DSRA★BENEFIT TRUST
BENEFIT PLANS FOR DELPHI RETIREES

IMPORTANT NOTICE
Updated as of October 5, 2013

FAQs Regarding Sunset of HCTC Premium Subsidies and Implementation of the Affordable Care Act

As members of the DSRA-BT Board of Directors, we are actively working to gain an understanding of changes in federal law that will impact our membership and the plans that are offered through the DSRA-BT, and to communicate those changes to members as soon as possible. With that in mind, we have been working to gain clarity on two major changes in federal law: the HCTC sunset provision, and the Affordable Care Act ("ACA"), commonly known by terms such as "health care reform" and "Obamacare." The purpose of this notice is to provide some initial general information about these issues in the FAQ format. Much remains unknown at this point. However, as relevant guidance is released and/or new questions are raised by members, we will continue adding FAQs to this communication. The latest version of FAQ will always be found at the DSRA BT website www.dsrabenefittrust.net

FAQ #1: What does it mean for the HCTC program to "sunset," and how will this impact the cost of my health plan through DSRA-BT?

ANSWER: The Health Coverage Tax Credit (HCTC) is set to expire on December 31, 2013, and HCTC funding will no longer be available after December 31, 2013. The loss of the HCTC funding will be a significant impact on pre-65 DSRA-BT members. As you may know, bipartisan legislation has been introduced in Congress to extend the HCTC. It is more important than ever that you write and call your Representatives and Senators to ask them to support the permanent extension of HCTC. **Please note that if Congress extends the HCTC after the pre-65 election deadline (Wednesday, November 6th), the DSRA-BT will reopen enrollment to allow you to make elections based on the extension.**

The DSRA-BT currently subsidizes health plan premiums for eligible members who do not receive HCTC funds, and the intent will be to continue providing a health premium subsidy to pre-65 members after HCTC funding ends. The express goal of the DSRA-BT is to provide benefits to our members for as long as possible. With that goal in mind, the Trust will not be able to match what HCTC currently provides, which equals 72.5% of the premium cost. This means that the net cost to you for coverage in the BCBSM plans will rise dramatically beginning 1/1/14 due to the loss of HCTC. The Board has determined subsidies for 2014, and this information was published in the 9/26/13 e-blast to members. Subsidy details will also be included in written OE materials mailed to members in October.

FAQ #2: Will tax credits or other subsidies under the ACA replace the expiring HCTC program and provide continued premium assistance for my health plan through DSRA-BT?

ANSWER: Unfortunately, no. Although some members will be eligible for premium tax credits and cost-sharing subsidies under ACA provisions, such credits/subsidies are only available if individual health coverage is purchased in a state-based "Public Exchange" established pursuant to ACA requirements. Individuals cannot receive ACA premium tax credits and cost-sharing subsidies for health coverage purchased through an employment-based plan such as the DSRA-BT.

FAQ #3: The term "health insurance exchange" has been in the news a lot lately. What is a health insurance exchange, and how does this term apply to me?

ANSWER: Simply put, a "health insurance exchange" is a marketplace for purchasing health coverage. However, the term takes on special meaning under the ACA, **because the ACA requires that a "Public Exchange" – one that is operated by either the state or federal government - is established in each state effective in January of 2014.** Two primary purposes of the Public Exchange under the ACA are: 1) to provide options for the purchase of health insurance coverage so that individuals can meet the new federal requirement to buy health insurance, and 2) to provide low income individuals the opportunity to qualify for and receive financial assistance with health insurance premiums and out-of-pocket medical expenses. *(Please refer to*

FAQ #4 for details regarding household income levels that will trigger assistance with health premiums under ACA guidelines.)

The ACA requires the Public Exchange in each state to be available no later than October 1, 2013 so that individuals have time to enroll in a qualified health insurance plan effective January 1, 2014. A private benefit plan such as the DSRA-BT is not eligible to become a Public Exchange, because the ACA requires these to be operated exclusively by the state or federal government.

