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		022 Schedule HC		FOR 2-I						
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Sc	hedul	le HC, Health Care Information, must be completed b	v all							
		r residents and certain part-year residents (see instru	-							
	-	Schedule HC must be enclosed with your Form 1 or Fo								
	NR/P\	Y. Failure to do so will delay the processing of your re	turn.							
	FI	IRSTNAMEXXXXXXXX I LÅSTNAM	<b>1EXXXXXX</b>	XXXXXX S	OCIALSE	CNO				
					V		\/\/			
	1a.	Date of birth XXXXXXXX 1b. Spouse's	s date of birth	XXXXXXX	X 1c. Famil	y size	XX			
								VVVV	VVV	/VVVV
	2.	Federal adjusted gross income					2 -	хххх	XX	(XXXXX
	2	Indicate the time period that you were entalled in a N	Ainimum Cradita	bla Cayaraga (M	C) health incurs	aaa nlan	(a) The Ferm		00 110	from vour
	3.	Indicate the time period that you were enrolled in a I insurer will indicate whether your insurance met MC		,			٠,			
		Veterans Administration and Tri-Care, meet the MCC								-
		that did not meet MCC requirements, see the specia		-		133-1101	ioni your ins	uiei, oi y	you na	iu ilisulalice
		that did not meet woo requirements, see the specia	ii section on wo	5 requirements in	trie matructions.					
		See instructions if, during 2022, you turned 18, you		<b>3a</b> You:	X Full-year MC	c X	Part-year M	icc X	No	MCC/None
		were a part-year resident or a taxpayer was decease		3a Spouse:	X Full-year MC	c X	Part-year M	icc X	,	MCC/None
		If you filled in the full-year or part-year MCC oval, go								
					, 0					
	4.	Indicate the health insurance plan(s) that met the Mi	nimum Creditabl	e Coverage (MC	C) requirements in	n which y	ou were enr	olled in 2	2022,	as
		shown on Form MA 1099-HC (check all that apply).	If you did not rec	eive this form, fill	in line(s) 4f and/d	r 4g and	see instruct	ions. Fill	l in if y	ou were
		enrolled in private insurance and MassHealth or Cor	mmonwealth Car	e and enter your	private insurance	informat	ion in line(s)	4f and/o	or 4g a	and go
		to line 5.								
							V		V	
		4a. Private insurance, including ConnectorCare (con	mpletes line(s) 4	f and/or 4g below	)		X	You	X	Spouse
		<ul><li>4a. Private insurance, including ConnectorCare (co.</li><li>4b. MassHealth. Fill in and go to line 5</li></ul>					X	You	X	Spouse
		<ul><li>4a. Private insurance, including ConnectorCare (co.</li><li>4b. MassHealth. Fill in and go to line 5</li><li>4c. Medicare (including a replacement or supplement)</li></ul>	ntal plan). Fill in	and go to line 5				You You		Spouse Spouse
		<ul> <li>4a. Private insurance, including ConnectorCare (co.</li> <li>4b. MassHealth. Fill in and go to line 5</li> <li>4c. Medicare (including a replacement or suppleme</li> <li>4d. U.S. Military (including Veterans Administration)</li> </ul>	ntal plan). Fill in and Tri-Care). Fil	and go to line 5 I in and go to line	5		X	You You You	X	Spouse Spouse Spouse
		<ul> <li>4a. Private insurance, including ConnectorCare (co.</li> <li>4b. MassHealth. Fill in and go to line 5</li> <li>4c. Medicare (including a replacement or suppleme</li> <li>4d. U.S. Military (including Veterans Administration</li> <li>4e. Other program (enter the program name(s) only</li> </ul>	ntal plan). Fill in and Tri-Care). Fil in lines 4f and/o	and go to line 5 I in and go to line	5	et	X	You You	X	Spouse Spouse
