Department of Labor
Pension and Welfare Benefits Administration

Instructions for Form M-1

Annual Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)

ERISA refers to the Employee Retirement Income Security Act of 1974

Paperwork Reduction Act Notice

We ask for the information on this form to carry out the law as specified in ERISA. You are required to give us the information. We need it to determine whether the MEWA or ECE is operating according to law. You are not required to respond to this collection of information unless it displays a current, valid OMB control number.

The average time needed to complete and file the form is estimated below. These times will vary depending on individual circumstances.

Learning about the law or the form	Preparing the form
2 hrs.	50 min. - 1 hr and 35 min.

Contents

The instructions are divided into three main sections.

SECTION 1

1.1 Introduction

This form is required to be filed under section 101(g){h}* and section 734 of the Employee Retirement Income Security Act of 1974, as amended (ERISA) and 29 CFR 2520.101-2.

The Department of Labor, Pension and Welfare Benefits Administration (PWBA) is committed to working together with administrators to help them comply with this filing requirement. Filer's guides, which may be helpful in filing this report are available by calling the PWBA toll-free publication hotline at 1-800-998-7542 and on the Internet at: http://www.dol.gov/dol/pwba. If you have any questions (such as whether you are required to file this report) or if you need any assistance in completing this report, please call the PWBA help desk at (202) 219-8818.

All Form M-1 reports are subject to a computerized review. It is, therefore, in the filer's best interest that the responses accurately reflect the circumstances they were designed to report.

* Both the Small Business Job Protection Act of 1996 (Pub. L. 104-188) and the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) created a new section 101(g) of ERISA. Accordingly, section 101(g) of ERISA that relates to reporting by certain arrangements is referred to in this document as section 101(g){h} of ERISA.

1.2 Who Must File

General rules

The "administrator" (defined below) of a "multiple employer welfare arrangement" (MEWA, defined below) generally must file this report for every calendar year, or portion thereof, that the MEWA offers or provides benefits for medical care to the employees of two or more employers (including one or more self-employed individuals). The administrator of an "entity claiming exception" (ECE, defined below) must file the report each year for the three years after the ECE is "originated" (defined below). (Warning: An ECE may be "originated" more than once. Each time an ECE is "originated," more filings are triggered.)

However, in no event is reporting required by the administrator of a MEWA or ECE if the MEWA or ECE is licensed or authorized to operate as a health insurance issuer in every State in which it offers or provides coverage for medical care to employees.

Accordingly, subject to the exception described above for licensed or authorized health insurance issuers, the administrator of a MEWA is required to file annually. By contrast, the administrator of an ECE is required to file for three years following an origination. Whether or not an entity is a MEWA or ECE is determined by the administrator acting in good faith. Therefore, if an administrator makes a good faith determination at the time of the filing that the entity is maintained pursuant to one or more collective bargaining agreements, the entity is an ECE, and the ECE is not required to file because its most recent origination was more than three years ago, then a filing is not required. Even if the entity is later determined to be a MEWA, filings are not required prior to the determination that the entity is a MEWA if at the time the filings were due, the administrator made a good faith determination that the entity was an ECE. However, filings are required for years after the determination that the entity is a MEWA.

In contrast, while an administrator's good faith determination that an entity is an ECE may eliminate the requirement that the administrator of the entity file under this section for more than three years after the entity's origination date, the administrator's determination does not affect the applicability of State law to the entity. Accordingly, incorrectly claiming the exception may eliminate the need to file under this section, if the claiming of the exception is done in good faith. However, the claiming of the exception for ECEs under this filing requirement does not prevent the application of State law to an entity that is later determined to be a MEWA. This is because the filing, or the failure to file, under this section does not in any way affect the application of State law to a MEWA.

Definition of "Administrator"

For purposes of this form, the "administrator" is the person specifically designated by the terms of the MEWA or ECE. However, if the MEWA or ECE is a group health plan and the administrator is not so designated, the plan sponsor (as defined in section 3(16)(B) of ERISA) is the administrator. Moreover, in the case of a MEWA or ECE for which an administrator is not designated and a plan sponsor cannot

be identified, the administrator is the person or persons actually responsible (whether or not so designated under the terms of the MEWA or ECE) for the control, disposition, or management of the cash or property received by or contributed to the MEWA or ECE, irrespective of whether such control, disposition, or management is exercised directly by such person or persons or indirectly through an agent or trustee designated by such person or persons.

Definition of "Multiple Employer Welfare Arrangement" or "MEWA"
In general, a multiple employer welfare arrangement (MEWA) is an employee welfare benefit plan or other arrangement that is established or maintained for the purpose of offering or providing medical benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, except that the term does not include any such plan or other arrangement that is established or maintained under or pursuant to one or more agreements that the Secretary finds to be collective bargaining agreements, by a rural electric cooperative, or by a rural telephone cooperative association. See ERISA section 3(40).

Definition of "Entity Claiming Exception" or "ECE"
For purposes of this report, the term "entity claiming exception" or "ECE" means any plan or other arrangement that is established or maintained for the purpose of offering or providing medical benefits to the employees of two or more employers (including one or more self-employed individuals), or to their beneficiaries, and that claims it is not a MEWA because the plan or other arrangement claims the exception relating to plans established or maintained pursuant to one or more collective bargaining agreements (contained in section 3(40)(A)(i) of ERISA).

The administrator of an ECE must file this report each year for the first three years after the ECE is "originated". (Warning: An ECE may be "originated" more than once. Each time an ECE is "originated," more filings are triggered.)

Definition of "Originated"
For purposes of this report, a MEWA or ECE is "originated" each time any of the following events occur:

(1) The MEWA or ECE first begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals),

(2) The MEWA or ECE begins offering or providing such coverage after any merger of MEWAs or ECEs (unless all MEWAs or ECEs involved in the transaction have been offering or providing coverage for at least three years prior to the transaction), or

(3) The number of employees to which the MEWA or ECE offers or provides coverage for medical care is at least 50 percent greater than the number of such employees on the last day of the previous calendar year (unless such increase is due to a merger with another MEWA or ECE under which all MEWAs and ECEs that participate in the merger were last originated at least three years prior to the merger).

