Excellus
165 Court Street
Rochester, NY 14647

A nonprofit independent licensee of the BlueCross BlueShield Association

Company Name
Contact Name
Company Address 1
Company Address 2
City, St Zip

2012 IMPORTANT INFORMATION. PLEASE READ CAREFULLY.

Dear Group Administrator,

Due to various state and federal regulations, Excellus BlueCross BlueShield is required to obtain certain information regarding your group on an annual basis. As your health insurance provider, we know this information as it relates to the members you have with us, but we may not have an accurate understanding of this information as it applies to all of your employees. As you will see below, regulations differ with regard to the type and level of information needed.

Why is this important to you?

Your group's health insurance benefits and premiums are affected by your group size.

Federal Mental Health Parity and Addiction Equity Act

Depending on your group size, you may be required to make changes to the mental health and substance abuse benefits covered by your group policy as a result of the federal Mental Health Parity and Addiction Equity Act enacted in late 2008.

The law requires that health plans provide expanded mental health and substance abuse benefits for insured and self-funded large groups. However, unlike New York law, group size is determined by the average "total" number of employees. A group with an average of 51 or more total employees during the prior calendar year is considered "large."

This means that in New York, a small group with 50 or fewer *eligible* employees, but with an average of 51 or more *total* employees, is subject to the federal Mental Health Parity and Addiction Equity Act.

This is why we now must ask you for counts of your *eligible* employees and *average total* employees.

Patient Protection and Affordable Care Act

Section 2718 of the Public Health Service Act, as added by the Patient Protection and Affordable Care Act, requires health insurance issuers to submit a medical loss ratio report to the Secretary 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 Patient Protection and Affordable Care Act. There is a medical loss ratio reported for small groups and a medical loss ratio reported for large groups.

New York State Community Rating

Under the New York insurance law, all small groups must be community rated. This means that the premium rate a small group pays is based on the average claims experience of all small groups enrolled with a particular health insurance company.

SAMPLE

In order to level the playing field, all insurance companies must provide information to the New York State Department of Financial Services that identifies small groups vs. large groups. This is part of a process to stabilize community rates for all small groups in New York. Therefore, it is important that we accurately identify all small groups that offer one of our insurance plans.

Please note that employer groups are responsible for providing accurate information to the health plan in a timely manner. Employer groups will be held accountable for the payment of any penalties imposed on the health plan as a result of inaccurate or misleading information supplied by the group or the group's failure to provide the requested information.

Who is eligible?
According to New York law, this is any person in your company who is eligible for health insurance coverage. At a minimum, this may include one or all of the following:

- Full-time employees
- Part-time employees (must work minimum required hours each week)
- Seasonal employees (three or more months of employment is required)
- Retirees
- Union employees who are eligible for coverage through your company and are not offered coverage directly through their union
- Individuals on COBRA/New York continuation coverage
- Owners and partners

Who is an employee?
This is any person employed by your company. This includes all of the above "eligible" employees as well as:

- Part-time employees (regardless of how many hours a week they work)
- Seasonal employees (regardless of months worked or if they can enroll in your health plan)
- Union employees who are eligible for coverage directly through their union but are not eligible for coverage through your company

We need your help!
In order for us to have the most up-to-date information, please complete the enclosed questionnaire and return it to us in the postage-paid envelope by *due date*.

You can also provide us with this information by completing the online questionnaire at *www.excellusbcbs.com/verifygroupinfo.* Your customer identification for completing the online questionnaire is:

Recipient I.D. & Product I.D.

We appreciate your cooperation in providing this information. If needed, we may use this information to generate a Master Group Agreement. If you have any questions, please contact your account consultant, broker, or Chamber Trust & Association administrator.

Sincerely,

Lisa A. Ryan

Lisa A. Ryan

Director, Underwriting

SAMPLE

Excellus
165 Court Street
Rochester, NY 14647

Annual Group Information Form

Failure to respond may result in your policy being cancelled.