		<ul> <li>4a. Private insurance, including ConnectorCare (co.</li> <li>4b. MassHealth. Fill in and go to line 5</li> <li>4c. Medicare (including a replacement or suppleme</li> <li>4d. U.S. Military (including Veterans Administration)</li> </ul>	ntal plan). Fill in and Tri-Care). Fil in lines 4f and/o	and go to line 5 I in and go to line	5	et	X	You You You	X	Spouse Spouse Spouse
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2022 Schedule HC ng 2	A	REA	ARE	ESEF	RVE	D				
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14	1 \	J1 1 2	י ט י							
15										
16										
17										
18 19 You might be eligible for low- or no-cost health insurance coverag	Δ									
20 If you (and/or your spouse, if married filing jointly) do not have health insurance		nt be eligit	ble for he	ealth insur	ance cov	erage	e progr	ams r	nade	
available by the Commonwealth of Massachusetts. By filling in the oval below, y										
with the Health Connector. If you are married filing jointly, both spouses must ch										
<sup>23</sup> Connector will assess your eligibility for those coverage options, including low-										
You: X I authorize DOR to share this tax return including attach			achusett	s Health (	Connecto	or for t	the pur	pose	of as	sessing
my eligibility for insurance affordability programs and contacting me with information Spouse: X I authorize DOR to share this tax return including attact			achusatt	e Hoolth (	Connocto	or for t	the pur	naca	of ac	coccina
27 my eligibility for insurance affordability programs and contacting me with information			acriuseii	S Healin C	Johneed	ו וטו ונ	irie pui	pose	UI as	sessing
28 Your Health Insurance	anon about the can									
6. Was your income in 2022 at or below 150% of the federal poverty level						6		Yes		
If you answer Yes, you are not subject to a penalty in 2022. Skip the remainder										
31 in a health insurance plan that met the MCC requirements for part, but not all, o			swer No	and you h	ad no in	suran	nce or y	ou w	ere er	nrolled
in a plan that did not meet the MCC requirements during the period that the mai 7. Complete this section <b>only if</b> you, and/or your spouse if married filing ju			Ith insura	ance nlan	s) that m	net the	e Minin	num (	:redit	able
Coverage (MCC) requirements for part, but not all of 2022. Fill in below										
did not receive this form, fill in the months you were covered by a plan										
18, you were a part-year resident or a taxpayer was deceased, fill in	the oval(s) below fo	r the mon	th(s) tha	t met the l	MCC rec	uiren	nents d	uring	the p	eriod
that the mandate applied. See instructions.								_		
You may only fill in the month(s) you had health insurance that met MC you must skip this section and go to line 8a.	C requirements. If	you had h	ealth ins	urance, bi	it it did n	iot me	eet MC	C req	uirem	ients,
you must skip this section and go to line 8a.										
Months Covered By Health Insurance										
You: X Jan. X Feb. X March X April X May X	June X July	X AL	ug. X	Sept.	X Oct.	X	Nov.	Χ	Dec.	
Spouse: X Jan. X Feb. X March X April X May X	June X July	ν <mark>X</mark> Αι	ug. X	Sept.	X Oct.					
If you had four or more consecutive months either with no insurance or insurance						e blan	ık mon	ths in	a rov	v),
45 go to line 8a. Otherwise, a penalty does not apply to you in 2022. Skip the rema	inder of this sched	ule and co	omplete y	your tax re	turn.					