Therefore, a MEWA or ECE may be originated more than once. Each time an ECE is originated, filings are triggered.

1.3 When to File

General Rule
The administrator of a MEWA or ECE that is required to file must file the Form M-1 no later than March 1 following any calendar year for which a filing is required.

*** Transition Rule for Year 2000 Filings:
For the 1999 Year to be Reported, the administrator of a MEWA or ECE that is required to file must file the Form M-1 no later than May 1, 2000.

90-Day Origination Report
In general, an expedited filing is required after a MEWA or ECE is originated. To satisfy this requirement, the administrator must complete and file the Form M-1 within 90 days of the date the MEWA or ECE is originated (unless the last day of the 90-day period is a Saturday, Sunday, or federal holiday, in which case the form must be filed no later than the following business day).

Exceptions to the 90-Day Origination Report Requirement
(1) No 90-Day Origination Reports are due before May 1, 2000. (Therefore, for an entity that is originated, for example, on January 1, 2000, no 90-day origination report is required. Nonetheless, for an entity that is originated, for example, on April 1, 2000, a 90-Day Origination Report is required to be completed and filed no later than June 30, 2000.)

(2) No 90-Day Origination Report is required if the entity was originated in October, November, or December.

Extensions
A one-time extension of time to file will automatically be granted if the administrator of the MEWA or ECE requests an extension. To request an extension, the administrator must complete and file Parts I and II of the Form M-1 (and check **Box B(3)** in Part I) no later than the normal due date for the report. In such a case, the administrator will have an additional 60 days to file a completed Form M-1. A copy of the request for extension must be attached to the completed Form M-1 when filed.

1.4 Where to File

Completed copies of the Form M-1 should be sent to:

Public Documents Room, Pension and Welfare Benefits Administration
Room N-5638, U.S. Department of Labor
200 Constitution Avenue, NW.
Washington, DC 20210

1.5 Penalties

Good Faith Safe Harbor for Filings Due in Year 2000. The Department of Labor, Pension and Welfare Benefits Administration is committed to working together with administrators to help them comply with this filing requirement. In this regard, the Department does not intend to assess penalties in cases where there has been a good faith effort to comply with a filing due in the Year 2000.

However, in instances where there has not been a good faith effort to comply with a filing due in the Year 2000, and for any filing due after the Year 2000 (whether or not the administrator has made a good faith effort to comply), please be aware that ERISA provides for the assessment or imposition of a penalty for failure to file a report, failure to file a completed report, and late filings. In the event of no filing, an incomplete filing, or a late filing, a penalty may apply of up to $1,000 a day for each day that the administrator of the MEWA or ECE fails or refuses to file a complete report. In addition, certain other penalties may apply.

SECTION 2

2.1 Year to be Reported

General rule
The administrator of a MEWA or ECE that is required to file should complete the form using the previous calendar year's information. (Thus, for example, for a filing that is due by May 1, 2000, calendar year 1999 information should be used.)

Fiscal year exception

The administrator of a MEWA or ECE that is required to file may report using fiscal year information if the administrator of the MEWA or ECE has at least six continuous months of fiscal year information to report. (Thus, for example, for a filing that is due by May 1, 2000, fiscal year 1999 information may be used if the administrator has at least six continuous months of fiscal year 1999 information to report.) In this case, the administrator should check **Box A(2)** and specify the fiscal year.

2.2 The 90-Day Origination Report

When a MEWA or ECE is originated, a 90-Day Origination Report is generally required. (See section 1.3 on When to File). When filing a 90-Day Origination Report, the administrator is required to complete the Form M-1 using information based on at least 60 continuous days of operation by the MEWA or ECE.

Remember, there are two exceptions to the 90-Day Origination Report requirement: (1) No 90-Day Origination Reports are due before May 1, 2000. (Nonetheless, for an entity that is originated, for example, on April 1, 2000, a 90-Day Origination Report is required to be completed and filed by June 30, 2000.); and (2) No 90-Day Origination Report is required if the entity was originated in October, November, or December.

2.3 Signature and Date

The administrator must sign and date the report. The signature must be original. The name of the individual who signed as the administrator must be typed or printed clearly on the line under the signature line.

2.4 Amended Report

To correct errors and/or omissions on a previously filed Form M-1, submit a completed Form M-1 with Part I, **Box B(2)** checked and an original signature. When filing an amended report, answer all questions and circle the amended line numbers.

SECTION 3

Important: "Yes/No" questions must be marked "Yes" or "No," but not both. "N/A" is not an acceptable response unless expressly permitted in the instructions to that line.

3.1 Line-By-Line Instructions

Part I - Annual Report Identification Information

Complete either **Item A** or **Item B**, as applicable.

Item A: If this is an annual report, check either box A(1) or box A(2).
Check **box A(1)** if calendar year information is being used to complete this report. (See Section 2.1 on Year to be Reported.)
Check **box A(2)** if fiscal year information is being used to complete this report. Also specify the fiscal year. (For example, if fiscal year 1999 information is being used instead of calendar year 1999 information, specify the date the fiscal year begins and ends.) (See Section 2.1 on Year to be Reported.)

Item B: If this is a special filing, check either box B(1), box B(2), or box (B)(3).
Check **box B(1)** if this form is a 90-Day Origination Report. (See Section 1.2 on Who Must File, Section 1.3 on When to File, and Section 2.2 on 90-Day Origination Reports.)
Check **box B(2)** if this form is an Amended Report. (See Section 2.4 on Amended Reports.)
Check **box B(3)** if the administrator of the MEWA or ECE is requesting an extension. (See Section 1.3 on When to File.)