Please complete and return by *due date* or complete the online questionnaire at *www.excellusbcbs.com/verifygroupinfo*.
Your customer identification number for completing the online questionnaire is: *Recipient I.D. & Product I.D.*

SECTION ONE: GENERAL GROUP INFORMATION

1. Group name or DBA name, if applicable: _____
2. Legal entity name, if different than group name: _____
3. List owner(s)/partners: _____
   List commonly owned businesses (if applicable): _____
4. Group number(s): _____ Sub group number(s): _____
5. Next renewal date: _____
6. Is your health plan governed by ERISA? Yes ____ No ____ (check one) If Yes, ERISA plan month: _____
7. Physical location of employer: _____
   Physical location of company headquarters: _____
8. Mailing address of employer (if different than physical address): _____
9. Information for contact person at employer group:

   _____ _____ _____ _____ _____ _____ _____ _____
   Name Title Phone # Email Address
10. Description of business:_____ SIC code: _____ EIN/TIN #: _____
11. Type of group sponsor: (check one)
    Employer ____ Union ____ Trustees of Fund ____ Association ____ Other: _____
12. Organization type: (check one) State government ___ Local government ___ Church group ____
    Nonprofit ___ Trust ___ Publicly traded organization ___ Privately held corporation ____
    Privately held non-incorporated ___ Not-for-profit ____ Other: _____
13. Is coverage obtained through a Chamber Trust or Association, including a professional society?
    Yes ___ No ___ (check one)
    CTA Name _____ Professional Society Name _____
14. Are you a subsidiary company? Yes ___ No ___ (check one)
    If yes, list parent company name & address _____
15. Are you a parent company with subsidiary companies? Yes ____ No ____ (check one)
    If yes, please attach a list of the related companies, the locations and the number of eligible employees working at each location.
16. How many hours per week must an employee work to be eligible for insurance? _____

SAMPLE

Revision Date: 02/21/2012

17. Are there any other health plans in place for your group? Yes ____ No ____ (check one)

    If yes, type of plan(s) _____ Number of individuals enrolled in this plan _____

SECTION TWO: REGULATORY INFORMATION*

18. Group Size	Medical	Dental
a) Total number of employees at all locations	_____	_____
b) Total number of eligible full-time and part-time employees at all locations	_____	_____
c) Total number of eligible retirees at all locations	_____	_____
d) Total number of individuals enrolled due to COBRA/New York continuation of coverage at all locations	_____	_____
e) Total eligible (**e = b + c + d**)	_____	_____
f) Eligible individuals at other locations not eligible for the programs offered through our plan	_____	_____
g) Eligible employees declining coverage due to a valid waiver (please see instructions)	_____	_____
h) Retirees who are offered a Medicare Advantage or a Retiree Health Plan group product with our health plan	_____	NA
i) Net eligible for our health plan (**i = e – f – g – h**)	_____	_____
j) Eligible individuals enrolling in group products (excluding those enrolled in a Medicare Advantage or a Retiree Health Plan group product)	_____	_____
k) Group participation percentage (**k = j ÷ i**)	_____	_____
19. Average number of total employees at all locations, during the prior calendar year, for federal mental health parity and federal medical loss ratio reporting	_____	NA
20. Do you employ any Vermont residents who work at employer locations in Vermont, including telecommuters working from their home in Vermont? Yes ____ No ____ (check one) If yes, please provide the number	_____	_____
21. Do you employ any other out-of-state residents who work at out-of-state employer locations other than Vermont? Yes ____ No ____ (check one) If yes, please provide the number	_____	_____

Signature: The undersigned certifies that, to the best of my knowledge and belief and under penalty of perjury, the information listed above is true and complete, including the number of persons proposed for coverage who work at least the minimum required hours per week.

Employer Authorized Representative Signature	**Date**	**Email Address**	**Title**

_____

Print Name

*Additional instructions for this section are available at the end of this packet

SAMPLE

Excellus
165 Court Street
Rochester, NY 14647

Annual Group Information Form

Failure to respond may result in your policy being cancelled.

