FULL-YEAR RESIDENTS AND CERTAIN PART-YEAR RESIDENTS MUST COMPLETE AND ENCLOSE SCHEDULE HC WITH RETURN.

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

Schedule HC Health Care Information. You must enclose this schedule with Form 1 or Form 1-NR/PY. 2013

1 **a.** Date of birth ► M M D D Y Y Y Y **b.** Spouse's date of birth ► M M D D Y Y Y Y **c.** Family size ► (see instructions)

2 Federal adjusted gross income (**required** information). If married filing separately, see instructions (from U.S. Forms 1040, line 37; 1040A, line 21; or 1040EZ, line 4). . . . . ► **2** 0 0

3 Indicate the time period that you were enrolled in a Minimum Creditable Coverage (MCC) health insurance plan(s). You **must** fill in an oval. The Form MA 1099-HC from your insurer will indicate whether your insurance met MCC requirements. **Note:** MassHealth, Commonwealth Care, 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 section on MCC requirements in the instructions.

► **3a** You: Full-year MCC Part-year MCC No MCC/None

► **3b** Spouse: Full-year MCC Part-year MCC No MCC/None

Note: See instructions if, during 2013, you turned 18, you were a part-year resident or a taxpayer was deceased.

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 2013, as shown on Form MA 1099-HC (check all that apply). If you did not receive this form, fill in the oval in line(s) 4f and/or 4g and see instructions. If you were enrolled in private insurance and MassHealth or Commonwealth Care, fill in the ovals, enter your private insurance information in line(s) 4f and/or 4g and go to line 5.

4a	Private insurance (complete lines 4f and/or 4g below). If more than two, complete Schedule HC-CS.	**4a**	You Spouse
4b	MassHealth or Commonwealth Care. Fill in oval(s) and go to line 5.	**4b**	You Spouse
4c	Medicare (including a replacement or supplemental plan). Fill in oval(s) and go to line 5.	**4c**	You Spouse
4d	U.S. Military (including Veterans Administration and Tri-Care). Fill in oval(s) and go to line 5.	**4d**	You Spouse
4e	Other government 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.	**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) | SPOUSE'S 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) | SPOUSE'S SUBSCRIBER NUMBER (from Form MA 1099-HC)

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

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 2013, you are not subject to a penalty. **Skip the remainder of this schedule and continue completing your tax return.**

If you filled in the "Part-year MCC" or "No MCC/None" in line 3, you must complete line 6.

BE SURE YOU FILLED IN LINES 2 & 3 ABOVE. YOU MUST COMPLETE AND ENCLOSE SCHEDULE HC WITH YOUR RETURN.

Attach, with a single staple, copy of Form MA 1099-HC, if applicable.

FIRST NAME | M.I. | LAST NAME | SOCIAL SECURITY NUMBER

Uninsured for All or Part of 2013

6 Was your income in 2013 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 2013. 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 2013, 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 2013. 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 2013, 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 2013. **Skip the remainder of this schedule and complete your tax return.**

Religious Exemption and Certificate of Exemption

8 **a. RELIGIOUS EXEMPTION.** Are you claiming an exemption from the requirement to purchase health insurance based on your sincerely held religious beliefs? ► **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 2013 tax year? ► **8b** You: ○ Yes ○ No Spouse: ○ Yes ○ 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. 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 Commonwealth Health Insurance Connector Authority for the 2013 tax year? ► **9** You: ○ Yes ○ No Spouse: ○ Yes ○ No

If you answer **Yes**, enter the certificate number below, **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 CERTIFICATE NUMBER

SPOUSE'S CERTIFICATE NUMBER

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.

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Affordability as Determined By State Guidelines

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 2013 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.

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 2013 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 Commonwealth Health Insurance Connector Authority. 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 Connector Authority 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 Commonwealth Health Insurance Connector Authority 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: ○ I wish to appeal the penalty. I authorize DOR to share this tax return including this schedule with the Commonwealth Health Insurance Connector Authority 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 Commonwealth Health Insurance Connector Authority for purposes of deciding this appeal.

BE SURE TO ENCLOSE SCHEDULE HC WITH YOUR RETURN.