



Instructions on Completing 2018 MA Health Insurance Responsibility Disclosure Filing

Important Note! The MassTaxConnect system does not appear to allow interim saving. You should be prepared to handle data entry in one sitting. This process should take approximately 15 minutes. Once you have logged in to MassTaxConnect, click “Withholding Tax” on the bottom left of the screen.

The screenshot shows the MassTaxConnect dashboard for user ALLISON HARRISON. The 'Accounts' section is expanded, showing a list of accounts. The 'Withholding Tax' account is highlighted with a red circle. The account details include: Depository: WTH-11268404-003, BOSTON CATHOLIC DEVELOPMEN..., 66 BROOKS DR, BRAINTREE MA 02184-3839 USA. The balance is \$0.00.

Then click “File health insurance responsibility disclosure” under “I Want To” on the right.

The screenshot shows the 'Withholding Tax' page for the account BOSTON CATHOLIC DEVELOPMENT SERVICES INC. The 'I Want To' section is expanded, showing a list of actions. The 'File health insurance responsibility disclosure' link is circled in red. The account details include: Withholding Tax Depository: WTH-11268404-003, Balance: \$0.00.

Click "Next" on the General Information screen.

Mass.gov MassTax CONNECT

2018 Health Information Responsibility ... Welcome, ALLISON HARRISON Settings Log Off

Home > Withholding Tax > 2018 Health Information Responsibility Disclosure

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Employer Health Insurance Responsibility Disclosure (HIRD) Form - General Information

Per guidelines set forth by the Executive Office of Health and Human Services, you are required to file the HIRD form on MassTaxConnect if

1. You are an employer who currently has (or had) six or more employees in any month during the past 12 months preceding the due date of this form (Nov 30th of filing year).
2. You must complete this Form only for a plan(s) offered to Massachusetts employees for the employer's next upcoming Plan Year (a.k.a. Rate Year), if available. If plan information for the upcoming Plan Year is not available, employers must provide information only for a plan(s) offered to Massachusetts employees for the employer's current Plan Year. The employer's Plan Year (a.k.a. Rate Year) is defined as the effective date of any changes in a group Health Insurance plan during the Open Enrollment Period.
3. Employers must complete all sections of this Form, unless otherwise specified in the instructions.

Contact and Support Information

For additional information and filing support, including FAQs specific to the HIRD form

Click the "Frequently Asked Questions" link above and choose the "HIRD" tab.
For further questions regarding the HIRD reporting requirement, please contact the Department of Revenue's customer service center at 617-466-3940 and choose the option to speak with a HIRD representative.
Note that any questions submitted in writing directly to the HIRD form web portal itself cannot be responded to.

Save and Close Cancel Next >

Screen 1: At the top of the next screen, on the right, enter the contact information for the person completing the form. Then enter the correct information for the blanks below. Suggested responses are outlined immediately below.

Does the employer offer group health insurance? YES

What is the minimum number of scheduled hours per week... : 20 for non-schools; 24 for schools; or a higher number (up to 30 per week) if your location (non-RCAB) requires more hours to be worked for benefit eligibility.

What is the time period (in months) that a new employee...: Enter 1 for any RCAB location; if your non-RCAB location has a longer waiting period, enter the correct number of months.

02184

Company's Insurance Profile

Does the employer offer group health insurance? [Click for help.](#)

What is the minimum number of scheduled hours per week that the employer requires an employee to work to be considered eligible for health plan benefits? [Click for help.](#)

What is the time period (in months) that a new employee must work before he or she is eligible for health plan benefits? Value must be greater than or equal to 1. [Click for help.](#)

Does employer determine employee eligibility . . . NO.

Does employer offer different benefits / rates for health plan rates . . . These are defaulted to NO. Leave them as is unless your location offers different cost sharing for at least one employee. Some locations have employees who pay less for health coverage based on seniority. If this applies, choose "YES" under "Other" and then add the following in the next two text boxes:

First box: "The employer offers less expensive health insurance to employees who were hired on or before ____ [date]. All employees are eligible for the RCAB Enhanced Blue Cross Health Plan and the RCAB Basic Blue Cross Health Plan if they are scheduled to work at least 1,000 hours/year."

Second box: "The employer offers less expensive health insurance to employees who were hired on or before ____ [date]. All employees are eligible for the RCAB Enhanced Blue Cross Health Plan and the RCAB Basic Blue Cross Health Plan if they are scheduled to work at least 1,000 hours/year."