FAQ #4: These FAQs reference federal financial assistance – premium tax credits and cost-sharing subsidies – that will be available to low income individuals beginning on January 1, 2014. How does the ACA define "low income" individuals, and how will I know if I qualify?

ANSWER: Under ACA provisions, individuals will qualify for premium tax credits and cost-sharing subsidies if their household modified adjusted gross income ("MAGI") falls between 100% and 400% of the Federal Poverty Line ("FPL"). For purposes of this determination, MAGI includes ordinary adjusted gross income (Form 1040 Line 37, Form 1040 EZ Line 4), any Social Security income benefits (including untaxed benefits), tax-exempt interest received or accrued during the tax year, and foreign earned income. Please visit the ACA website at https://www.healthcare.gov or call 1-800-318-2596 to determine if you qualify. To determine your household MAGI for qualification purposes, we recommend that you consult your personal tax advisor.

FAQ #5: Under the ACA, am I required to purchase health insurance for myself and/or my family? If so, when will this new rule take effect?

ANSWER: The ACA includes a requirement that most individuals buy minimum essential health coverage, both for themselves and for children residing in the taxpayer's household who are also tax dependents. This requirement – called the "individual mandate" – goes into effect on January 1, 2014. Most types of major medical insurance coverage will satisfy this requirement, including health coverage purchased through an employer and qualified individual health insurance policies purchased on the Public Exchanges or in the private marketplace as well as Medicare Part A, Medicaid or state high risk pool coverage. Health coverage purchased through the DSRA-BT will satisfy this requirement.

FAQ #6: What is the penalty if I do not purchase health insurance as required by the ACA's individual mandate?

ANSWER: If you do not purchase health coverage to satisfy the individual mandate, you will be subject to a tax penalty beginning with the 2014 taxable year. The penalty is assessed for each adult (including retiree, spouse and children 18 and older who are tax dependents) and child in the taxpayer's household. The penalty is reported annually and collected as part of the federal Form 1040 filing. The amount of the penalty increases each year according to this schedule:

- 2014 Penalty: $95 per adult and $47.50 per child under 18 (capped at $285 per family), or 1% of household adjusted gross income (AGI), whichever is greater
- 2015 Penalty: $325 per adult and $162.50 per child under 18 (capped at $975 per family) or 2% of household AGI, whichever is greater
- 2016 Penalty: $695 per adult and $347.50 per child under 18 (capped at $2,085 per family) or 2.5% of household AGI, whichever is greater

Kaiser Family Foundation has published a flowchart that is helpful in understanding the individual mandate. This chart is found at: http://healthreform.kff.org/~/media/Files/KHS/Flowcharts/requirement_flowchart_2.pdf

FAQ #7: Under the ACA, am I also required to purchase dental and vision coverage in order to meet the individual mandate?

ANSWER: No. The ACA does not require the purchase of either dental or vision coverage in order to satisfy the individual mandate. In addition, health plans and health insurance policies are not required to include dental and vision coverage. We anticipate that separate dental and vision policies will continue to be available for optional purchase in the private market, as well as in each state's Public Exchange, although availability in the Public Exchange cannot be verified until each state's Public Exchange is fully developed. Regardless of availability elsewhere, the intent is to continue offering dental and vision benefit options in the DSRA-BT.

FAQ #8: Will the DSRA-BT continue to offer multiple health plan options to its pre-65 and post-65 members after the ACA is fully implemented in January of 2014?

