Full-year residents and certain part-year residents must complete and enclose Schedule HC with return.

TAXPAYER'S FIRST NAME | M.I. | LAST NAME | TAXPAYER'S SOCIAL SECURITY NUMBER

Schedule HC Health Care Information.

You must **enclose** this schedule with Form 1 or Form 1-NR/PY. **2024**

1 a. Date of birth MMDDYYYY b. Spouse's date of birth MMDDYYYY c. Family size. See instructions

2 Federal adjusted gross income (**required** information; from U.S. Form 1040, line 11). If married filing separately, see instructions 2 00

3 Indicate the time period that you were enrolled in a Minimum Creditable Coverage (MCC) health insurance plan(s). See Form MA 1099-HC from your insurer or Schedule HC instructions. **You must fill in an oval.**

a. You	Full-year MCC	Part-year MCC	No MCC/None
b. Spouse	Full-year MCC	Part-year MCC	No MCC/None

If you filled in "Full-year MCC" or "Part-year MCC," 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. See Form MA 1099-HC from your insurer or Schedule HC instructions. **Check all that apply.**

a. Private insurance, including ConnectorCare. Complete lines 4f and/or 4g below	4a	You	Spouse
b. MassHealth. Fill in oval(s) and go to line 5	4b	You	Spouse
c. Medicare (including a replacement or supplemental plan). Fill in oval(s) and go to line 5	4c	You	Spouse
d. U.S. military (including Veteran's Administration and Tri-Care). Fill in oval(s) and go to line 5	4d	You	Spouse
e. Other program. Enter program name(s) only in lines 4f and/or 4g below (see instructions)	4e	You	Spouse

4f YOUR HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5.

1. NAME OF PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM (from box 1 of Form MA 1099-HC)

SUBSCRIBER NUMBER (from Form MA 1099-HC) **Note:** If you were not issued Form MA 1099-HC, enter the Identification number from your health insurance card.

2. NAME OF SECOND PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM IF NECESSARY (from box 1 of Form MA 1099-HC)

SUBSCRIBER NUMBER (from Form MA 1099-HC) **Note:** If you were not issued Form MA 1099-HC, enter the Identification number from your health insurance card.

4g SPOUSE'S HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5.

1. NAME OF PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM FOR SPOUSE (from box 1 of Form MA 1099-HC)

SUBSCRIBER NUMBER (from Form MA 1099-HC) **Note:** If you were not issued Form MA 1099-HC, enter the Identification number from your health insurance card.

2. NAME OF SECOND PRIVATE INSURANCE COMPANY, ADMINISTRATOR OR OTHER GOVERNMENT PROGRAM IF NECESSARY FOR SPOUSE (from box 1 of Form MA 1099-HC)

SUBSCRIBER NUMBER (from Form MA 1099-HC) **Note:** If you were not issued Form MA 1099-HC, enter the Identification number from your health insurance card.

5 **Skip the remainder of this schedule and continue completing your return if** you had health insurance that met MCC requirements for the full year, including private insurance, MassHealth or ConnectorCare; **or** if, at any point during 2024, you had Medicare (including supplement or replacement plan), U.S. Military (including Veterans Administration and Tri-Care), or other government insurance. You are **not** subject to a penalty.

You must complete and enclose this Schedule HC with your return.

IF YOU HAD HEALTH INSURANCE THAT MET MCC REQUIREMENTS FOR THE FULL YEAR, INCLUDING PRIVATE INSURANCE, MASSHEALTH OR CONNECTORCARE, OR IF YOU HAD MEDICARE, U.S. MILITARY OR OTHER GOVERNMENT INSURANCE AT ANY POINT DURING 2024, YOU ARE NOT SUBJECT TO A PENALTY. SKIP THE REMAINDER OF SCHEDULE HC AND CONTINUE COMPLETING YOUR TAX RETURN.

TAXPAYER'S FIRST NAME | M.I. | LAST NAME | TAXPAYER'S SOCIAL SECURITY NUMBER

Schedule HC Uninsured for All or Part of 2024.

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: ◯ 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: ◯ 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.

6 Was your income in 2024 at or below 150% of the federal poverty level? (See worksheet) . . . . . 6 ◯ Yes ◯ 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 Minimum Creditable Coverage (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 the ovals below for the months that met the MCC requirements, as shown on Form MA 1099-HC. If you did not receive this form, fill in the ovals for 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 oval(s) for 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 THAT MET MINIMUM CREDITABLE COVERAGE

	JAN	FEB	MARCH	APRIL	MAY	JUNE	JULY	AUG	SEPT	OCT	NOV	DEC
You:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Spouse:	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

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 ovals in a row), go to line 8a. Otherwise, **you are not subject to a penalty in 2024. Skip the remainder of this schedule and complete your tax return.**

Schedule HC Religious Exemption and Certificate of Exemption

Do not complete if you are not subject to a penalty.

8 a. **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 ◯ Yes ◯ No
Spouse ◯ Yes ◯ No

If you answer **Yes**, go to line 8b. If you answer **No**, go to line 9. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

b. If you are claiming a religious exemption in line 8a, did you receive medical health care during the 2024 tax year?

8b. You ◯ Yes ◯ No
Spouse ◯ Yes ◯ No

If you answer **No** to line 8b, **you are not subject to a penalty in 2024. Skip the remainder of this schedule and continue completing your tax return.**
If you answer **Yes** to line 8b, go to line 9. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

9 **Certificate of exemption.** Have you obtained a Certificate of Exemption issued by the Massachusetts Health Connector for the 2024 tax year?

9. You ◯ Yes ◯ No
Spouse ◯ Yes ◯ No

Note: If you received a Certificate of Exemption from the Federal shared responsibility requirement in 2024, issued by the Federal Health Insurance Marketplace, do not enter that information in line 9.

If you answer **Yes**, enter the certificate number below, **you are not subject to a penalty in 2024. Skip remainder of schedule and continue completing your tax return.** If you answer **No** to line 9, go to line 10. If you are filing a joint return and one spouse answers **Yes** but the other spouse answers **No**, see instructions.

YOUR MASSACHUSETTS CERTIFICATE NUMBER | SPOUSE'S MASSACHUSETTS CERTIFICATE NUMBER

TAXPAYER'S FIRST NAME | M.I. | LAST NAME | TAXPAYER'S SOCIAL SECURITY NUMBER

Schedule HC Affordability as Determined By State Guidelines

Do not complete if you are not subject to a penalty.

Note: This section will require the use of worksheets and tables. 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 the minimum creditable coverage requirements as determined by completing the Schedule HC Worksheet for Line 10?

10. You ○ Yes ○ No
Spouse ○ Yes ○ No

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

If you answer **No**, go to line 11. If you answer **Yes**, go to the Health Care Penalty Worksheet to calculate your penalty amount.

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

11. You ○ Yes ○ No
Spouse ○ Yes ○ No

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

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

12. You ○ Yes ○ No
Spouse ○ Yes ○ 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 to calculate your penalty amount.

Schedule HC 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 met 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 oval(s) below. The appeal will be heard by the Massachusetts Health Connector. By filling in the oval 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.

Important information if you are filing an 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 this return. You will be required to submit substantiating hardship documentation at a later date during the appeal process.

You: ○ 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: ○ 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.

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.