06 07 0	08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42	2 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80			
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11	2018 Schedule HC AREA RESERVED				
12	FOR 2-D BARCODE				
13 / 14					
	dule HC, Health Care Information, must be completed by all	1			
	ear residents and certain part-year residents (see instructions).				
-	: Schedule HC must be enclosed with your Form 1 or Form	1			
18 1-NR	R/PY. Failure to do so will delay the processing of your return.	1			
19	FIRSTNAMEXXXXXXXI I LASTNAMEXXXXXXXX	XXXX SOCIALSECNO			
20		2			
21		2'			
22 1a	a. Date of birth XXXXXXX 1b. Spouse's date of birth	XXXXXXX 1c. Family size XX			
23		22			
	2. Federal adjusted gross income	2 —XXXXXXXXXXX 2			
25	2 Indicate the time period that you were appelled in a Minimum On Altable	2 2 Coverage (MCC) health insurance plan(s). The Form MA 1099-HC from your insurer			
27 28		sHealth, Medicare, and health coverage for U.S. Military, including Veterans 2 receive a Form MA 1099-HC from your insurer, or you had insurance that did 2			
20	not meet MCC requirements, see the special section on MCC requirements				
30		3			
31	See instructions if, during 2018, you turned 18, you 3a	You: X Full-year MCC X Part-year MCC X No MCC/None			
32		Spouse: X Full-year MCC X Part-year MCC X No MCC/None 3			
33	If you filled in the full-year or part-year MCC oval, go to line 4. If you filled				
34		3			
35 4	4. Indicate the health insurance plan(s) that met the Minimum Creditable Co				
36	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				
37	enrolled in private insurance and MassHealth or Commonwealth Care ar	nd enter your private insurance information in line(s) 4f and/or 4g and go 3			
38	to line 5.	3			
39	4a. Private insurance, including ConnectorCare (completes line(s) 4f and				
40	4b. MassHealth. Fill in and go to line 5 4c. Medicare (including a replacement or supplemental plan). Fill in and				
41	 4c. Medicare (including a replacement of supplemental plan). Finn and 4d. U.S. Military (including Veterans Administration and Tri-Care). Fill in 				
42 43	4e. Other government program (enter the program name(s) only in lines				
44	is not considered insurance or minimum creditable coverage.	4 and/or 49 below). Note: nearin Salety Net X 100 X Spouse 4			
45		4			
46 4	4f. Your Health Insurance. Complete if you answered line(s) 4a or 4e a	nd go to line 5. X Fill in if you were not issued Form MA 1099-HC. 4			
47	NAMEOFINSURANCECOMPANYXXXXXXXXXXX	FEDERALIDEN SUBSCRIBERNUMBERXXXXX 4			
48	NAMEOFINSURANCECOMPANYXXXXXXXXXXX	FEDERALIDEN SUBSCRIBERNUMBERXXXXX 4			
49		4			
50 4	4g. Spouse's Health Insurance. Complete if you answered line(s) 4a of the second se	r 4e and go to line 5. X Fill in if you were not issued Form MA 1099-HC.			
	NAMEOFINSURANCECOMPANYXXXXXXXXXX	FEDERALIDEN SUBSCRIBERNUMBERXXXXX			
	NAMEOFINSURANCECOMPANYXXXXXXXXXX	FEDERALIDEN SUBSCRIBERNUMBERXXXXX s			
53 	E If you had had the insurance that mat MCC as minutes to the full	5			
		including private insurance, MassHealth, Commonwealth Care or ConnectorCare, 5			
55	you are not subject to a penalty. Skip the remainder of this schedule and				
56	If you had Medicare (including a replacement or supplemental plan). If S	5. Military (including Veterans Administration and Tri-Care), or other government			
57 58		b the remainder of this schedule and continue completing your tax return. Other-			
59	wise, go to line 6.				
50 50		6			
51	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX			
52		60			
63		6			
06 07 0	08 09 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42	2 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80			

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¹² 2018 Schedule HC. pg. 2	AREA RESERVED
12 2018 Schedule HC, pg. 2 13 SOCIALSECNO XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	FOR 2-D BARCODE
15	
16	
17	
18	
¹⁹ Uninsured for All or Part of 2018	
 6. Was your income in 2018 at or below 150% of the federal poverty lev 	el? 6 X Yes X No
	of this schedule and complete your tax return. If you answer No and you were enrolled
²² In a nearth insurance plan that met the MCC requirements for part, but not all, c ²³ a plan that did not meet the MCC requirements during the period that the mand	of 2018, go to line 7. If you answer No and you had no insurance or you were enrolled in
	jointly, were enrolled in a health insurance plan(s) that met the Minimum Creditable
	by the months that met the MCC requirements, as shown on Form MA 1099-HC. If you that mot the MCC requirements at least 15 days or more. If during 2018, you turned
	n that met the MCC requirements at least 15 days or more . If, during 2018, you turned
	n the oval(s) below for the month(s) that met the MCC requirements during the period
that the mandate applied. See instructions.	