ANSWER:

Here is a glimpse of what is staying the same and what is new to our benefit plans next year:

- Continued partnership with Blue Cross Blue Shield of Michigan for pre-65 and pre-65 Medicare disabled medical/prescription benefits
- **No changes** to the plan designs – the same GOLD, SILVER, and BRONZE plans as we offer today. The GOLD and SILVER plans are traditional PPO pre-65 medical/prescription plan options. The BRONZE plan is a High Deductible Health Plan (HDHP) which offers the opportunity to establish a Health Savings Account (HSA).
- Continued partnership with SelectQuote for our post-65 members which allows Medicare eligible retirees a "hybrid" solution and choice between the medical/prescription plans option through The Hartford – including a **new**, third option – or an "individual" Medicare supplement, Medicare Advantage and Part D prescription plan in your area; a SelectQuote counselor will be available to help you evaluate your options
- Continued partnership with Blue Cross Blue Shield of Michigan for pre- and post-65 dental benefits with **no changes** to benefits
- **New** vision insurance benefits through Blue Cross Blue Shield of Michigan and the VSP network for pre- and post-65 members, replacing the plan and provider network currently provided through Superior Vision
- Continued voluntary life insurance benefits through Reliance Standard for our Delphi salaried retirees only

FAQ #9: ACA premium tax credits and cost sharing subsidies are available for qualifying low income individuals based on the second lowest cost "silver" plan in the Public Exchange. A sliver plan in the Public Exchange is a plan that covers essential health benefits at a 70% actuarial value. If I were to go to the Public Exchange and purchase a silver plan, how would the value of the benefits that I receive compare to the benefits currently provided under the DSRA-BT "Gold Plan"?

ANSWER: According to BCBSM estimates, the existing Gold Plan currently offered under the DSRA-BT is 25% richer than the "silver" plan that is the basis for subsidies in the Public Exchange – paying roughly 95% of the Actuarial Value ("AV") of covered benefits. In contrast, a silver plan offered in the Public Exchange will pay only 70% of the AV of covered benefits, based on each state's benchmark silver plan. (*AV is calculated as the percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an AV of 70 percent, on average, a consumer would be responsible for 30 percent of the costs of all covered benefits.*)

In addition, according to many insurance industry sources, provider networks for policies offered in the Public Exchange will be significantly more limited – likely offering only "narrow network" plans that will drive policyholders to a much more limited group of providers and treatment facilities within a particular state. In addition to considering premium cost, members considering the Public Exchange will want to take into account differences in plan designs, additional out-of-pocket expenses, and-network limitations vs. the DSRA-BT offerings in making this decision.

If you qualify for premium tax credits in the Public Exchange, you are **not** required to purchase your state's silver plan offering – you can buy up to platinum or gold, or buy down to bronze. However, your premium tax credit will be based on the cost of the silver plan, and you will be required to make up any difference with your own funds. However, if you qualify for cost-sharing subsidies, you will only receive those if you purchase a silver plan in your state's Public Exchange.

FAQ # 10: Is information available related to which states will operate their own Public Exchange, and which states have refused to do so and will default to a federally-run Public Exchange? Will this distinction (state v. federal) make a difference in terms of the coverage options and premium costs in each state's Public Exchange?

ANSWER: Now that the Public Exchanges are open for enrollment (as of October 1, 2013), information on the Exchange in each state may be found at the following link: https://www.healthcare.gov/what-is-the-marketplace-in-my-state. Whether the state or the federal government operates the Public Exchange in your state of residence should have no impact on the Exchange plan offerings available to you. Instead, the plans offered in each state depend on many market-based factors. These factors include which insurers have decided to offer plans in your state, differing benefit mandates and regulatory requirements in each state, differences in negotiated rates between physician and hospital networks and insurers, and the demographics of your region within a particular state.

FAQ#11: In determining eligibility for ACA premium tax credits and cost-sharing subsidies based on household modified adjusted gross income, is a household's MAGI calculated in the same way even if the household includes joint taxpayers, one of whom is under age 65 and the other who is age 65 or older?

