Health care reforms for 2014

As part of federal health care reform, the Affordable Care Act (ACA) was signed into law in March 2010. The ACA includes a number of changes in medical coverage standards for employers that gradually take effect through the year 2020. Several of the required changes that occurred between 2010 and 2013 were already part of the BB&T Health Care Plan and minimally impacted the medical coverage offered to associates.

By law, many of the mandates and provisions under the ACA become effective January 1, 2014. Beginning this October, you will receive information from the federal government concerning insurance subsidies, the availability of insurance marketplaces and the individual mandate. BB&T is committed to providing you with answers to your questions about the new requirements and helping you make an informed decision about your health care coverage.

The information below applies to all benefit eligible associates. If you will not be eligible for BB&T's benefits on January 1, 2014, (if you are scheduled to work less than 20 hours per week), you may qualify for some discounts through the insurance marketplaces.

What changes will be required in the BB&T Medical Program for 2014?
Effective January 1, 2014, the BB&T Medical Program will no longer apply pre-existing condition exclusions. Specifically, associates, covered spouses, covered Domestic Partners and covered children will not be subject to pre-existing conditions exclusion for medical coverage.

I heard that the federal government delayed the requirements under the ACA for one year. Does that delay affect the individual mandate requirement? No. The federal government has said the delay does not affect the requirement to have medical coverage, qualify for an exemption, or pay a tax penalty (for not having medical coverage). The delay affects certain other requirements that apply to employers and insurance companies.

Will I be able to keep the coverage I have with BB&T? Yes, all benefits-eligible associates are eligible to elect and/or continue medical coverage under the Select Option or the Consumer Option for themselves and eligible dependents. Certain benefits-eligible associates that live in California are eligible for the Kaiser medical option.

Will part-time associates lose their coverage? No. A benefits-eligible associate is anyone who is scheduled to work at least 20 hours per week and is classified as a "regular" associate (not a temporary or contract associate). BB&T will continue to offer our Flexible Benefits Plan to associates that are eligible.

Can I cover my dependent children to age 26? Yes, you may continue to cover qualified dependent children to age 26.

Is our plan still "grandfathered"? Yes. Under the ACA, a "grandfathered" plan is defined as a health care plan that was in existence on March 23, 2010 and has not undergone significant changes since that date. BB&T's plan meets this requirement. Maintaining our status as a grandfathered health care plan gives BB&T flexibility and control in our benefit plan design.

Will my costs increase in 2014? Yes, there will be added taxes and fees built into our costs to help pay for the ACA. We will provide further details as we approach open enrollment, which will start November 1, 2013.

Will everyone have to buy health insurance? What happens if they don't? Yes, the ACA contains an "individual mandate." This mandate requires individuals not covered by employer- or government-sponsored insurance plans to maintain minimum essential health insurance coverage or pay a penalty unless exempted for religious beliefs or financial hardship.

What is the penalty for not having medical coverage (minimum essential health insurance coverage)? The penalty for not obtaining medical insurance that meets the government's minimum coverage requirements in 2014 is either 1% of income or $95 (whichever is greater). The penalty for 2015 is the greater of $325 or 2% of taxable income and for 2016 is the greater of $695 or 2.5% of taxable income.

When does the new federal requirement for tax penalties go into effect? The requirement begins on January 1, 2014, and it applies to each month in the calendar year. Any tax penalty owed will generally be based on the number of months in a year that an individual is without coverage or an exemption.

What is minimum essential health insurance coverage? The type of coverage an individual needs to have to meet the individual mandate under the ACA.

What is an affordable, minimum-value plan? An affordable minimum value plan is a plan that covers at least 60% of the cost of covered medical procedures for a premium cost that does not exceed 9.5% of the associate's household income.

