Ge VIS 30165 Dioyee Offer of Coverage April 12 Months Adairsville Employee's Age on January 1 All 12 Months All 12 Mon	Dioyee Tee (first name, middle initial, last name) To Villanueva To Villanueva To Villanueva To Villanueva To Villanueva To Name of employer Premier Yarn Dyers, Inc. Solve Street address (including room 128 East George Street To State or province GA US 30165 To Name of employer Premier Yarn Dyers, Inc. Solve East George Street To State or province GA US 30165 To State or province GA US 30165 To State or province GA US 30165 To State or province Adairsville To	Applicable Large Employ Yillanueva	Applicable Large Employer Member Applicable Large Employer Applicable Large Empl	Applicable Large Employer Member (Employer Section Section	Applicable Large Employer Member (Employer)		

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.

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

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

Part I. Employee

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

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

Part I. Applicable Large Employer Member (Employer)

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

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

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

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

Part III Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (e) Months of coverage (c) DOB (if SSN or other (a) Name of covered individual(s) (b) SSN or other TIN (d) Covered First name, middle initial, last name TIN is not available) all 12 months Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec \times \times \times \times |X||X| \times X |X| $|\times|$ |X|18 Claudia Villanueva XXX-XX-7740 \times \times \times |X||X| $|\times|$ \times X $|\times|$ \times \times 19 0 Picon XXX-XX-5558 Hassen \times \times \times \times \times \times \times |X||X||X||X||X|0 Picon Villanue XXX-XX-7790 Hassen 21 22 23 24 25 26 27 28 29 30

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

Charlene Vinall 61 Gordon Road Taylorsville, GA 30178

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Depar						

Employer-Provided Health Insurance Offer and Coverage

VOID

OMB No. 1545-2251

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

Internal Revenue Se	rvice		Go to www.ir	s.gov/Form	v/Form1095C for instructions and the latest information.									
Part I Emp	oloyee						Ар	plicable La	rge Employ	er Membe	r (Employe	er)		
1 Name of employ	ee (first name, n	niddle initial, last	name)	2 Social s	ecurity number	(SSN)	7 Name of emplo	oyer			8 Empl	oyer identification	n number (EIN)	
Charlene		Vinall		X	(XX-XX-47)	28 F	Premier Yar	n Dyers, Ind	C.			58083167	76	
3 Street address (i	ncluding apartm	ent no.)				9	9 Street address (including room or suite no.)				10 Conta	10 Contact telephone number		
61 Gordon Ro	oad					-	128 East Ge	orge Street	t			77077336	95	
4 City or town	5	State or province	ce	6 Country a	and ZIP or foreigr	n postal code 1	11 City or town		12 State or prov	/ince	13 Count	ry and ZIP or fore	ign postal code	
Taylorsville		GA		US 301	US 30178				GA		US 30	103		
Part II Emp	oloyee Offe	r of Covera	nge	E	mployee's	Age on Ja	anuary 1		Plan Start	Month (ent	er 2-digit nu	mber):	01	
	All 12 Months	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	
14 Offer of Coverage (enter required code)		1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	
15 Employee Required Contribution (see instructions)	\$	\$ 120.00	\$ 120.00\$	120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)		2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	
17 ZIP Code													205 0 (222)	

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Cat. No. 60705M

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	(a) Name of on First name, mi	covered industrial	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	June	of covera July	ge Aug	Sept	Oct	Nov	Dec
18	Charlene		Vinall	XXX-XX-4728			\times	\boxtimes	\times	\times	\times	\times	\times	\times	\times	\times	\times	\times
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Form 1095-C (2024)

Instructions for Recipient (continued)

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Part III. Covered Individuals, Lines 18–30

Cassie B Womack 19 Herring Street Cartersville, GA 30120

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

VOID

OMB No. 1545-2251

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

internal Revenue Ser	vice			GO to www.ii	s.gov/Form	1095C IOI IIIS	u ucuons and	u tile latest lill	ormation.					
Part I Emp	loyee							Ар	plicable La	rge Emplo	yer Membe	r (Employe	r)	
1 Name of employe	ee (first name,	midd	e initial, last	name)	2 Social s	security number	(SSN)	7 Name of emplo	oyer			8 Emplo	yer identificatio	n number (EIN)
Cassie		В	Womac	:k		XXX-XX-27	50	Premier Yar	n Dyers, Ind	3 .			5808316	76
3 Street address (in	ncluding apartr	nent i	10.)					9 Street address	(including room	or suite no.)		10 Conta	ct telephone nu	ımber
19 Herring Str	eet							128 East Ge	eorge Street	t			77077336	595
4 City or town		5 Sta	ate or provinc	ce	6 Country	and ZIP or foreigr	n postal code	11 City or town		12 State or pro	vince	13 Count	ry and ZIP or fore	eign postal code
Cartersville		GΑ			US 301	20		Adairsville		GA		US 30	103	
Part II Emp	loyee Off	er o	f Covera	ige	E	Employee's	Age on J	anuary 1		Plan Start	: Month (ent	er 2-digit nur	nber):	01
	All 12 Months		Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
14 Offer of Coverage (enter required code)			1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E	1E
15 Employee Required Contribution (see instructions)	\$	\$	120.00	\$ 120.00\$	120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00	\$ 120.00
16 Section 4980H Safe Harbor and Other Relief (enter code, if applicable)			2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C	2C
17 ZIP Code				Lat Nation						2070514				00F C (200)

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Cat. No. 60705M

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

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

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

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

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

Pa	Covered Individuals If Employer provided self-insured coverage, check the box and enter the information for each individual enrolled in coverage, including the employee. (a) Name of covered individual(s) (b) SSN or other TIN (c) DOB (if SSN or other) (d) Covered (e) Months of coverage																	
(a) Name of covered individual(s) First name, middle initial, last name				(b) SSN or other TIN	(c) DOB (if SSN or other TIN is not available)	(d) Covered all 12 months	Jan	Feb	Mar	Apr	(e) Months May June		of coverage July Aug		Sept Oct		Nov	Dec
18	Cassie	В	Womack	XXX-XX-2750			\times	\times	\times	\times	X	\times	X	\times	\times	\times	\times	\times
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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