ANSWER: Yes. The definition of a household's modified adjusted gross income, which is the amount utilized in determining eligibility for federal premium tax credits and cost-sharing subsidies, is not impacted based on age or Medicare eligibility. *(Please refer to FAQ #4 for more information about MAGI and qualifying for financial assistance under the ACA.)*

FAQ#12: Once the Public Exchanges are up and running in 2014, will a group health plan offer a cost advantage over an individual policy for people who do not qualify for premium tax credits and cost-sharing subsidies?

ANSWER: We anticipate that most group health plans, and particularly the DSRA-BT plans, will continue to offer cost advantages over unsubsidized individual policies, both inside and outside of the Public Exchange. This is in part because individual health insurance policies will be subject to community rating rules that determine premiums uniformly across a state's pooled population, allowing premium differences based only on four factors: coverage category (single v. family), rating area (as determined within a state) age, and tobacco use. Health status cannot be considered, so individuals within the group do not benefit from being healthier in terms of premium cost. In contrast, the premiums charged for coverage within DSRA-BT and larger employer group plans will continue to be based, at least in part, on group-specific claims experience. In past years, DSRA-BT's claims experience has been, on average, better than the general population used by BCBSM to determine rates, creating some premium savings for members. It is important to note that the cost of individual policies in the Public Exchange varies widely from state to state, so it is important to shop the marketplace in your particular state to determine if a comparable policy is available at a lower cost.

FAQ # 13: With the need for a "HCTC qualified" health plan going away when the HCTC program ends, will new plans be cheaper?

ANSWER: Individual health plans available under the ACA must also meet certain standards, which are different than the standards required for our current HCTC qualified plan. Under the ACA, plans must cover at least 10 categories of service, referred to as Essential Health Benefits ("EHBs"). A plan purchased inside a state's Public Exchange may cover up to 60% ("bronze"), 70% ("silver"), 80% ("gold") or 90% ("platinum") of EHBs. Obviously, the level of coverage that is provided within these tiers will affect the premium cost. Different states may also require plans to cover state-mandated benefits outside of EHBs, which would also increase premium cost. Ultimately, plan costs and benefits will vary in each state. You may be able to find cheaper alternatives on the

individual market in the state where you live, or you may not. Available provider networks will also vary by state and by the individual policy that is purchased.

Group health plans such as the DSRA-BT plans are not required to cover EHBs. However, the DSRA-BT plans must meet the ACA's minimum value requirement (paying at least 60% of all covered services under the plan) in order to satisfy members' individual requirement to purchase coverage.

FAQ # 14: How much federal financial assistance will be available for families who qualify for subsidized health coverage? Are there special rules for families with household MAGI that falls at or below 250% of FPL?

ANSWER: In general, you will qualify for premium tax credits to assist with health insurance premiums if your household MAGI falls between 100%[1] and 400% of FPL. If your family is on the lower end of the MAGI scale – with household MAGI up to 250% of FPL – **two** types of federal financial assistance will be available for coverage purchased in the Public Exchange: premium tax credits and cost-sharing subsidies.

- Premium tax credits for qualifying individuals will be applied in advance to reduce the premium that is paid to purchase a QHP (Qualified Health Plan) in the Public Exchange. The amount of premium tax credit is determined on a sliding scale for households with MAGI between 100%and 400% of FPL, with the largest credit available to households with MAGI at or below 250% of FPL. The available premium credit will be determined on a state-by-state basis, using the cost of the second lowest cost benchmark silver plan in each state's Public Exchange, as compared to a percentage of household MAGI. If your household qualifies for premium tax credits, you will still have a choice about whether to enroll in a silver plan or choose a different Public Exchange offering in your state - you do not have to purchase the State's benchmark silver plan to receive premium tax credits. If you choose a less expensive plan option (for example, a bronze plan), your household will receive the same premium tax credit (based on the silver plan) and you will pay a smaller portion of the premium with your own funds. If you choose a more expensive plan (a gold or platinum plan), your household will still receive premium tax credits based on the benchmark silver plan, and you will pay a larger portion of the premium cost with your own funds.