Employer Contribution*

Group Name_____ Group Number/Sub Group Number_____ Health Plan Governed by ERISA? Yes___ No___	Next Renewal Date _____ Contribution Effective Date _____ Contribution End Date_____

Please note: If your contribution amount/type changes you are required to notify the Health Plan of these changes.

Rate Tier:	Premium Contribution Type:	Other - please explain:
☐ 2 - Tier ☐ 3 - Tier ☐ 4 - Tier	☐ Fixed $ amt. ☐ % of premium	

If your group's number of plan options per class exceeds three, please complete an additional form(s) or attach a spreadsheet with the contribution details.

If your group's employer contribution differs by subgroup, please complete the form for each subgroup.

Class Names:

A001 - All Actives	A004 - Management	A007 - Non-Union	R001 - Retired Non-Medicare Eligible
A002 - Hourly	A005 - Non-Management	A008 - Full-Time	R002 - Retired Medicare Eligible
A003 - Salaried	A006 - Union	A009 - Part-Time	

Class Name	Plan Offering	Monthly Tier Contribution				HSA/HRA Annual Contribution if applicable
		Single	Subscriber & Spouse	Subscriber & Child/Children	Family	

Signature: The undersigned certifies that, to the best of my knowledge and belief, the information provided above is true and complete.

_____ _____ _____ _____

Employer Authorized Representative Signature **Date** **Phone Number** **Email Address**

_____

Print Name

***Additional instructions for this section are available at the end of this packet

SAMPLE

Revision Date: 02/21/2012

Excellus
165 Court Street
Rochester, NY 14647

Instructions for Questions #18-21

18. Group Size

This information is required for community-rated and experience-rated groups to verify that the group meets the participation requirements of the New York State Department of Financial Services and our health plan. If you are a community-rated group, question 18 (a-e) pertains to the New York State Department of Financial Services requirement to verify small group eligibility by reviewing the total number of eligible employees within each group. Eligible employees are individuals who are eligible to enroll in your health plan(s) through all carriers.

a) Total full-time and part-time number of employees at all locations

- *Enter the total number of all employees actively working at the employer group. This number should include full-time, part-time and seasonal employees working at all locations of the company. The owners and partners should be included. This is all active employees, not just the employees eligible for coverage through your health plan.*

b) Total eligible full-time and part-time employees

- *This includes only those full-time and part-time employees who are eligible to enroll in your health plan through any of your locations. Do not list total employees, only those eligible for coverage.*
- *Include all individuals eligible for health insurance, including all owners and partners.*
- *Do not include full-time and part-time employees who have not met your new hire waiting period for eligibility for health insurance.*
- *Do not include seasonal employees if they are not eligible to enroll in your health plan and/or have not worked at least three months.*
- *Do not include union employees if coverage is offered directly through their union.*

c) Eligible retirees

- *Include those retirees who are eligible to enroll in the same plan as the actives.*
- *Include those retirees eligible for Medicare Advantage or a Retiree Health Plan specifically designed for Medicare eligible.*
- *If your group does not offer health insurance to retirees, please enter zero.*
- *Do not include spouses enrolled under their own name, e.g., surviving spouses.*

d) Individuals enrolled in your health plan due to COBRA/New York continuation of coverage

- *Include any individuals who have experienced a qualifying event and have elected to temporarily continue their health plan coverage and pay the premiums themselves. They may be entitled to continue their coverage due to COBRA or New York law.*
- *Do not include spouses or children enrolled under their own names, e.g., divorced spouses, dependents enrolled in their own policy, such as a "young adult" option.*

e) Total eligible calculation

- *Add together lines b + c + d*
- *Total eligible individuals should not be 0. If you believe 0 is correct, please contact your account consultant for assistance.*

f) Eligible individuals at other locations not eligible for our plan

- *Include only those eligible individuals at other locations not eligible for insurance on our health plan.*
- *This should include full-time and part-time eligible employees, retirees (not on a Medicare Advantage or a Retiree Health Plan, and COBRA that are eligible for health insurance under the group through other locations, but not for our health plan).*

