Q. Why do I have to complete this form?

A. Due to various state and federal regulations, Univera Healthcare is required to obtain certain information regarding your group and your employees on an annual basis. In other words, this form should be completed every year regardless of any changes to your previous group information forms. We are required to have the most up to date form on file for every year.

Q. What are the state and federal regulations Univera Healthcare is required to follow?

A. Regulations differ with regard to the type and level of information required. The Patient Protection and Affordable Care Act (PPACA) requires health insurance issuers to submit a medical loss ratio report to the Secretary of Health and Human Services and requires insurers to issue a rebate to enrollees if the issuer's medical loss ratio is less than the applicable percentage established in section 2718(b) of the PPACA. Insurers report a separate medical loss ratio for small and large groups.

Q. What is a medical loss ratio?

A. A medical loss ratio is the percentage of premium dollars insurers spend to provide covered medical services and improve the quality of health care for their members.

Q. What happens if I do not return the form?

A. All of the information requested on the form is required by state and regulatory agencies and thus, without that information, we would be unable to renew your coverage.

Q. What if my company is no longer in business?

A. If your business is no longer active, please note that on the form and return it to us. There is no need to complete the form in its entirety.

Q. Where can I find my group number and sub group number?

A. You should be able to locate your group and sub group numbers on your bill or annual rate notice. It would be on the first page in the upper right hand corner.

Q. Why do I need to initial and date corrections that are made to the form after the original submission?

A. We require the initialing and dating of changes to the form for your benefit. This process not only ensures that corrections are accurate and have been made by an authorized representative for your group, but it also prevents someone else from falsifying information on your Annual Group Information Form.

Q. What is ERISA?

A. The Employment Retirement Income Security Act of 1974 (ERISA) is a federal law that sets minimum standards for most voluntarily established pension and health plans in private industry to provide protection for individuals in these plans. Most plans are governed by ERISA with the exception of non-federal governmental plans and some church plans.

Q. Why do I need to know if my plan is governed by ERISA or not?

A. It is important that you know whether or not you are governed by ERISA because if rebates are due, under the medical loss ratio provision of the PPACA, the plan sponsor (employer group) will be responsible for the distribution of the funds to its employees. Whether or not you are governed by ERISA dictates how that money needs to be distributed. If you are unsure whether or not your plan is governed by ERISA, you should consult your legal counsel or accountant to assist you in making the determination. You may also refer to the following websites for additional information regarding ERISA:

- http://search.usa.gov/search?query=erisa&affiliate=u.s.departmentoflabor
- http://www.dol.gov/ebsa/newsroom/tr11-04.html

Q. What is a SIC code?

A. The Standard Industrial Classification (SIC) code is a four-digit code indicating the industry in which your company is classified. If you need assistance in determining your company's SIC code or would like more information, please go to http://www.osha.gov/pls/imis/sicsearch.html.

Q. What is a tier?

A. A tier refers to the rate structure that you have set up for your group. For example, if you have two sets of rates for your group, you are a two tier; if you have three sets of rates, you are a three tier; and so on. In the applicable boxes, please indicate how much you contribute to the premium for each tier.

Q. What is the monthly tier contribution?

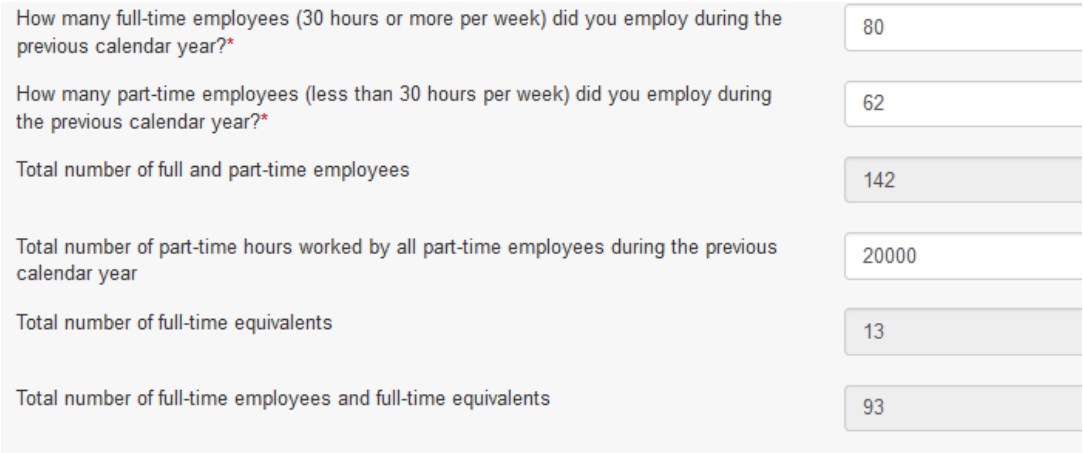
A. The monthly tier contribution is how much you contribute to the monthly health insurance premium for your employees. Often, employer groups contribute different amounts to the various tiers. If this is the case, you will need to enter a different amount in each of the tiers. If you contribute the same to each tier, please note the amount for each applicable tier.

Q. How is group size determined?

A. Group size is determined by the number of full time equivalent employees a business employs. Exact calculations are reached by calculating the number of full time equivalent employees employed during the previous calendar year. Groups with 100 employees or less are considered small group. Groups with 101 or more employees would be considered large group. Under New York state insurance law, all small groups must be community rated. This means that the premium rate that a small group pays is based on the average claims experience of all small groups enrolled with a particular health insurance company. In order to be fair, all insurance companies must provide information to the New York State Department of Financial Services that identifies small groups versus large groups. This is part of the process to stabilize community rates for all small groups in New York. It is very important that we accurately identify all small groups that offer one or more of our insurance plans.

Q. What is the FTE calculation?

A. For the purpose of the Employer Shared Responsibility provisions of the Affordable Care Act, the number of full-time employees and full-time equivalents (FTEs) an employer has in the previous calendar year determines whether the employer is large or small for the next year. In the example below, the group has 80 full-time employees and 62 part-time employees, totaling 142 employees. The total number of part-time hours worked is then divided by 1440 (20,000/1,440) to receive the total number of full-time equivalents. The FTE count is then added to the full-time employee count to give a total of 93. This group was considered large group, but would be small group for their next renewal because they are less than 100 employees.



Q. What is the common law employee requirement?

A. To obtain group health insurance, the Affordable Care Act and the New York state Insurance Law include a requirement that a company have at least one common-law employee enrolled in insurance coverage. Generally, a common-law employee is anyone who performs services for an employer, and receives wages, if the employer can control what the employee does and how it is accomplished. A common-law employee does not include the sole proprietor, a partner of a business or a spouse of the sole proprietor or partner.