

Rating and Renewability Disclosure Form

Employers with 2-50 Employees

Return a copy of completed form to: Quotes@aspirushealthplan.com or fax: 715.843.1246

Purpose

This disclosure form is required by Wisconsin Insurance Law to make you aware of our rating and renewability practices.

This disclosure applies only to groups who employed an average of at least two (2) but not more than fifty (50) employees in Wisconsin, including part-time and seasonal employees, during the preceding year.

Note: The protections afforded to small employers under Chapter 635 of the Wisconsin statutes and Ins. 8 would no longer apply at renewal if you employ, on average, less than two (2) or more than fifty (50) employees during the preceding plan year.

How Your Rate is Determined

Your premium rate is determined using our company experience and actuarial calculations.

Factors, which affect your rate, include:

- The benefits, coverage, and network you choose
- Geographic rating area and increases in medical costs in your area
- Number of individuals enrolled in the plan, their ages, and smoking status
- Effective date of coverage

Rate Changes

We may change the premium rates on your plan:

- Due to changes in benefit design (like adding a copay or deductible) and changes in case characteristics (example: the number of enrollees on the plan and their ages)
- Based on the manual rate change, which reflects the overall experience of all insured groups
- By an adjustment, not to exceed 15% per year for factors related to your claim experience

The extent of the effects of these rating factors can be minimal or significant, depending on the circumstances and choices of the employer group.

Guaranteed Renewability

Our small group health insurance plans are guaranteed renewable and cannot be terminated based on claims experience. However, coverage may be canceled should you:

- Fail to pay premium
- Engage in fraud or misrepresentation
- Breach the contract
- Fail to meet minimum participation or contribution requirements
- Discontinue business, lose status as an independent legal entity, or move your business out of the service area where Aspirus Health Plan offers small employer coverage

SIGNATURES

Group

I have read and received a copy of the disclosure notice.

Employer (Group name)	Employer Authorized Signature	Date
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Agent or Aspirus Health Plan Representative

I certify that I have reviewed this disclosure with the employer prior to completing the application for insurance and left a copy of the form with the employer.

Agent or Sales Representative Signature	Date
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