Part II - MEWA or ECE Identification Information

Items 1a through 1d: Enter the name and address of the MEWA or ECE, the telephone number of the MEWA or ECE, and any employer identification number (EIN) and plan number (PN) used by the MEWA or ECE in reporting to the Department of Labor or the Internal Revenue Service. If the MEWA or ECE does not have any EINs associated with it, leave **Item 1c** blank. If the MEWA or ECE does not have any PNs associated with it, leave **Item 1d** blank. In answering these questions, list only EINs and PNs used by the MEWA or ECE itself and not by group health plans or employers that purchase coverage through the MEWA or ECE.

Items 2a through 2c: Enter the name and address of the administrator of the MEWA or ECE, the telephone number of the administrator, and any employer identification number (EIN) used by the administrator in reporting to the Department of Labor or the Internal Revenue Service. For this purpose, use only an EIN associated with the administrator as a separate entity. Do not use any EIN associated with the MEWA or ECE itself.

Items 3a through 3c: Enter the name and address of the entity sponsoring the MEWA or ECE, the telephone number of the sponsor, and any employer identification number (EIN) used by the sponsor in reporting to the Department of Labor or the Internal Revenue Service. For this purpose, use only an EIN associated with the sponsor. Do not use any EIN associated with the MEWA or ECE itself. If the MEWA or ECE is a group health plan, the sponsor is the "plan sponsor," which is defined in ERISA section 3(16)(B) as (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan. If the MEWA or ECE is not a group health plan, the administrator should enter the name, address, or telephone number of the entity that establishes or maintains the MEWA or ECE. If there is no such entity, leave **Item 3** blank and skip to **Item 4**.

Part III - Registration Information

Item 4: Enter the date the MEWA or ECE was most recently "originated." For this purpose, a MEWA or ECE is "originated" each time any of the following events occur:
(1) The MEWA or ECE first begins offering or providing coverage for medical care to the employees of two or more employers (including one or more self-employed individuals);
(2) The MEWA or ECE begins offering or providing such coverage after any merger of MEWAs or ECEs (unless all MEWAs or ECEs involved in the transaction have been offering or providing coverage for at least three years prior to the transaction); or
(3) The number of employees to which the MEWA or ECE offers or provides coverage for medical care is at least 50 percent greater than the number of such employees during the previous calendar year (unless such increase is due to a merger with another MEWA or ECE under which all MEWAs and ECEs that participate in the merger were last originated at least three years prior to the merger).

Item 5: Complete the chart. If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with

information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.)

Item 5a. Under **Item 5a**, enter all States in which the MEWA or ECE offers or provides benefits for medical coverage.

In answering this question, a "State" includes any State of the United States, the District of Columbia, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, and the pertinent areas and installations of the Canal Zone.

Item 5b. Under **Item 5b**, specify whether the MEWA or ECE is licensed or otherwise authorized to operate as a health insurance issuer in each such State. (A "health insurance issuer" is defined, in pertinent part, in § 2590.701-2 of the Department's regulations, "an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law which regulates insurance . . . . Such term does not include a group health plan.")

Item 5c. If the answer to Item 5b is "yes," under **Item 5c**, enter the National Association of Insurance Commissioners (NAIC) number.

Item 5d. If the answer to Item 5b is "no," under **Item 5d** specify whether the MEWA or ECE is fully-insured by a health insurance issuer in each State.

Item 5e. If the answer to Item 5d is "yes," under **Item 5e** enter the name of the insurer and its NAIC number.

Item 5f. Under **Item 5f**, specify whether the MEWA or ECE has purchased any stop-loss coverage. For this purpose, stop-loss coverage includes any coverage defined by the State as stop-loss coverage. For this purpose, stop-loss coverage also includes any financial reimbursement instrument that is related to liability for the payment of health claims by the MEWA or ECE, including reinsurance.

Item 5g. If the answer to Item 5f is "yes," under **Item 5g** enter the name of the stop-loss insurer and its NAIC number.

If more space is needed to complete **Item 5**, additional pages may be attached. These pages must indicate "Item 5 Attachment" in the upper right corner and must be in a format similar to that of **Item 5**.

Item 6: Of the States identified in **Item 5a**, identify all States in which the MEWA or ECE conducted 20 percent or more of its business (based on the number of participants receiving coverage for medical care under the MEWA or ECE).

For example, consider a MEWA that offers or provides coverage to the employees of six employers. Two employers are located in State X and 70 employees of the two employers receive coverage through the MEWA. Three employers are located in State Y and 30 employees of the three employers receive coverage through the MEWA. Finally, one employer is located in State Z and 200 employees of the employer receive coverage through the MEWA. In this example, the administrator of the MEWA should specify State X and State Z under Item 6 because the MEWA conducts 23*a*% of its business in State X (70÷300 = 23*a*%) and 66*b*% of its business in State Z (200÷300 = 66*b*%). However, the administrator should not specify State Y because the MEWA conducts only 10% of its business in State Y (30÷300 = 10%)

If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.)

Item 7: Identify the total number of participants eligible to receive coverage for benefits under the MEWA or ECE.

If the report is a 90-Day Origination Report, complete this item with information that is current as of the 60th day following the origination date. Otherwise, complete this item with information that is current as of the last day of the year to be reported. (See Section 2.1 on Year to be Reported.)

Part IV - Information for Compliance with Part 7 of ERISA

Background Information on Part 7 of ERISA: On August 21, 1996, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) was enacted. On September 26, 1996, both the Mental Health Parity Act of 1996 (MHPA) and the Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act) were enacted. On October 21, 1998, the Women's Health and Cancer Rights Act of 1998 (WHCRA) was enacted. All of the foregoing laws amended Part 7 of ERISA with new requirements for group health plans. With respect to most of these requirements, corresponding provisions are contained in Chapter 100 of Subtitle K of the Internal Revenue Code (Code) and Title XXVII of the Public Health Service Act (PHS Act). These provisions generally are substantively identical.