Does employer determine employee eligibility for health plan benefits according to employment based categories for different groups of employees? [Click for help](#)

No Yes

Does employer offer different health plan benefits / rates for health plan benefits according to employment based categories for different groups of employees? [Click for help](#)

No Yes

Select the employment-based categories that the employer utilizes. (Select as many employment-based categories as necessary). [Click for help](#)

Regular Full-time <input checked="" type="radio"/> No <input type="radio"/> Yes	Regular Part-time <input checked="" type="radio"/> No <input type="radio"/> Yes	Management <input checked="" type="radio"/> No <input type="radio"/> Yes	Non-Management <input checked="" type="radio"/> No <input type="radio"/> Yes
Temporary Full-time <input checked="" type="radio"/> No <input type="radio"/> Yes	Temporary Part-time <input checked="" type="radio"/> No <input type="radio"/> Yes	Exempt <input checked="" type="radio"/> No <input type="radio"/> Yes	Non-Exempt <input checked="" type="radio"/> No <input type="radio"/> Yes
Salaried <input checked="" type="radio"/> No <input type="radio"/> Yes	Hourly <input checked="" type="radio"/> No <input type="radio"/> Yes	Wage Based <input checked="" type="radio"/> No <input type="radio"/> Yes	Intern <input checked="" type="radio"/> No <input type="radio"/> Yes
Union <input checked="" type="radio"/> No <input type="radio"/> Yes	Non-Union <input checked="" type="radio"/> No <input type="radio"/> Yes	Other <input checked="" type="radio"/> No <input type="radio"/> Yes	

If the employer answered Yes to "other", describe the "other" employment-based category(ies) and indicate which specific health plan(s) the employees in each "other" category have access to.

If applicable, describe how the employer defines each employment-based category and the employer's eligibility requirements for health plan benefits according to each category. [Click for help](#)

Does the employer employ any union members... NO. Then leave next box blank.

Applicable dates: see screen shot below. You may also want to add the comment, "The RCAB Health Plan will change its Plan Year start date to July 1 starting in 2019" shown below in the "Only if necessary" text box. Then click "Next."

Does the employer employ any union members who receive Group Health Insurance through a union rather than through the employer? [Click for help](#)

No Yes

If applicable, list the unions from which the employer's unionized employees receive group health insurance. [Click for help](#)

Open enrollment period: Start Date [Click for help](#).

20-Aug-2018

Plan year's (a.k.a rate year) Start date [Click for help](#).

01-Oct-2018

Open enrollment period: End Date. [Click for help](#)

14-Sep-2018

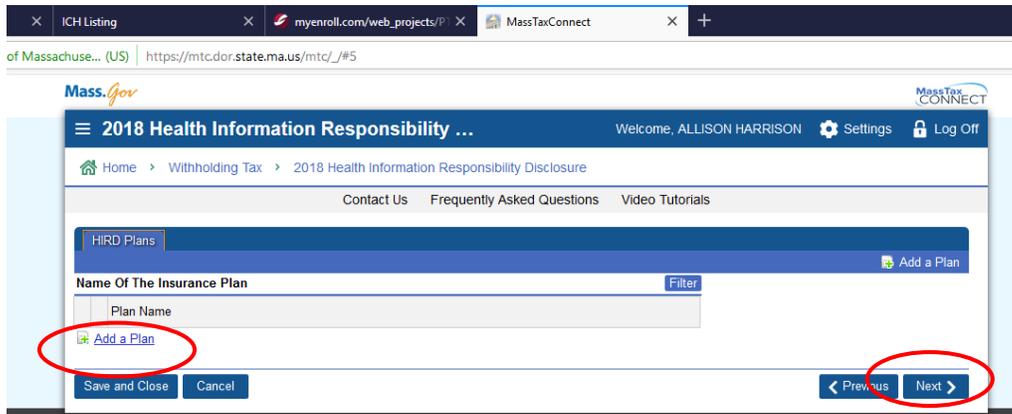
Plan year's (a.k.a rate year) End date. [Click for help](#)

30-Jun-2019

Only if necessary, use this space to report additional information not otherwise captured in this form that is necessary to explain the employer's group health insurance offerings and/or eligibility requirements. [Click for help](#)

The RCAB Health Plan will change its Plan Year start date to July 1 starting in 2019.

Screen Two: Under Name of The Insurance Plan, click “Add a Plan” and then “Next.”



