Schedule HC form Instructions

1

Fill in the primary taxpayer's name (first, m.i., last) and SSN

2

Lines 1A-1B

Enter the date of birth for yourself and your spouse (if applicable).

3

Line 1C

Enter the number of household members. For assistance in determining your household size, refer to the Schedule HC Instructions Worksheet.

- For married participants filing separately, please refer to the Schedule HC Instructions Worksheet.

4

Lines 3A-3B

The SAG-AFTRA Health Plan did not meet the Minimum Creditable Coverage (MCC) requirements in 2020. Consequently, this section must be marked "No MCC/None"" for both, yourself, and your spouse. Skip lines 4-5 and go to line 6.

NOTE: If you or your spouse had coverage with other plan(s) that met the Minimum Creditable Coverage (MCC) requirements in 2020, please refer to the instructions. If the other coverage the primary position over your SAG-AFTRA Health Plan coverage, you may need to complete this form according to that plan's policy.

Also note that you may automatically meet the MCC requirement if you were enrolled in some government sponsored plans such as Medicare Part A or B, MassHealth, and Student Health Insurance Plan (SHIP). (For a full list of plans that automatically meet the MCC requirements, please refer to the 2020 MA Schedule HC Instructions Sheet).

TAXPAYER'S FIRST NAME: JOHN | M.I. | LAST NAME: SMITH | TAXPAYER'S SOCIAL SECURITY NUMBER: 123456789

Schedule HC Health Care Information. You must **enclose** this schedule with Form 1 or Form 1-NR/PY. 2020

1 a. Date of birth MM/DD/YYYY 00/00/0000 b. Spouse's date of birth MM/DD/YYYY 00/00/0000 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 2020. 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. 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)

Line 6

5 Use page HC-6 of the Schedule HC Instructions Worksheet and Table to determine where your 2020 income falls in accordance with the Annual Income Standards.

- If your 2020 income was at or below 150% of the federal poverty level, skip the remainder of the Schedule HC Forms.
- If your 2020 income was NOT at or below 150% of the federal poverty level, go to line 7.

6

Line 7

You must skip line 7 and go to line 8a if you and your spouse were married filing jointly and only had coverage through the SAG-AFTRA Health Plan in the year 2020.

TAXPAYER'S FIRST NAME M.I. LAST NAME

J O H N S M I T H

1 2 3 4 5 6 7 8 9

Schedule HC Uninsured for All or Part of 2020. Do not complete if you are not subject to a penalty.

6 Was your income in 2020 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 2020. 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 2020, 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 2020. 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 2020, 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

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 2020. **You are not subject to a penalty in 2020. Skip the remainder of this schedule and complete your tax return**.

7

Line 8A-8B

Complete lines 8A-8B based on the applicability of religious exemption for yourself and your spouse.

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 2020 tax year?

8b. You ○ Yes ○ No
Spouse ○ Yes ○ No

If you answer **No** to line 8b, **you are not subject to a penalty in 2020. 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.

8

Line 9

Unlike last year (for 2019 filing), the MA Health Connector will not be issuing individual exemption numbers to Plan participants for 2020 filing. Accordingly, this section should be marked as “No” and Certification Numbers for both yourself and your spouse must be left blank.

9 **Certificate of exemption.** Have you obtained a Certificate of Exemption issued by the Massachusetts Health Connector for the 2020 tax year?

9. You ○ Yes ○ No
Spouse ○ Yes ✕ No

Note: If you received a Certificate of Exemption from the Federal shared responsibility requirement in 2020, 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 2020. 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

9

Filing an Appeal

The following section of the form is a crucial step into ensuring your intent to appeal is acknowledged by the Massachusetts Health Connector. You must mark the designated box(es) for yourself and your spouse (if applicable) as an indication that you will be filing an appeal. Once you receive the follow-up letter from MA Health Connector requesting your statement, refer to the “Statement of Grounds for Appeal of Health Care Penalty” form (also available on our website) for instructions on how to file.

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 2020 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.