  Under ACA regulations, the amount of premium tax credits available to you is a function of what federal regulators have established as the maximum premium expense you should be able to afford, calculated as a percentage of your household MAGI. This means that what you pay in annual health insurance premiums **for a policy purchased in the Public Exchange** will depend on where your household falls on the FPL scale. The below chart illustrates this concept *(please note that dollar amounts are estimated)*.

[1] Eligibility for ACA financial assistance begins at 100% FPL, unless the individual resides in a state which adopted the ACA Medicaid expansion. In those states, eligibility for ACA financial assistance will begin where Medicaid eligibility ends, ranging from 100% to 138% of FPL.

Household MAGI Level (as a % of 2013 FPL)	Maximum Annual Premium Expense as a % of household MAGI (the most you will be required to pay for a QHP)	Maximum Annual Premium Expense as a dollar amount (based on 2013 FPL[2], MAGI of single person household)	Maximum Annual Premium Expense as a dollar amount (based on 2013 FPL[3], MAGI of two-person household)
At least 100% but less than 133%	2.0%	$229.80 to $303.34	$310.12 to $409.46
At least 133% but less than 150%	3-4%	$458.45 to $684.80	$618.85 to $924.39
At least 150% but less than 200%	4-6.3%	$689.40 to $1440.50	$930.60 to $1944.49
At least 200% but less than 250%	6.3-8.05%	$1447.74 to $2303.11	$1954.26 to $3108.90
At least 250% but less than 300%	8.05%-9.5%	$2312.36 to $3263.73	$3121.39 to $4405.62
At least 300% but less than 400%	9.5%	$3274.65 to $4366.20	$4420.35 to $5893.80

- Assistance in meeting out-of-pocket expenses (called a "cost-sharing subsidy") is also available under the ACA. However, this cost-sharing assistance is available to you only if your household MAGI falls between 100% and 250% of FPL. In addition, in order to receive cost-sharing subsidies, you must enroll in a silver plan variation on your state's Public Exchange. The amount of cost-sharing subsidies available to you depends on your household MAGI. Those with incomes between 100% and 200% of FPL will get a 2/3 reduction in the plan's out-of-pocket maximum. Those with incomes between 200% and 250% of FPL will get a ½ reduction in the plan's out-of-pocket maximum.

FAQ # 15: Does the ACA have different (more lenient) household income subsidy qualification criteria for disabled people, or for people who have particular financial hardships such as medical or educational expenses?

ANSWER: As referenced throughout these FAQs, the availability of federal financial assistance is based on the MAGI of your household. To the extent that you (or your spouse) are unable to earn income due to a disability, this would decrease your household MAGI and increase the probability that your family will qualify for premium tax credits and cost-sharing subsidies. However, there are no special qualification rules related to disability or other personal financial hardships. The availability of federal financial assistance is strictly based on your household MAGI. (*Please refer to FAQs #4 and #11 for more information about MAGI.)*

FAQ # 16: Will the new law require DSRA-BT members who would qualify for subsidies to go to a Public Exchange, or could these members continue to choose a private option such as DSRA-BT? How can I determine which option will be better based on my personal financial situation?

ANSWER: The ACA does not require any individual to purchase coverage through the Public Exchange, and individuals will continue to be able to purchase private coverage after the Public Exchanges are in place. However, an individual must purchase coverage through the Public Exchange to qualify for premium tax credits or cost-sharing subsidies. (*Please refer to FAQs #2 and #4 for more information about qualifying for tax credits/subsidies through a Public Exchange.)* **Current federal regulations require the Public Exchange in each state to begin**

[2] 100% of the 2013 FPL for a single individual is $11,490 (*source: http://aspe.hhs.gov/poverty/13poverty.cfm#guidelines last visited March 20, 2013).*

[3] 100% of the 2013 FPL for a two-person household is $15,510 (*source: http://aspe.hhs.gov/poverty/13poverty.cfm#guidelines last visited March 20, 2013).*

taking applications from individuals beginning on October 1, 2013. In order to elect Public Exchange coverage for a January 1, 2014 effective date, you must make a final coverage selection on or before December 15, 2013. As part of the application process, the Public Exchange will determine whether an applicant will qualify for premium tax credits and cost-sharing subsidies based on your household MAGI. An applicant will also be given information about the total cost and coverage options available to the applicant in the Public Exchange.