The Departments of Labor, the Treasury, and Health and Human Services first issued interim final regulations implementing HIPAA's portability, access, and renewability provisions on April 1, 1997 (published in the Federal Register on April 8, 1997, 62 FR 16893). Two clarifications of the HIPAA regulations were published in the Federal Register on December 29, 1997 at 62 FR 67687. Regulations implementing the MHPA provisions were published in the Federal Register on December 22, 1997 at 62 FR 66931. Also, regulations implementing the substantive provisions of Newborns' Act were published in the Federal Register on September 9, 1998 at 63 FR 48372 and on October 27, 1998 at 63 FR 57545. Moreover, the notice requirements with respect to group health plans that provide coverage for maternity or newborn infant coverage are described in the Department's summary plan description (SPD) content regulations at 29 CFR 2520.102-3(u), 63 FR 48372 (September 9, 1998). Finally, on November 23, 1998, the Department issued informal guidance on WHCRA in the form of questions and answers. All of the above-mentioned guidance is available on the Department's website at www.dol.gov/dol/pwba and via the Pension and Welfare Benefits Administration's toll-free publications hotline at 1-800-998-7542.

General Information Regarding the Applicability of Part 7: In general, the foregoing provisions apply to group health plans and health insurance issuers in the group market. A group health plan means an employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees or their dependents (defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. A health insurance issuer or issuer means an insurance company, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a State and that is subject to State law that regulates insurance. Such term does not include a group health plan. Group market generally means the market for health insurance coverage offered in connection with a group health plan.

Many MEWAs and ECEs are group health plans or health insurance issuers. However, even if the MEWA or ECE is neither a group health plan nor a health insurance issuer, if the MEWA or ECE offers or provides coverage in the group market, the coverage is required to comply with Part 7 of ERISA.

Relation to Other Laws:
States may, under certain circumstances, impose stricter laws with respect to health insurance issuers. Generally, questions concerning State laws should be directed to the State Insurance Commissioner's Office.

For More Information: To obtain copies of the Department of Labor's booklet, "Questions and Answers: Recent Changes in Health Care Law," which includes information on HIPAA, MHPA, the Newborns' Act, and WHCRA, you may call the Department's toll-free publication hotline at 1-800-998-7542. This booklet is also available on the Internet at : www.dol.gov/dol/pwba. If you have any additional questions concerning Part 7 of ERISA, you may call the Department of Labor office nearest you or the Department's health care question hotline at 202-219-8776.

Items 8a and 8b: With respect to **Item 8a**, check "yes" or "no" as applicable. For this purpose, do not include any audit that does not result in required corrective action. If you answer "yes" under **Item 8a**, identify, in **Item 8b,** any such litigation or enforcement proceeding. If you need more space, you may attach additional pages. These pages must read "Item 8b Attachment" in the upper right corner.

Item 9a: The portability requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) comprise sections 701, 702, and 703 of ERISA, sections 9801, 9802, and 9803 of the Internal Revenue Code of 1986 (Code), and sections 2701 and 2702 of the Public Health Service Act (PHS Act).

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that meets the exception for certain small group health plans or if you are the administrator of a MEWA or ECE that offers only to small group health plans (as described in section 732(a) of ERISA and § 2590.732(a) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Similarly, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet A may be helpful.

Item 9b: The Mental Health Parity Act of 1996 (MHPA) provisions are in section 712 of ERISA, section 9812 of the Code, and section 2705 of the PHS Act.

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that meets the exception for certain small group health plans or if you are the administrator of a MEWA or ECE that offers only to small group health plans (as described in section 732(a) of ERISA and § 2590.732(a) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Second, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Third, if you are the administrator of a MEWA or ECE that does not provide both medical/surgical benefits and mental health benefits, you may answer "N/A." Finally, if you are the administrator of a MEWA or ECE that offers or provides coverage only to small employers (as described in the small employer exemption contained section 712(c)(1) of ERISA and § 2590.712(e) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder) or if the coverage satisfied the requirements for the increased cost exemption (described in section 712(c)(2) of ERISA and § 2590.712(f) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet B may be helpful.

Item 9c: The Newborns' and Mothers' Health Protection Act of 1996 (Newborn's Act) provisions are in section 711 of ERISA, section 9811 of the Code, and section 2704 of the PHS Act.

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A."

Moreover, if you are the administrator of a MEWA or ECE that does not provide benefits for hospital lengths of stay in connection with childbirth, you may answer "N/A." Finally, if you are the administrator of a MEWA or ECE that is subject to State law regulating such coverage, instead of the federal Newborns' Act requirements, in all States identified in **Item 5a**, in accordance with section 711(f) of ERISA and § 2590.711(e) of the Department's regulations (and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet C may be helpful.

Item 9d: The Women's Health and Cancer Rights Act of 1998 (WHCRA) provisions are in section 713 of ERISA and section 2706 of the PHS Act.

In general, you should answer "yes" or "no" to this question if you are the administrator of a MEWA or ECE that is a group health plan or if you are providing coverage in the group market (regardless of whether you are a health insurance issuer).

However, if you are the administrator of a MEWA or ECE that meets the exception for certain small group health plans or if you are the administrator of a MEWA or ECE that offers only to small group health plans (as described in section 732(a) of ERISA and § 2590.732(a) of the Department's regulations, and the corresponding provisions of the PHS Act and the regulations issued thereunder), you may answer "N/A." Similarly, if you are the administrator of a MEWA or ECE that offers or provides coverage that consists solely of excepted benefits (described in section 732(b) of ERISA and § 2590.732(b) of the Department's regulations, and the corresponding provisions of the Code and the PHS Act and the regulations issued thereunder), you may answer "N/A." Lastly, if you are the administrator of a MEWA or ECE that does not provide medical/surgical benefits with respect to a mastectomy, you may answer "N/A." Otherwise, answer "yes" or "no," as applicable.

For purposes of determining if a MEWA or ECE is in compliance with these provisions, Worksheet D may be helpful.

3.2 Voluntary Worksheets

Voluntary worksheets, which may be used to help assess an entity's compliance with Part 7 of ERISA, are included on the following pages of these instructions. These worksheets may also be helpful in answering **Items 9a** through **9d** of the Form M-1.