	ICC requirements. If you had health insurance, but it did not meet MCC requirements,
you must skip this section and go to line 8a.	
31 29 Martha Covered Du Haalth Incurrence	
³² Months Covered By Health Insurance	
33 You X Jan. X Feb. X March X April X May	X June X July X Aug. X Sept. X Oct. X Nov. X Dec. X June X July X Aug. X Sept. X Oct. X Nov. X Dec.
	nce that did not meet the MCC requirements (four or more blank months in a row),
³⁶ go to line 8a. Otherwise, a penalty does not apply to you in 2018. Skip the rem	ainder of this schedule and complete your tax return.
37 29 Deligious Everytics and Cartificate of Everytics	
³⁸ Religious Exemption and Certificate of Exemption	rement to purchase health insurance based 8a You X Yes X No
39 8a. Religious exemption: Are you claiming an exemption from the requi	
40 on your sincerely held religious beliefs that cause you to object to sub the sub-sub-sub-sub-sub-sub-sub-sub-sub-sub-	
41 health insurance?	Spouse X Yes X No
⁴² If you answer Yes, go to line 8b. If you answer No, go to line 9.	
⁴³ 8b. If you are claiming a religious exemption in line 8a, did you receive m	
44	Spouse X Yes X No
⁴⁵ If you answer No to line 8b, skip the remainder of this schedule and continue of	
46 9. Certificate of exemption: Have you obtained a Certificate of Exemp	
47 Connector for the 2018 tax year?	Spouse X Yes X No
⁴⁸ If you answer Yes, enter the certificate number, skip the remainder of this sche	edule and continue completing your tax CERTNUMB
⁴⁹ return. If you answer No to line 9, go to line 10.	SPCERTNO
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61	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
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11 12	2018 Schedule HC, pg. 3 AREA RESERVED						11
13	018 Schedule HC, pg. 3	FOR 2-D BARC	ODE				1:
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	IRSTNAMEXXXXXXX I LASTNAMEXXXXX	XXXXXXX SOCIALSECNO					19
20							20
	dability as Determined By State Guidelines						2
	This section will require the use of worksheets and tables found in t able to you during the 2018 tax year.	the instructions. You must complete the worksheet(s) to	determine if he	alth insu	urance	e was	2
	Did your employer offer affordable health insurance that met mini	imum creditable coverage requirements	10 You	X Yes	X	No	23
25	as determined by completing the Schedule HC Worksheet for Lin			X Yes			2
26 Fill in	No if your employer did not offer health insurance that met minimum		e for health ins	urance c	offered	d by	20
-	mployer, you were self-employed or you were unemployed.			V	V		2
	Were you eligible for government-subsidized health insurance as	determined by completing the Schedule HC		X Yes X Yes			2
29 30 If vou	Worksheet for Line 11 in the instructions? answer No, go to line 12. If you answer Yes, go to the Health Care I	Penalty Worksheet in the instructions to calculate your r			Λ	INO	2
	Were you able to purchase affordable private health insurance th			X Yes	Х	No	3
32	as determined by completing the Schedule HC Worksheet for Lin		Spouse	X Yes	Х	No	3
Ŧ	answer No, you are not subject to a penalty. Continue completing ye	our tax return. If you answer Yes, go to the Health Care	Penalty Works	heet in t	he		3
34 instru	tions to calculate your penalty amount.						3
35 36 Com	blete Only If You Are Filing An Appeal						3
	nust complete the Health Care Penalty Worksheet to determine	your penalty amount before completing this section	1.				3
	ay have grounds to appeal if you were unable to obtain affordable in						3
	ip or other circumstances. The grounds for appeal are explained in						3
	ne field(s) below. The appeal will be heard by the Massachusetts He izing DOR to share information from your tax return, including this s						4
	rill receive a follow-up letter asking you to state your grounds f						4 at 4
	within the time specified in the letter will lead to dismissal of yo	•••••••••••••••••••••••••••••••••••••••					4
	ived, it will be reviewed by the Massachusetts Health Connector an	nd you may be required to attend a hearing on your case	. You will be re	quired to	o file y	our	4
	under the pains and penalties of perjury.						4
	If you are filing an appeal, make sure you have calculated the pena Ir Form 1 or Form 1-NR/PY. Also, do not include any hardship docu						4
	information at a later date during the appeal process.	intentation with your original return. Too will be required		laniialiin	y nan	Jellih	4
49							4
50		hare this tax return including this schedule with the Mas	sachusetts Hea	alth Con	necto	r	50
51	for purposes of deciding this appeal.						5
52	Spouse X I wish to appeal the penalty. I authorize DOR to s	hare this tax return including this schedule with the Mas	sachusatte Hor	alth Con	necto	r	5
53	for purposes of deciding this appeal.	mare this tax return molecung this schedule with the Mas	3001030113110		IECIU		5
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59 60							5
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