We believe the best way to assess whether purchasing coverage in the Public Exchange rather than through DSRA-BT or another private plan is right for you will be to complete the Public Exchange application as soon as possible after it becomes available on October 1, 2013. Through the application process, you will be able to understand your premium costs in the Public Exchange (including any available tax credits and cost-sharing subsidies) as well as the types of coverage available. Armed with that information, you should be able to make an informed decision about which choice is best for your personal situation.

Please refer to the recently issued 2014 Pre-Enrollment Letter for DSRA-BT premium rates.

FAQ # 17: Does the ACA have any significant impact on post-65 individuals who purchase Medicare, Medigap, or Medicare Advantage plans? What changes to these plans, if any, are coming about as a result of the ACA's full implementation?

ANSWER: The ACA's full implementation in 2014 will have the broadest and most noticeable impact on private health coverage provided to individuals who are not participating in Medicare. As a result, individuals who are age 65 and older and participating in Medicare will see a less significant impact. Medicare Parts A and B will change very little as a result. Part D prescription drug plans will see the "donut hole" closing a little more each year, with total elimination of the donut hole by 2020.

Medigap plans will be impacted by ACA beginning in 2015. Congress has noted that Medigap plans C and F require policyholders to pay almost nothing toward Part B physician services. The ACA requires the National Association of Insurance Commissioners (NAIC) to review available studies and reports to add "nominal cost-sharing" so that the "appropriate" use of Part B physician services is encouraged. The NAIC review and subsequent changes will be effective January 1, 2015. It is anticipated that after the NAIC changes, Medigap policy G will provide the most comprehensive benefits. Please note that the current Hartford plan offered by DSRA-BT is closest in benefit design to Medigap policy D, with the added benefit of prescription drug coverage.

Medicare Advantage (MA) plans are already beginning to be impacted by the ACA. Between 2013 and 2022, ACA provisions will cut billions of dollars in funding from Medicare, and the deepest cuts are to MA plans. Under the current system, Medicare pays MA plans a monthly amount for each person covered by the plan based on a benchmark determined for each county (or "county-like" jurisdiction) in the United States. An MA plan submits a bid to provide services for each county in which it wants to do business. If the bid is less than the benchmark, the difference is shared between the MA plan and its covered members. That's why some plans have $0 monthly premium. If the bid is more than the benchmark, the covered member pays the difference. Going forward, the ACA is making changes in the way the benchmark is computed. The result is that MA plans will see reduced benchmarks in every county. And, the star rating, which has been used to help consumers select a plan, will now be used to determine part of the MA plan's payment. In addition, ACA's annual fee on insurers applies to MA plans. The net result is that MA plans will increase monthly premiums or withdraw from the market. Some very efficiently run plans may still be able to offer $0 monthly premium, but there will be fewer of those plans available.

FAQ #18: Does our medical plan carrier, Blue Cross Blue Shield of Michigan, offer any tools to help me better understand the ACA's impact on my BCBSM coverage?

ANSWER: BCBSM recently introduced an interactive website, **HealthReformBasics.com**. The stated goal of the website is to explain the ACA and its impacts on BCBSM members in an easy and useful way. The site includes video explanations of why health care reform is needed, what the reform provisions include, the potential impact

of reform on the cost of coverage, and the timing of these impacts, from the perspective of BCBSM. This site is available to all DSRA-BT members. *(Please note that if you are using Internet Explorer, you may have trouble playing the videos on the site. If you have trouble, you may be able to enable the videos by clicking on the "Compatibility View" icon in your address bar and then playing the videos again. Otherwise, you could try Mozilla Firefox as an alternative browser.)*

FAQ #19: If I qualify for a premium tax credit and/or cost-sharing subsidy to purchase health insurance on the Public Exchange but my household MAGI increases during the tax year, is it possible that I might have to repay the tax credit or subsidy at a later date? What happens if my household MAGI decreases during the tax year?