Worksheet A (Form M-1)	**Determining Compliance with the HIPAA Provisions in Part 7 of Subtitle B of Title I of ERISA** Do NOT file this worksheet.	Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the HIPAA provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to any of the questions below, you should review your entity's operations because the entity may not be in full compliance with the HIPAA provisions in Part 7 of ERISA. If you need help answering these questions or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

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(1) Does the MEWA or ECE issue certificates of creditable coverage automatically to individuals who lose coverage under the MEWA or ECE and to individuals upon request? . . . . . ' 9 Yes 9 No

- Section 701(e) of ERISA and § 2590.701-5 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) require group health plans and group health insurance issuers to issue, free of charge, certificates of creditable coverage automatically to individuals who lose coverage and to any individual upon request.

- In the case of a certificate issued automatically, the certificate should reflect the most recent continuous period of creditable coverage. In the case of a certificate issued upon request, the certificate should reflect all creditable coverage that the individual had in the 24 months prior to the date of request. However, in no event is a certificate required to reflect more than 18 months of creditable coverage.

- Most health coverage is creditable coverage. However, coverage consisting solely of excepted benefits is not creditable coverage. Examples of benefits that may be excepted benefits include limited-scope dental benefits, limited-scope vision benefits, hospital indemnity benefits, and Medicare supplemental benefits.

- If you have a question whether health coverage offered by a MEWA or ECE is creditable coverage or is coverage consisting solely of excepted benefits, contact the Department of Labor office nearest you or call the Department's health care question hotline at 202-219-4377. This is not a toll-free number.

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(2) Has the MEWA or ECE made available a procedure for individuals to request and receive certificates? . . . . . ' 9 Yes 9 No

- Section 2590.701-5(a)(4)(ii) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) requires group health plans and group health insurance issuers to establish a procedure for individuals to request and receive certificates.

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(3) If the MEWA or ECE imposes a preexisting condition exclusion period, does it issue a notice informing individuals of the exclusion, the terms of the exclusion, and the right of individuals to demonstrate creditable coverage to reduce the period of the exclusion? . . . . . ' 9 Yes 9 No 9 N/A

- Section 2590.701-3(c) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) requires that a group health plan, and a group health insurance issuer, may not impose a preexisting condition exclusion with respect to a participant or a dependent of the participant before notifying the participant, in writing, of the existence and terms of any preexisting condition exclusion under the plan and of the rights of individuals to demonstrate creditable coverage.

- The description of the rights of individuals to demonstrate creditable coverage includes a description of the right of the individual to request a certificate from a prior plan or issuer, if necessary, and a statement that the current plan or issuer will assist in obtaining a certificate from any prior plan or issuer, if necessary.

(4) If the MEWA or ECE imposes a preexisting condition exclusion period, does it issue letters of determination and notification of creditable coverage within a reasonable time after the receipt of individuals' creditable coverage information? . . . . . ' 9 Yes 9 No 9 N/A

- Section 2590.701-5(d) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) states that, within a reasonable time following receipt of evidence of creditable coverage, a plan or issuer seeking to impose a preexisting condition exclusion with respect to an individual is required to disclose to the individual, in writing, its determination of any preexisting condition exclusion period that applies to the individual, and the basis for such determination, including the source and substance of any information on which the plan or issuer relied.

- In addition, the plan or issuer is required to provide the individual with a written explanation of any appeal procedures established by the plan or issuer, and with a reasonable opportunity to submit additional evidence of creditable coverage.

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(5) If the MEWA or ECE imposes a preexisting condition exclusion period, does it comport with HIPAA's limitations on preexisting condition exclusion periods? . . . . . ' 9 Yes 9 No 9 N/A

- Section 701(a)(1) of ERISA and § 2590.701-3(a)(1)(i) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that a plan or issuer may impose a preexisting condition exclusion period only if it relates to a condition for which medical advice, diagnosis, care, or treatment was recommended or received within the 6-month period ending on the individual's enrollment date in the plan or coverage. (Therefore, genetic information is not treated as a preexisting condition in the absence of a diagnosis of the condition related to such information.) The enrollment date, for purposes of the HIPAA limitations on preexisting condition exclusion periods, is the first day of coverage or, if there is a waiting period, the first day of the waiting period. (For health insurance issuers, State law may prescribe a shorter period than the 6-month period that generally applies.)

- Section 701(a)(2) of ERISA and section § 2590.701-3(a)(1)(ii) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that any preexisting condition exclusion period is limited to 12 months (18 months for late enrollees) after an individual's enrollment date in the plan or coverage. (For health insurance issuers, State law may prescribe a shorter period.)

- Section 701(a)(3) of ERISA and § 2590.701-3(a)(1)(iii) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that any preexisting condition exclusion period is reduced by the number of days of an individual's creditable coverage prior to his or her enrollment date.

- When determining the number of days of creditable coverage, the plan or issuer is not required to take into account any days that occur prior to a significant break in coverage. The federal law defines a significant break in coverage as a break of 63 days or more. However, State law applicable to health insurance coverage offered or provided by health insurance issuers may provide for a longer period.

- In any case, section 701(d) of ERISA and § 2590.701-3(b) provide that a group health plan, and a group health insurance issuer, may not impose any preexisting condition exclusion period with regard to a child who enrolls in a group heath plan within 30 days of birth, adoption, or placement for adoption and who does not incur a subsequent significant break in coverage. In addition, a group health plan, and a group health insurance issuer, may not impose a preexisting condition exclusion relating to pregnancy. (For health insurance issuers, State law may further restrict the extent to which a preexisting condition exclusion may be imposed.)

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(6) Does the MEWA or ECE issue notices of special enrollment rights to individuals who are eligible to enroll in the plan or coverage? . . . . . ' 9 Yes 9 No

- Section 2590.701-6(c) of the Department's regulations (as well as the corresponding provisions of the regulations issued under the Code and the PHS Act) requires that, on or before the time an employee is offered the opportunity to enroll in a group health plan or coverage, the plan or issuer provide the employee with a description of the plan's special enrollment rules.