Screen Three: Type in the Roman Catholic Archdiocese of Boston Blue Cross **Enhanced** Health Plan under “Name of the health insurer” and add the Plan group number(s) shown below. The Group Numbers are listed in the cover email to this document and can be cut and pasted into the website.

Answer **YES** to question about minimum creditable coverage. Answer **NO** to question about wellness credits. Enter **10/1/2018** into the field “Enter the date on which the following...”

For the question “Indicate the employment-based categories . . .,” click **YES** if your location offers different cost-sharing to different employees. Click **NO** if your location does not.

HIRD Plans ROMAN CATHOLIC ARCHDIOCES ROMAN CATHOLIC ARCHDIOCES
ROMAN CATHOLIC ARCHDIOCES

Plan's Profile

Name of the health insurer and Name of the health plan. [Click for help](#)
ROMAN CATHOLIC ARCHDIOCESE OF BOSTON BLUE CROSS ENHANCED HEALTH PLAN

Plan group number(s)
004061470
004061472
004061474
004061475
004061476
004061477

Do the benefits provided under the health insurance plan satisfy the minimum creditable coverage requirements of 956 CMR 5.03(1)(a)? [Click for help](#)
 No Unknown Yes

Does the employer offer its employees wellness credits that may reduce the employee contribution to the premium for this plan? [Click for help](#)
 No Yes

Enter the date on which the following costs and coverage information became or will become effective for this plan. [Click for help](#)
01-Oct-2018

Indicate the employment-based categories that have access to this plan (Select as many employment-based categories as necessary). [Click for help](#)
Wage Based
 No Yes

Levels of Coverage

Individual	YES
Employee Plus One	NO
Employee Plus Children	NO
Family	YES

Plan's Total Monthly Costs

Individual	778.00
Family	1,947.96

Employee's Monthly Contribution

Individual *calculate based on location cost sharing; 25% is shown here*

Family *calculate based on location cost sharing; 40% is shown here*

✓ Levels Of Coverage

Which levels of coverage are offered by this plan? [Click for help](#)

Individual
 No Yes

Employee Plus One
 No Yes

Employee Plus Children
 No Yes

Family
 No Yes

For each Level of Coverage offered by this plan (i.e., individual, employee plus one, employee plus child/children, family), complete the following information.

<p>✚ Plan's Total Monthly Costs</p> <p>Click for help</p> <p>Individual <input type="text" value="778.00"/></p> <p>Family <input type="text" value="1,947.96"/></p>	<p>✚ Employee's Monthly Contribution</p> <p>Click for help</p> <p>Individual <input type="text" value="194.50"/></p> <p>Family <input type="text" value="779.18"/></p>
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Annual Deductibles and Annual Out of Pocket Max Expenses

Enter amounts below. Then click "Add a Plan" to enter information about the Blue Cross Basic Plan.

✚ In-Network Annual Deductibles

[Click for help](#)

Individual

Employee Plus One

Family

✚ Annual Out Of Pocket Max Expenses

[Click for help](#)

Individual

Employee Plus One

Family

[✖ Remove a Plan](#) [✚ Add a Plan](#)

[Save and Close](#) [Cancel](#)

[< Previous](#) [Next >](#)

(continued on next page)

Screen Four: Type in Roman Catholic Archdiocese of Boston Blue Cross **Basic** Health Plan under Name of the health insurer and add the Plan group number(s) shown below. The Group Numbers are listed in the cover email to this document and can be cut and pasted into the website.

Answer **YES** to question about minimum creditable coverage.

Answer **NO** to question about wellness credits.

Enter **10/1/2018** into the field “Enter the date on which the following...”

For the question “Indicate the employment-based categories . . .,” click **YES** if your location offers different cost-sharing to different employees. Click **NO** if your location does not.

ROMAN CATHOLIC ARCHDIOCESES Remove a Plan Add a Plan

Plan's Profile

Name of the health insurer and Name of the health plan. [Click for help](#)

ROMAN CATHOLIC ARCHDIOCESE OF BOSTON BLUE CROSS BASIC PLAN

Plan group number(s)

004061478
004061480
004061482
004061483
004061484
004061485

Do the benefits provided under the health insurance plan satisfy the minimum creditable coverage requirements of 956 CMR 5.03(1)(a)? [Click for help](#)

No Unknown Yes

Does the employer offer its employees wellness credits that may reduce the employee contribution to the premium for this plan? [Click for help](#)