What qualifies as minimum essential coverage? The BB&T Medical Program coverage (including COBRA coverage and retiree coverage) qualifies as minimum essential coverage. Other types of coverage meeting the minimum essential coverage requirements include the following:

- Coverage purchased in the individual market
- Medicare Part A coverage and Medicare Advantage
- Most Medicaid coverage
- Children's Health Insurance Program (CHIP) coverage
- Certain types of veterans health coverage administered by the Veterans Administration
- TRICARE

Minimum essential coverage does not include coverage providing only limited benefits, such as coverage only for vision care or dental care, Medicaid covering only certain benefits such as family planning, workers' compensation, or disability policies.

What are these insurance exchanges or marketplaces? A health insurance exchange is a marketplace for purchasing health insurance. They are intended to primarily serve individuals without access to employer-sponsored insurance and small businesses. While all insurance plans are offered by private companies, the Marketplace is run by either your state or the federal government.

Click here to access a list of states offering a state-run marketplace.

Will I be receiving general information about the insurance marketplace? Yes, employers are required to distribute a Marketplace Coverage Options Notice by October 1, 2013. You will receive the Notice through corporate email; the Notice will also be posted on BBTBenefits.com.

What are the subsidies being offered through the insurance marketplace?
The ACA provides two forms of subsidies to help pay for health insurance: a monthly premium tax credit to help lower premiums and cost-sharing assistance to limit a person's maximum out-of-pocket costs. Subsidies are intended to help individuals without access to employer-sponsored coverage or any other government-sponsored insurance.

If I have coverage at BB&T, will I be eligible for these subsidies or premium tax credits? No, benefits-eligible associates and their children (under age 26) are not eligible for subsidies or premium tax credits. BB&T offers associates and their dependents medical coverage that is both affordable and exceeds the minimum essential coverage requirements of the ACA.

Will I be eligible for the subsidies or premium tax credits if I elect "no coverage" under the BB&T Medical Program? No, benefits-eligible associates and their children (under age 26) are not eligible for subsidies or

premium tax credits because BB&T offers medical coverage that is both affordable and exceeds the minimum essential coverage requirements of the ACA. Whether you choose to elect coverage under the BB&T Medical Program or elect another form of medical coverage, you and your children under age 26 will be ineligible for subsidies or premium tax credits.

Do my spouse and dependent children have to be covered under the same medical coverage that covers me? No. You, your spouse and your dependent children do not have to be covered under the same medical plan (For example, your spouse may be covered by his or her employer's plan). Please note that everyone must have minimum essential coverage or qualify for an exemption, or you will owe a tax penalty when you file your taxes.

What if I apply for a subsidy in the insurance marketplace, and I am awarded a premium tax credit in error? You will eventually have to repay the subsidy if disqualified. The IRS will reconcile advance payments of the premium tax credits when consumers file their annual tax returns and will recoup overpayments. We would also note that application filers must attest, under penalty of perjury, that they are not providing false or fraudulent information.

What if I drop my BB&T coverage? May I purchase medical coverage from the insurance marketplace? You can enroll in a plan in the insurance marketplace, but you will not be eligible for a subsidy.

Please note when purchasing coverage from the insurance marketplace, you will be paying the full premium with after-tax dollars. BB&T subsidizes approximately 75% of Medical Program premiums and provides for premiums to be paid with pre-tax dollars.

How will people prove they have health insurance? Health plans will provide documents to employers and individuals that will be used to certify that they have the minimum coverage required by the law. This required information will be provided in the Summary of Benefits and Coverage (SBC) document, which will be posted to BBTBenefits.com in October. Employers will also be required to report to the government in 2015 the types of coverage offered to all associates.

If someone is age 65 or older and covered by Medicare, can they purchase coverage through the marketplace and receive a subsidy? Seniors age 65 or older who qualify for Medicare may choose to purchase coverage in the insurance marketplace in addition to, or instead of, enrolling in Medicare; however they will not be eligible for premium tax credits and must pay the full cost of coverage. It is very unlikely that many seniors will elect coverage in the marketplace.

Where do I go for additional information about this new law? Visit https://www.healthcare.gov/ or call 800-318-2596 (TTY: 855-889-4325).