- For this purpose, the plan may use the following model description of special enrollment rules:

  > If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

(7) Does the MEWA or ECE provide special enrollment rights to individuals who lose other coverage and to individuals who acquire a new dependent, if they request enrollment within 30 days of the loss of coverage, marriage, birth, adoption, or placement for adoption? . . . . . ' 9 Yes 9 No

- Section 701(f) of ERISA and § 2590.701-6 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) require group health plans, and group health insurance issuers, if certain conditions are met, to permit an employee who is eligible, but not enrolled, for coverage under the terms of the plan (or a dependent of such an employee if the dependent is eligible, but not enrolled, for coverage under such terms) to enroll for coverage under the terms of the plan if the individual loses other coverage or acquires a new dependent through marriage, birth, adoption, or placement for adoption.

- For State laws applicable to health insurance issuers that may provide individuals with additional special enrollment rights, check with an attorney or the Insurance Commissioner's Office in your State.

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(8) Do the MEWA's or ECE's rules for eligibility (including continued eligibility) comply with the nondiscrimination requirements that prohibit discrimination against any individual or a dependent of an individual based on any health factor? . . . . . ' 9 Yes 9 No

- Section 702(a) of ERISA and § 2590.702(a) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that a group health plan, and a group health insurance issuer, may not establish rules for eligibility (including continued eligibility, rules defining any applicable waiting periods, and rules relating to late and special enrollment) of any individual to enroll under the terms of the plan based on a health factor.

- The health factors are: health status, medical condition (including both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), and disability.

- However, nothing requires a plan or group health insurance coverage to provide particular benefits other than those provided under the terms of the plan or coverage. In addition, nothing prevents a plan or coverage from establishing limitations or restrictions on the amount, level, extent, or nature of benefits or coverage for similarly situated individuals enrolled in the plan or coverage.

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(9) Does the MEWA or ECE comply with the nondiscrimination requirements that prohibit requiring any individual (as a condition of enrollment or continued enrollment) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health factor? . . . . . ' 9 Yes 9 No

- Section 702(b) of ERISA and § 2590.702(b) of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) provide that a group health plan, and a group health insurance issuer, may not require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution that is greater than the premium or contribution for a similarly situated individual enrolled in the plan on the basis of any health factor (defined above).

- However, nothing restricts the amount that an employer may be charged for coverage under a group health plan and nothing prevents a plan or issuer from establishing premium discounts or rebates or modifying applicable copayments or deductibles in return for adherence to bona fide wellness programs.

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(10) If the entity is a multiemployer plan or a MEWA, does it comply with the guaranteed renewability requirements, which generally prohibit it from denying an employer whose employees are covered under a group health plan continued access to the same or different coverage under the terms of the plan? . . . . . ' 9 Yes 9 No 9 N/A

- Section 703 of ERISA (as well as the corresponding provisions in the Code) provides that a group health plan that is a multi-employer plan or a MEWA may not deny an employer whose employees are covered under the plan continued access to the same or different coverage under the terms of the plan, other than for nonpayment of contributions; for fraud or other intentional misrepresentation of material fact by the employer; for noncompliance with material plan provisions; because the plan is ceasing to offer any coverage in a geographic area; in the case of a plan that offers benefits through a network plan, because there is no longer any individual enrolled through the employer who lives, resides, or works in the service area of the network plan and the plan acts without regard to the claims experience of the employer or any health factor in relation to those individuals or their dependents; and for failure to meet the terms of an applicable collective bargaining agreement, to renew a collective bargaining or other agreement requiring or authorizing contributions to the plan, or to employ employees covered by such an agreement.

- For other laws applicable to health insurance issuers that may provide additional guaranteed renewability requirements, check with an attorney or the Insurance Commissioner's Office in your State.

Worksheet B (Form M-1)	Determining Compliance with the Mental Health Parity Act (MHPA) Provisions in Part 7 of Subtitle B of Title I of ERISA Do NOT file this worksheet.	Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the MHPA provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to the question below, you should review your entity's operations because the entity may not be in full compliance with the MHPA provisions in Part 7 of ERISA. If you need help answering this question or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

Q. If the MEWA or ECE offers or provides both mental health benefits and medical/surgical benefits, does the MEWA or ECE comply with the requirements of the MHPA provisions, which are contained in section 712 of ERISA (as well as the corresponding provisions of the Code and the PHS Act)? . . . . . ' 9 Yes 9 No 9 N/A

- Section 712 of ERISA and § 2590.712 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) generally provide for parity in the application of aggregate lifetime dollar limits and in the application of annual dollar limits between benefits for medical and surgical care and benefits for mental health coverage.
- However, these provisions do not require a group health plan or group health insurance coverage to provide any mental health coverage. And, MHPA does not apply to benefits for substance abuse or chemical dependency.
- In addition, there are exemptions for small employers and certain plans or coverage with increased costs.
- Finally, MHPA does not apply to benefits for services furnished on or after September 30, 2001.
- Contact the Department of Labor Office nearest you or call the Department's health care hotline at 202-219-4377 to find out more about these provisions.

Worksheet C (Form M-1)	**Determining Compliance with the Newborns' and Mothers' Health Protection Act (Newborns' Act) Provisions in Part 7 of Subtitle B of Title I of ERISA** Do NOT file this worksheet.	Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the Newborns' Act provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to the questions below, you should review your entity's operations because the entity may not be in full compliance with the Newborns' Act provisions in Part 7 of ERISA. If you need help answering these questions or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

(1) If the MEWA or ECE offers or provides benefits for hospital stays in connection with childbirth and is subject to the Newborns' Act, does the MEWA or ECE comply with the Newborns' Act's substantive requirements, which are contained in section 711 of ERISA (as well as the corresponding provisions of the Code and the PHS Act)? . . . . . ' 9 Yes 9 No 9 N/A

- Section 711 of ERISA and § 2590.711 of the Department's regulations (as well as the corresponding provisions in the Code and the PHS Act and the regulations issued thereunder) generally provide that a group health plan, and a group health insurance issuer, that offers benefits for hospital lengths of stay in connection with childbirth may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or her newborn child, following a vaginal delivery to less than 48 hours, and following a cesarean section to less than 96 hours, unless the attending provider, in consultation with the mother, decides to discharge earlier.

