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. **2017**

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

2 Federal adjusted gross income (**required** information; from U.S. Forms 1040, line 37; 1040A, line 21; or 1040EZ, line 4). If marriedt filing separately, see instructions . . . . . 2 X 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 2017. 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 government program. Enter program name(s) only in lines 4f and/or 4g below	4e	⬭ You	⬭ Spouse

4f YOUR HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5. ⬭ Fill in if you were not issued Form MA 1099-HC.

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

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SUBSCRIBER NUMBER (from Form MA 1099-HC)

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

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SUBSCRIBER NUMBER (from Form MA 1099-HC)

4g SPOUSE'S HEALTH INSURANCE. Complete if you answered line(s) 4a or 4e and go to line 5. ⬭ Fill in if you were not issued Form MA 1099-HC.

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

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SUBSCRIBER NUMBER (from Form MA 1099-HC)

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

FEDERAL IDENTIFICATION NUMBER OF INSURANCE CO. (from box 2 of Form MA 1099-HC) | SUBSCRIBER NUMBER (from Form MA 1099-HC)

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 2017, 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.

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

Schedule HC Uninsured for All or Part of 2017. Do not complete if you are not subject to a penalty.

6 Was your income in 2017 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 2017. 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 2017, 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 2017. 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 2017, 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, a penalty does not apply to you in 2017. **You are not subject to a penalty in 2017. 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 2017 tax year?

8b. You ○ Yes ○ No
Spouse ○ Yes ○ No

If you answer **No** to line 8b, **you are not subject to a penalty in 2017. 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 2017 tax year?

9. You ○ Yes ○ No
Spouse ○ Yes ○ No

Note: If you received a Certificate of Exemption from the Federal shared responsibility requirement in 2017, 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 2017. Skip the remainder of this 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

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.

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 2017 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 2017 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.

Note: You may also be subject to a separate federal penalty if you were uninsured. Visit irs.gov for more information on the federal requirements.

If you are subject to a federal penalty, you must enter that amount on Form 1, line 35c or Form 1-NR/PY, line 39c.

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.