No Yes

Enter the date on which the following costs and coverage information became or will become effective for this plan. [Click for help](#)

01-Oct-2018

Indicate the employment-based categories that have access to this plan (Select as many employment-based categories as necessary). [Click for help](#)

Wage Based

No Yes

Levels of Coverage

Individual YES
Employee Plus One NO
Employee Plus Children NO
Family YES

Plan's Total Monthly Costs

Individual 696.41
Family 1,743.63

Employee's Monthly Contribution

Individual *calculate based on location cost sharing; 15% is shown here*

Family *calculate based on location cost sharing; 35% is shown here*

✓ Levels Of Coverage

Which levels of coverage are offered by this plan? [Click for help](#)

Individual
 No Yes

Employee Plus One
 No Yes

Employee Plus Children
 No Yes

Family
 No Yes

For each Level of Coverage offered by this plan (i.e., individual, employee plus one, employee plus child/children, family), complete following information.

Plan's Total Monthly Costs	Employee's Monthly Contribution
Click for help	Click for help
Individual <input type="text" value="696.41"/>	Individual <input type="text" value="104.46"/>
Family <input type="text" value="1,743.63"/>	Family <input type="text" value="610.27"/>

Annual Deductibles and Annual Out of Pocket Max Expenses

Enter amounts below. Then click Next.

In-Network Annual Deductibles

[Click for help](#)

Individual

Family

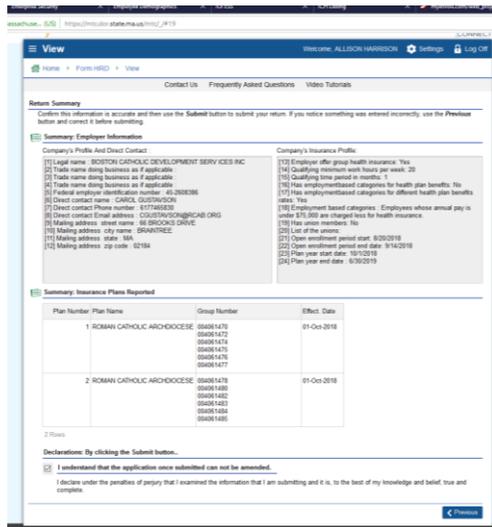
Annual Out Of Pocket Max Expenses

[Click for help](#)

Individual

Family

Screen Five: Review the information summarized on the Return Summary page to ensure it is correct. Then check the box to certify the information is correct and complete, then click "Submit." You will need to re-enter your password to complete the submission.



Attempt to print the Submission page by clicking “Print Confirmation.” The screen disappears once the “OK” button is clicked; before doing so, you may wish to print to PDF by choosing that option from the Printer drop down menu, then saving it.

Enter Information
Review & Submit
Complete

2018 Health Information Responsibility Disclosure - Submit Summary

Confirmation Number: 1-405-617-792
Saved Date and Time: 11/2/2018 5:34:40 PM

Taxpayer Name: ROMAN CATHOLIC ARCHBISHOP OF BOSTON A CORPORATION SOLE
FEIN: 04-2106175

Your 2018 Health Information Responsibility Disclosure has been submitted. **Please print this page by clicking the *Print* button.**

View Your Submitted Submission
 This submission is available to be viewed at any time. From the home page, select the **Submissions** tab. The *Submitted* column displays a list of recently saved submissions or you can click the **View All** button and select the **Submitted** tab to view all submitted submissions by confirmation number. The form submission date is the date that the form is considered to be filed.

Contact Us
 If you need further assistance, please contact the Department of Revenue at or toll-free in Massachusetts at (800) 392-6089. Business hours are 8:30AM to 4:30PM Monday - Friday.

OK
Print Confirmation

If for some reason you cannot get these pages to print or save to PDF, you should still receive an email from the DOR confirming your submission. You can also return to the Home page and click “Submissions” and view Form HIRD under Submissions.

Account

BOSTON CATHOLIC DEVELOPMENT SERVICES INC
45-2608386

Withholding Tax Depository
WTH-11268404-003

Balance: \$0.00

Account Alerts

✓ There are no alerts

I Want To

Manage payments

Manage returns

Close my tax account

File a dispute

Print ACH credit layout

Recent Periods

Submissions

Correspondence

Names and Addresses

Payments prior to 11/30/2015

Refunds

Draft Submissions

None need attention

Submitted

None have been submitted

Processed

Form HIRD

View All