- In addition, such a plan or issuer may not require that the provider obtain authorization from the plan or issuer for prescribing any length of hospital stay up to 48 hours following a vaginal delivery and up to 96 hours following a cesarean section. Nor may such a plan or issuer penalize an attending provider for complying with this law or provide incentives to an attending provider to provide care in a manner that is inconsistent with this law. Nor may such a plan or issuer deny the mother or newborn eligibility or continued eligibility, or provide incentives to mothers to encourage them to accept less than the minimum length of stay required. Nor may such a plan or issuer restrict benefits for any portion of a period within a hospital length of stay required by this law in a manner that is less favorable than the benefits provided for any preceding portion of the stay.

- The Newborns' Act's requirements apply to all self-insured benefits offered in connection with childbirth. However, State law rather than federal law may apply to health insurance coverage offered in connection with childbirth if the State law meets certain criteria specified in section 711(d) of ERISA and § 2590.711(d) of the Department's regulations. (These criteria are also specified in the Code and the PHS Act and the regulations issued thereunder.) Based on a preliminary review of State laws as of July 1, 1998, State law rather than federal law applies to health insurance coverage offered in connection with childbirth in the following States:

  Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, the District of Columbia, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Virginia, Washington, and West Virginia. Health insurance coverage offered in connection with childbirth in other States should also comply with the federal Newborns' Act requirements.

  Moreover, the following States appear to have a State law applicable to health insurance coverage that references the federal Newborns' Act provisions:

  Delaware, Idaho, and Oregon.

  Finally, the following States and other jurisdictions do not appear to have a law regulating coverage for newborns and mothers that would apply to health insurance coverage. Therefore, the federal Newborns' Act provisions appear to apply to health insurance coverage in the following States:

  Hawaii, Michigan, Mississippi, Nebraska, Utah, Vermont, Wisconsin, Wyoming, Puerto Rico, the Virgin Islands, American Samoa, Guam, Wake Island, the Northern Mariana Islands, and the pertinent areas and installations of the Canal Zone.

(2) If the MEWA or ECE or provides benefits in connection with childbirth and is a group health plan, does the MEWA or ECE comply with the disclosure requirements under the Newborn's Act? . . . . . ' 9 Yes 9 No 9 N/A

- Section 711(d) of ERISA and § 2520.102-3(u) require group health plans providing maternity benefits to include a statement in their summary plan descriptions advising individuals of the Newborns' Act's requirements.

- For this purpose, a MEWA or ECE that is subject to the Newborns' Act disclosure requirements through ERISA may use the following sample language:

  > Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

- MEWAs and ECEs that are nonfederal governmental plans are subject to a similar disclosure requirement. For mandated language required to be used by such plans, see 45 CFR § 146.130(d)(2) (published in the **Federal Register** at 63 CFR 57561 on October 27, 1998).

Worksheet D (Form M-1)	**Determining Compliance with the Women's Health and Cancer Rights Act (WHCRA) Provisions in Part 7 of Subtitle B of Title I of ERISA** Do NOT file this worksheet.	Department of Labor Pension and Welfare Benefits Administration

This worksheet may be used to help assess an entity's compliance with the WHCRA provisions of Part 7 of Subtitle B of Title I of the Employee Retirement Income Security Act of 1974, as amended (ERISA). However, it is not a complete description of all the provisions and is not a substitute for a comprehensive compliance review. Use of this worksheet is voluntary, and it should not be filed with your Form M-1.

If you answer "No" to the questions below, you should review your entity's operations because the entity may not be in full compliance with the WHCRA provisions in Part 7 of ERISA. If you need help answering these questions or want additional guidance, you should contact the U.S. Department of Labor Pension and Welfare Benefits Administration office in your region or consult with legal counsel or a professional employee benefits adviser.

(1) If the MEWA or ECE offers or provides mastectomy coverage, does the MEWA or ECE comply with WHCRA's substantive requirements, which are contained in section 713 of ERISA (as well as the corresponding provisions of the PHS Act)? . . . . . ' 9 Yes 9 No 9 N/A

- Section 713 of ERISA (as well as the corresponding provisions in the PHS Act) generally provides that a group health plan, and a group health insurance issuer, that offers mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and the patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

- In addition, a plan or issuer may not deny a patient eligibility, or continued eligibility, to enroll or to renew coverage under the terms of the plan, solely for the purpose of avoiding the requirements of WHCRA. Nor may a plan or issuer penalize or otherwise reduce or limit the reimbursement of an attending provider; or provide incentives (monetary or otherwise) to an attending provider, to induce such provider to furnish care to an individual participant or beneficiary in a manner inconsistent with WHCRA.

- Plans and issuers may impose deductibles or coinsurance requirements for reconstructive surgery in connection with a mastectomy, but only if the deductibles and coinsurance are consistent with those established for other benefits under the plan or coverage.

- State law protections may apply to certain health insurance coverage if the State law was in effect on October 21, 1998 (the date of enactment of WHCRA) and the State law requires at least the coverage for reconstructive breast surgery that is required by WHCRA.

(2) If the MEWA or ECE offers or provides mastectomy coverage, does the MEWA or ECE comply with the disclosure requirements under WHCRA? . . . . . ' 9 Yes 9 No 9 N/A

- Section 713(b) of ERISA (as well as the corresponding provisions of the PHS Act) establishes a one-time notice requirement under which group health plans, and their health insurance issuers, must furnish a written description of the benefits that WHCRA requires. This notice is required to be furnished as part of the next general mailing (made after October 21, 1998) by group health plans, and their health insurance issuers, or in the yearly information packet sent out regarding the plan, but, in any event, the one-time notice is required to be furnished not later than January 1, 1999.

