2024 Schedule HC

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Schedule HC, Health Care Information, must be completed by all full-year residents and certain part-year residents (see instructions).

Note: Schedule HC must be enclosed with your Form 1 or Form 1-NR/PY. Failure to do so will delay the processing of your return.

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1a. Date of birth XXXXXXXX 1b. Spouse's date of birth XXXXXXXX 1c. Family size XX

2. Federal adjusted gross income **2** –XXXXXXXXXXXX

3. Indicate the time period that you were enrolled in a Minimum Creditable Coverage (MCC) health insurance plan(s). The Form MA 1099-HC from your insurer will indicate whether your insurance met MCC requirements. Note: MassHealth, Medicare, and health coverage for U.S. Military, including Veterans Administration and Tri-Care, meet the MCC requirements. If you did not receive a Form MA 1099-HC from your insurer, or you had insurance that did not meet MCC requirements, see the special section on MCC requirements in the instructions.

See instructions if, during 2024, you turned 18, you were a part-year resident or a taxpayer was deceased.

3a You:	X	Full-year MCC	X	Part-year MCC	X	No MCC/None
3a Spouse:	X	Full-year MCC	X	Part-year MCC	X	No MCC/None

If you filled in the full-year or part-year MCC oval, go to line 4. If you filled in No MCC/None, go to line 6.

4. Indicate the health insurance plan(s) that met the Minimum Creditable Coverage (MCC) requirements in which you were enrolled in 2024, as shown on Form MA 1099-HC (check all that apply). If you did not receive this form, fill in line(s) 4f and/or 4g and see instructions. Fill in if you were enrolled in private insurance and MassHealth or Commonwealth Care and enter your private insurance information in line(s) 4f and/or 4g and go to line 5.

4a. Private insurance, including ConnectorCare (completes line(s) 4f and/or 4g below)	X	You	X	Spouse
4b. MassHealth. Fill in and go to line 5	X	You	X	Spouse
4c. Medicare (including a replacement or supplemental plan). Fill in and go to line 5	X	You	X	Spouse
4d. U.S. Military (including Veterans Administration and Tri-Care). Fill in and go to line 5	X	You	X	Spouse
4e. Other program (enter the program name(s) only in lines 4f and/or 4g below). Note: Health Safety Net is not considered insurance or minimum creditable coverage.	X	You	X	Spouse

4f. Your Health Insurance. Complete if you answered line(s) 4a or 4e and go to line 5.

NAMEOFINSURANCECOMPANYXXXXXXXXXX SUBSCRIBERNUMBERXXXXX
NAMEOFINSURANCECOMPANYXXXXXXXXXX SUBSCRIBERNUMBERXXXXX

4g. Spouse Health Insurance. Complete if you answered line(s) 4a or 4e and go to line 5.

NAMEOFINSURANCECOMPANYXXXXXXXXXX SUBSCRIBERNUMBERXXXXX
NAMEOFINSURANCECOMPANYXXXXXXXXXX SUBSCRIBERNUMBERXXXXX

5. If you had health insurance that met MCC requirements for the full-year, including private insurance, MassHealth, Commonwealth Care or ConnectorCare, you are not subject to a penalty. Skip the remainder of this schedule and continue completing your tax return. Other wise, go to line 6.

If you had Medicare (including a replacement or supplemental plan), U.S. Military (including Veterans Administration and Tri-Care), or other government insurance at any point during 2024, you are not subject to a penalty. Skip the remainder of this schedule and continue completing your tax return. Otherwise, go to line 6.

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2024 Schedule HC, pg. 2

SOCIALSECNO XXXXXXXXXXXXX

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You might be eligible for low- or no-cost health insurance coverage.

If you (and/or your spouse, if married filing jointly) do not have health insurance coverage, you might be eligible for health insurance coverage programs made available by the Commonwealth of Massachusetts. By filling in the oval below, you authorize DOR to share information from your tax return and attached schedules with the Health Connector. If you are married filing jointly, both spouses must check the box for the Health Connector to receive all of your information. The Health Connector will assess your eligibility for those coverage options, including low- or no-cost coverage, and contact you with information. See instructions.

You: X I authorize DOR to share this tax return including attached schedules with the Massachusetts Health Connector for the purpose of assessing my eligibility for insurance affordability programs and contacting me with information about the same.

Spouse: X I authorize DOR to share this tax return including attached schedules with the Massachusetts Health Connector for the purpose of assessing my eligibility for insurance affordability programs and contacting me with information about the same.

Your Health Insurance

6. Was your income in 2024 at or below 150% of the federal poverty level? **6** X Yes X No

If you answer Yes, you are not subject to a penalty in 2024. Skip the remainder of this schedule and complete your tax return. If you answer No and you were enrolled in a health insurance plan that met the MCC requirements for part, but not all, of 2024, go to line 7. If you answer No and you had no insurance or you were enrolled in a plan that did not meet the MCC requirements during the period that the mandate applied, go to line 8a.