SAMPLE

Revision Date: 02/21/2012

g) Eligible employees declining coverage due to a valid waiver

- *Spousal coverage through a commercial carrier or TRICARE*
- *Coverage with a parent through a commercial carrier*
- *Retiree coverage through a former employer through a commercial carrier*
- *Coverage with Family Health Plus*
- *Coverage with Medicare*
- *Coverage with Medicaid*
- *Coverage with Healthy NY*
- *Coverage with the Veterans Administration*

h) Medicare-eligible retirees offered Medicare Advantage or Retiree Health Plan group product

- *Include only those retirees with our health plan offered Medicare Advantage or a Retiree Health Plan specifically designed for Medicare-eligible persons.*
- *Do not include retirees eligible for the plan the group offers to its active population.*

i) Net eligible for our health plan

- *Subtract lines f through h from line e; these are the eligible individuals who will be used in the participation calculation*.

j) Eligible enrolling in our health plan

- *Include only those eligible individuals enrolled in our health plan. Do not include those who are enrolled in other health plans.*
- *Do not include retirees enrolled in a Medicare Advantage or a Retiree Health Plan group product.*

k) Group participation percentage

- *Divide line j by line i to calculate participation percentage.*

19. Average number of total employees for federal mental health parity and federal medical loss ratio reporting

Question 19 pertains to the federal government's requirement to identify the average number of total employees within each group for the purposes of mental health and substance abuse benefit determination and for medical loss ratio reporting.

Who qualifies as an employee?

- *All individuals who you employ, regardless of whether they are eligible for your health plan.*
- *Include full-time and part-time employees who have not met your new hire waiting period for eligibility for health insurance.*
- *Include part-time and seasonal employees, even if they are not eligible to enroll in your health plan and/or have not worked at least three months.*
- *Include union employees who are offered coverage directly through their union.*

How do I calculate the average number of total employees?

- *This is an average number of employees that you have employed on business days during the prior calendar year, not the number of employees you employ today. This includes each full-time, part-time and seasonal employee.*
- *For employers who were not in existence throughout the prior calendar year, please use the number of employees you expect to employ on business days during the current calendar year.*

SAMPLE

20. Vermont residents working at employer locations in Vermont

- *Include only employees who live and work in Vermont, including those who live in Vermont and telecommute from their residence.*
- *Do not include residents of other states working or telecommuting from their home in Vermont.*
- *Do not include residents of Vermont who work at employer locations in New York.*

21. Other out-of-state residents working at out-of-state employer locations other than Vermont

- *Include only employees who live and work out of state, including those who live out of state and telecommute from their residence.*
- *Do not include residents of Vermont working or telecommuting from their home in Vermont.*
- *Do not include out-of-state residents who work at employer locations in New York.*

Employer Contribution Instructions (page 3 of Annual Group Information Form):

Information regarding how you contribute to your eligible employees' premium is required for the medical loss ratio rebate and to verify underwriting eligibility. A separate attachment is included to capture this information.

Class name

- *If your contribution strategy differs by class, please list the employee class in this column and provide the information for each class. The standard class names are listed on the form. If it is not a standard class, please indicate the class name in this section. If you do not have more than one class of employees, or you contribute the same amount to each class, you can indicate "All" in this column. If your employer group has more than two classes of employees, you may need to complete a separate form for the additional classes.*

Plan

- *List all of the plans you offer in this column. Include dental, Medicare Advantage and Retiree Health Plan group products if offered. If your employer group exceeds the number of plans on the form, you may need to complete a separate form for the additional plans.*

Tier

- *Complete the amount you contribute monthly toward each tier based on the number of tiers you have.*

HSA/HRA contribution

- *If you have an HSA or HRA attached to your high-deductible health plan, please include the annual amount you contribute to the deductible in this column for each class.*

If responding by paper, send to:

Attn: Annual GIF Unit, 3rd Floor
PO Box 4809
Syracuse, NY 13221-9987

SAMPLE