ANSWER: Under current guidance, it is possible that an increase in your household income could result in the need to repay some portion of ACA premium tax credits and cost-sharing subsidies that you receive. This is because premium tax credits and cost-sharing subsides that you receive are advance payments, for which initial eligibility is determined based on household MAGI in the prior tax year. This means that you will use your recently completed 2012 tax return or recent pay stubs to complete the public exchange application later this year. This information will determine your initial eligibility for credits and subsidies in 2014, but your actual household MAGI in 2014 determines whether you remained eligible for those credits and subsidies received throughout the year. When you complete your 2014 federal income tax return in early 2015, if your household MAGI increases enough to reduce the premium tax credit or cost-sharing subsidy for which you were eligible, repayment will be necessary (or your refund will be reduced) when you file your federal taxes.

Fortunately, you will also get the benefit of any decrease in household MAGI. If your household MAGI decreases during the tax year as compared to the prior year MAGI that was used to calculate your advance premium tax credits and cost sharing subsidies, you will receive an additional payment when you file your income tax return.

FAQ #20: As 2014 draws closer, should I start investigating individual and family health insurance options available in my state in addition to the options available under the DSRA-BT?

ANSWER: Yes, the DSRA-BT Board recommends that you explore all options available to you based on your personal financial and medical needs. Due to the legally-required termination of HCTC funding for premiums as of 12/31/13, and the impact of new ACA-related taxes and fees on health insurance premiums both inside and outside of DSRA-BT, knowing your options will become especially important as we move toward the 2014 enrollment period. Although the Board is staying as up to date as possible on overall market trends and other factors impacting health insurance costs, it is not possible to monitor all options available to individual members in every state. As a starting point in your research, you could review the website for the Department of Insurance where you live to determine which insurers and insurance options are available in your state, as well as the status of Public Exchange development.

FAQ #21: Where can I find information on whether my state is adopting the ACA's Medicaid expansion?

ANSWER: Kaiser Family Foundation publishes a website that includes a great deal of state-specific information about health insurance rules and regulations. The website may be accessed at http://www.statehealthfacts.org. Specific information regarding state Medicaid expansion decisions may be found by visiting http://www.statehealthfacts.org/comparereport.jsp?rep=158&cat=17.

FAQ #22: If I don't qualify for premium tax credits and cost-sharing subsidies (MAGI > 400% of FPL), can I still buy healthcare from the Public Exchange in my state?

ANSWER: Yes. There are no income limitations applicable to purchasing an individual policy in the Public Exchange – they are open to all. Household income impacts only the availability to receive federal financial assistance.

FAQ #23: If we choose to check out other insurances in the Public Exchange, will any of them be qualified to receive the healthcare tax credit?

ANSWER: There is no way for anyone to know this answer for sure, but we believe the answer would be NO because the HCTC was scheduled to expire 12-31-13 so there was no need for the insurance companies with plans on the public exchanges to apply to the IRS for this qualification.

QUESTIONS?

We know that there are a lot of unanswered questions at this point. The Board of Directors has established a method to collect your ACA-related questions, which we will review and answer based on subject matter through periodic additions to these FAQs. That method is to send an email to the "ACA Questions" contact and can also be accessed through the DSRA-BT website under the "Contact Us" menu item at the top of the new website home page.

If you have questions about the benefits provided under any of the DSRA-BT plans, please contact Marsh, our plan administrator, at 1-877-336-DSRA (3772).

DSRA Benefit Trust Board of Directors