7. Complete this section **only if** you, and/or your spouse if married filing jointly, were enrolled in a health insurance plan(s) that met the Minimum Creditable Coverage (MCC) requirements for part, but not all of 2024. Fill in below the months that met the MCC requirements, as shown on Form MA 1099-HC. If you did not receive this form, fill in the months you were covered by a plan that met the MCC requirements at least **15 days or more**. If, during 2024, you **turned 18**, you were a **part-year resident** or a taxpayer was **deceased**, fill in the oval(s) below for the month(s) that met the MCC requirements during the period that the mandate applied. See instructions.

You may only fill in the month(s) you had health insurance that met MCC requirements. If you had health insurance, but it did not meet MCC requirements, you must skip this section and go to line 8a.

Months Covered By Health Insurance

	Jan.	Feb.	March	April	May	June	July	Aug.	Sept.	Oct.	Nov.	Dec.
You:	X	X	X	X	X	X	X	X	X	X	X	X
Spouse:	X	X	X	X	X	X	X	X	X	X	X	X

If you had four or more consecutive months either with no insurance or insurance that did not meet the MCC requirements (four or more blank months in a row), go to line 8a. Otherwise, a penalty does not apply to you in 2024. Skip the remainder of this schedule and complete your tax return.

Religious Exemption and Certificate of Exemption

8a. **Religious exemption:** Are you claiming an exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs that cause you to object to substantially all forms of treatment covered by health insurance? **8a** You X Yes X No / Spouse X Yes X No

If you answer Yes, go to line 8b. If you answer No, go to line 9.

8b. If you are claiming a religious exemption in line 8a, did you receive medical health care during the 2024 tax year? **8b** You X Yes X No / Spouse X Yes X No

If you answer No to line 8b, skip the remainder of this schedule and continue completing your tax return. If you answer Yes to line 8b, go to line 9.

9. **Certificate of exemption:** Have you obtained a Certificate of Exemption issued by the Massachusetts Health Connector for the 2024 tax year? **9** You X Yes X No / Spouse X Yes X No

If you answer Yes, enter the certificate number, skip the remainder of this schedule and continue completing your tax return. If you answer No to line 9, go to line 10. CERTNUMB SPCERTNO

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2024 Schedule HC, pg. 3

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Affordability as Determined By State Guidelines

Note: This section will require the use of worksheets and tables found in the instructions. You must complete the worksheet(s) to determine if health insurance was affordable to you during the 2024 tax year.

10. Did your employer offer affordable health insurance that met minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 10 in the instructions?

10 You X Yes X No

Spouse X Yes X No

Fill in No if your employer did not offer health insurance that met minimum creditable coverage requirements, you were not eligible for health insurance offered by your employer, you were self-employed or you were unemployed.

11. Were you eligible for government-subsidized health insurance as determined by completing the Schedule HC Worksheet for Line 11 in the instructions?

11 You X Yes X No

Spouse X Yes X No

If you answer No, go to line 12. If you answer Yes, go to the Health Care Penalty Worksheet in the instructions to calculate your penalty amount.

12. Were you able to purchase affordable private health insurance that met minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 12 in the instructions?

12 You X Yes X No

Spouse X Yes X No

If you answer No, you are not subject to a penalty. Continue completing your tax return. If you answer Yes, go to the Health Care Penalty Worksheet in the instructions to calculate your penalty amount.

Complete Only If You Are Filing An Appeal

You must complete the Health Care Penalty Worksheet to determine your penalty amount before completing this section.

You may have grounds to appeal if you were unable to obtain affordable insurance that meets the minimum creditable coverage requirements in 2024 due to a hardship or other circumstances. The grounds for appeal are explained in more detail in the instructions. If you believe you have grounds for appealing the penalty, fill in the field(s) below. The appeal will be heard by the Massachusetts Health Connector. By filling in the field below, you (or your spouse if married filing jointly) are authorizing DOR to share information from your tax return, including this schedule, with the Massachusetts Health Connector for purposes of deciding your appeal. **You will receive a follow-up letter asking you to state your grounds for appeal in writing, and submit supporting documentation. Failure to respond to that letter within the time specified in the letter will lead to dismissal of your appeal and will result in a future assessment of a penalty.** Once your documentation is received, it will be reviewed by the Massachusetts Health Connector and you may be required to attend a hearing on your case. You will be required to file your claims under the pains and penalties of perjury.

Note: If you are filing an appeal, make sure you have calculated the penalty amount that you are appealing, but do not assess yourself or enter a penalty amount on your Form 1 or Form 1-NR/PY. Also, do not include any hardship documentation with your original return. You will be required to submit substantiating hardship documentation at a later date during the appeal process.

You: X I wish to appeal the penalty. I authorize DOR to share this tax return including this schedule with the Massachusetts Health Connector for purposes of deciding this appeal.

Spouse: X I wish to appeal the penalty. I authorize DOR to share this tax return including this schedule with the Massachusetts Health Connector for purposes of deciding this appeal.

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