DeanHealthPlan
A member of SSM Health

1277 Deming Way
Madison, WI 53717
phone: 800-279-1301
Medicare: 888-422-3326
TTY: 711
deancare.com

Date

RESPONSE REQUIRED
COMPLETE AND RETURN WITHIN 10 DAYS OF THIS NOTICE

Group Name (prefilled by mail merge)
Group Address (prefilled by mail merge)
City, State Zip (prefilled by mail merge)

RE: CMS Regulations, Employee Count
Group Number: (prefilled by mail merge)

Dear Group Administrator:

Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007 (the Act) established mandatory reporting requirements for group health plans such as Dean Health Plan, Inc. (Dean). As a result, Dean must provide certain information to the Centers for Medicare and Medicaid Services (CMS), including a count of the number of your employees. It is very important that you complete the information below and return this form to Dean.

For the first four questions listed below, please include all full-time, part-time employees and seasonal employees regardless of their enrollment in a Dean plan. "*Employer size must be based on the size of the entire company or corporation, not just the subsidiary. When calculating the number of employees, entities should use the total number of employees in an organizational structure (parent, subsidiaries and siblings) rather than just the number of employees in the particular subsidiary being reported on." (GHP User Guide Version 4.9, April 4, 2016)*.

1. **In 2015, did you have 100 or more employees during 50 percent of the business days?**
   YES / NO (Please circle one.) Please indicate your employee count_____
   ("*An employer will be considered to employ 100 or more employees on a particular day if the employer has at least 100 full-time or part-time employees on his/her employment rolls on that day. This condition is met as long as the total number of individuals on the employer's rolls ads up to at least 100 regardless of the number of employees who work or who are expected to report for work on that day." (Medicare Secondary Payer Manual, Chapter 2, Section 30.2 - The 100 or More Employees Requirement (Rev. 49, Issued: 04-07-06; Effective/Implementation: 05-08-06)*

2. **In 2015, did you have 20 or more employees for 20 or more calendar weeks?**
   YES /NO (Please circle one.) Please indicate your employee count_____
   ("An employer is considered to have 20 or more employees for each working day of a particular week if the employer has at least 20 full-time or part-time employees on its employment rolls each working day of that week".) Medicare Secondary Payer Manual, Chapter 2, Section 10.3 - The 20-or-More Employees Requirement (Rev. 1, 10-01-03)

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If your employee count for 20 or more calendar weeks during 2014 was 19 and under and question 2 above is now yes, please provide the date in 2015 when your group size increased to 20 or more.

_____

Note: If you answered NO to Question 2 for 2015, and in 2016, your employee count changes to 20 or more employees for at least 20 calendar weeks, you must notify Dean immediately.

3. **In 2015, did your organization participate in a multi or multiple employer group health plan in which there was at least one employer who had 100 or more employees during 50 percent of their business days?** YES / NO (Please circle one.)

4. **In 2015, did your organization participate in a multi or multiple employer group health plan in which there was at least one employer who had 20 or more employees for 20 or more calendar weeks?** YES / NO (Please circle one.)

Please update Dean as this information changes throughout the year. Failure to supply this information and any updates may result in incorrect payments for your employees' claims and may raise issues for your group under applicable federal laws. Visit http://www.cms.gov/MandatoryInsRep for further information.

Additional Group Information required:

5. **What is the average number of employees working at your business during the most recent calendar year?** This number should include full-time, part-time, seasonal and temporary employees at all locations and commonly owned businesses. _____

Thank you for your cooperation. Please contact Dean at 800-279-1301 or your Dean Health Plan Account Manager with any questions or concerns.

Contact Name (please print): _____

Title of person completing the survey: _____

Phone Number: _____Date Completed: _____

Signature: _____ Date_____

Thank you for your cooperation,

Dean Health Plan

Note: Dean Health Plan reserves the right to request supporting documentation.