- Section 713(a)(3) of ERISA (as well as the corresponding provisions of the PHS Act) establishes a disclosure requirement under which group health plans, and their health insurance issuers, must again describe the benefits required under WHCRA, but the notice is to be provided upon enrollment in the plan and annually thereafter.

- Both notices must indicate that, in the case of a participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient for reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. The notice must also describe any deductibles and coinsurance limitations applicable to such coverage. (Under WHCRA, coverage of breast reconstruction benefits may be subject to deductibles and coinsurance limitations consistent with those established for other benefits under the plan or coverage.)

1999 Form M-1

MEWA/ECE Form

This Form is Open to Public Inspection

Annual Report for Multiple Employer Welfare Arrangements (MEWAs) and Certain Entities Claiming Exception (ECEs)

This report is required to be filed under section 101(g){h} of the Employee Retirement Income Security Act of 1974 and 29 CFR 2520.101-2.
See separate instructions before completing this form.

OMB No. 1210-0116

Department of Labor
Pension and Welfare Benefits Administration

PART I ANNUAL REPORT IDENTIFICATION INFORMATION

Complete either Item **A** or Item **B**, as applicable.

A If this is an annual report, specify whether it is for:
(*1*) The 1999 calendar year; or
(*2*) The fiscal year beginning _____, _____ and ending _____, _____.

B If this is a special filing, specify whether it is:
(*1*) A 90-day origination report;
(*2*) An amended report; or
(*3*) A request for an extension.

PART II MEWA OR ECE IDENTIFICATION INFORMATION

1a Name and address of the MEWA or ECE	**1b** Telephone number of the MEWA or ECE
	1c Employer Identification Number (EIN)
	1d Plan Number (PN)
2a Name and address of the administrator of the MEWA or ECE	**2b** Telephone number of the administrator
	2c Employer Identification Number (EIN)
3a Name and address of the entity sponsoring the MEWA or ECE	**3b** Telephone number of the sponsor
	3c Employer Identification Number (EIN)

PART III REGISTRATION INFORMATION

4 Specify the most recent date the MEWA or ECE was originated . . . . . _____

5 Complete the following chart. (See Instructions for **Item 5**)

5a	5b	5c	5d	5e	5f	5g
Enter all States where the entity offers or provides coverage.	Is the entity a licensed health insurance issuer in this State?	If you answer "yes" to **5b**, list any NAIC number.	If you answer "no," to **5b**, is the entity fully-insured?	If you answer "yes" to **5d**, enter the name of the insurer and its NAIC number.	Does the entity purchase stop-loss coverage?	If you answer "yes" to **5f**, enter the name of the stop-loss insurer and its NAIC number.
	Yes No		Yes No		Yes No	
	Yes No		Yes No		Yes No	
	Yes No		Yes No		Yes No	
	Yes No		Yes No		Yes No	

You may attach additional pages if necessary.

6 Of the States identified in **Item 5a**, list those States in which the MEWA or ECE conducted 20 percent or more of its business (based on the number of participants receiving coverage for medical care under the MEWA or ECE).

7 Total number of participants covered under the MEWA or ECE . . . . . _____

PART IV INFORMATION FOR COMPLIANCE WITH PART 7 OF ERISA

8a Has the MEWA or ECE been involved in any litigation or enforcement proceeding in which noncompliance with any provision of Part 7 of Subtitle B of Title I of ERISA was alleged? Answer for the year to which this filing applies and any time since then up to the date of completing this form. Answer "Yes" for any State, federal, administrative litigation or enforcement proceeding, whether the allegation concerns a provision under Part 7 of ERISA, a corresponding provision under the Internal Revenue Code or Public Health Service Act, a breach of any duty under Title I of ERISA if the underlying violation relates to a requirement under Part 7 of ERISA, or a breach of a contractual obligation if the contract provision relates to a requirement under Part 7 of ERISA. (The instructions to this form contain additional information that may be helpful in answering this question.) . . . . . Yes No

8b If you answered "Yes" to **Item 8a**, identify each litigation or enforcement proceeding. With respect to each, include: (1) the case number (if any), (2) the date, (3) the nature of the proceedings, (4) the court, (5) all parties (for example, plaintiffs and defendants or petitioners and respondents), and (6) the disposition. You may answer this question by attaching a copy of the complaint with the disposition of the case noted in the upper right corner. If you need additional space, you may attach additional pages.

9 Complete the following. (Note: The instructions to this form contain four detailed worksheets which may be helpful in completing this item. Please read the instructions carefully before answering the following questions.)

9a Is the MEWA or ECE in compliance with the portability provisions of the Health Insurance Portability and Accountability Act of 1996 and the Department's regulations issued thereunder? (See Worksheet A)	Yes	No	N/A
9b Is the MEWA or ECE in compliance with the Mental Health Parity Act of 1996 and the Department's regulations issued thereunder? (See Worksheet B)	Yes	No	N/A
9c Is the MEWA or ECE in compliance with the Newborns' and Mothers' Health Protection Act of 1996 and the Department's regulations issued thereunder? (See Worksheet C)	Yes	No	N/A
9d Is the MEWA or ECE in compliance with the Women's Health and Cancer Rights Act of 1998? (See Worksheet D)	Yes	No	N/A

IF MORE SPACE IS REQUIRED FOR ANY ITEM, ATTACH ADDITIONAL SHEETS THE SAME SIZE AS THIS FORM.

Caution: *Penalties may apply in the case of a late or incomplete filing of this report.*

Under penalty of perjury and other penalties set forth in the instructions, I declare that I have examined this report, including any accompanying attachments, and to the best of my knowledge and belief, it is true, correct, and complete.

Signature of administrator _____ Date _____

Type or print name of administrator _____