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

Go to www.irs.gov/Form1095C for instructions and the latest information. VOID Form 1095-C OMB No. 1545-2251 CORRECTED Department of the Treasury 2021 Internal Revenue Service Part I Employee Applicable Large Employer Member (Employer) 1 Name of employee (first name, middle initial, last name) 8 Employer identification number (EIN) 2 Social security number (SSN) 7 Name of employer VISHNUPRIYA \*\*\*-\*\*-5240 RxSense Holdings LLC 842124075 3 Street address (including apartment no.) 9 Street address (including room or suite no.) 10 Contact telephone number 22434 BRIGHT SKY DR 99 High St FL 28 8574002770 4 City or town 5 State or province 13 Country and ZIP or foreign postal code 6 Country and ZIP or foreign postal 11 City or town 12 State or province CLARKSBURG US 02110 Part !! Employee Offer of Coverage Employee Age's on January 1: Plan Start Month (enter 2-digit number): 01 14 Offer of All 12 Months Feb Mar Apr June July Sept Oct Dec May Aug Coverage (enter 1H 1H 1H 1H 1H 1H 1H 1A 1A required code) 1H 1H 1H 15 Employee Required 1 Contribution (see instructions) 16 Section 4980H Safe Harbor and Other Relief (enter 2A 2A 2A 2A 2A 2A 2A 2A 2D 2G 2G 2A code, if applicable) 17 ZIP Code 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 (e) Months of Coverage (d) Covered (a) Name of covered individual(s) (b) SSN or other TIN or other TIN is all 12 months Apr May June July Aug Sept Oct Nov Dec Jan Feb Mar First name, middle initial, last name not available)