Religious Exemption and Certificate of Exemption										
8a. Religious exemption: Are you claiming an exemption from the require	ement to purchase I	nealth insu	urance b	ased	88	You	Χ	Yes	Χ	No
on your sincerely held religious beliefs that cause you to object to subs										
health insurance?					Sp	ouse	X	Yes	X	No
If you answer Yes, go to line 8b. If you answer No, go to line 9.							V		V	
8b. If you are claiming a religious exemption in line 8a, did you receive med	dical health care du	ring the 2	.022 tax y	year?		You	X	Yes Yes		No No
53 54 If you answer No to line 8b, skip the remainder of this schedule and continue co	moleting your tay r	aturn If vo	nu anewe	ar Vae to li		ouse o to lir		Yes		INO
9. Certificate of exemption: Have you obtained a Certificate of Exemption		-			-	You	X	Yes	Χ	No
Connector for the 2022 tax year?						ouse		Yes		No
<sub>57</sub> If you answer Yes, enter the certificate number, skip the remainder of this sched	ule and continue co	mpleting	your tax		RTNU	MB				
se return. If you answer No to line 9, go to line 10.				SP	CERT	NÜ				
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## AREA RESERVED FOR 2-D BARCODE

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8	TRETHAMENYAWAY T LACTHAMENYAWAYAYAYAY GOCTAL CECHO					
9	IRSTNAMEXXXXXXX I LASTNAMEXXXXXXXXXXX SOCIALSECNO					
0 0.00						
	dability as Determined By State Guidelines					
	This section will require the use of worksheets and tables found in the instructions. You must complete the worksheet(s) to	determine if	health	ı insur	ance	was
	able to you during the 2022 tax year.	40.74	V	.,	V	
	Did your employer offer affordable health insurance that met minimum creditable coverage requirements	<b>10</b> You		Yes Yes		No No
5	as determined by completing the Schedule HC Worksheet for Line 10 in the instructions?	Spouse				
	No if your employer did not offer health insurance that met minimum creditable coverage requirements, you were not eligib	e for nealth in	ısurar	ice off	erea	by
F	mployer, you were self-employed or you were unemployed.	44.1/	V	V	V	
	Were you eligible for government-subsidized health insurance as determined by completing the Schedule HC	<b>11</b> You		Yes Yes	X	
9	Worksheet for Line 11 in the instructions?	Spouse		Yes	^	INO
T .	answer No, go to line 12. If you answer Yes, go to the Health Care Penalty Worksheet in the instructions to calculate your			Yes	V	NI.
	Were you able to purchase affordable private health insurance that met minimum creditable coverage requirements	12 You Spouse	Ŷ			No
2	as determined by completing the Schedule HC Worksheet for Line 12 in the instructions?					INO
1 7	answer No, you are not subject to a penalty. Continue completing your tax return. If you answer Yes, go to the Health Care	Penalty work	snee	. in the	,	
4 mstruc	tions to calculate your penalty amount.					
. Com	olete Only If You Are Filing An Appeal					
	nust complete the Health Care Penalty Worksheet to determine your penalty amount before completing this sectio	n.				
	ay have grounds to appeal if you were unable to obtain affordable insurance that meets the minimum creditable coverage		in 202	2 due	to a	
	nip or other circumstances. The grounds for appeal are explained in more detail in the instructions. If you believe you have					
	ne field(s) below. The appeal will be heard by the Massachusetts Health Connector. By filling in the field below, you (or you					
-	izing DOR to share information from your tax return, including this schedule, with the Massachusetts Health Connector for					
	ill receive a follow-up letter asking you to state your grounds for appeal in writing, and submit supporting docum					
	etter within the time specified in the letter will lead to dismissal of your appeal and will result in a future assessme					
	nentation is received, it will be reviewed by the Massachusetts Health Connector and you may be required to attend a hear					eguire
	your claims under the pains and penalties of perjury.					Ť
-	If you are filing an appeal, make sure you have calculated the penalty amount that you are appealing, but do not assess y	ourself or ente	er a pe	enalty	amo	unt
	ir Form 1 or Form 1-NR/PY. Also, do not include any hardship documentation with your original return. You will be required					
	nentation at a later date during the appeal process.					
.9						
10	You: X I wish to appeal the penalty. I authorize DOR to share this tax return including this schedule with the Ma	ssachusetts F	lealth	Conn	ector	r
1	for purposes of deciding this appeal.					
2						
3	Spouse: X I wish to appeal the penalty. I authorize DOR to share this tax return including this schedule with the Ma	ssachusetts F	lealth	Conn	ector	r
4	for purposes of deciding this appeal.					
5						
6						
7						
8						
9						
0						
1	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXX	XX	(XX		