2002 Form M-1

MEWA/ECE Form

This Form is Open to Public Inspection

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

This report is required to be filed under section 101(g) 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 REPORT IDENTIFICATION INFORMATION

Complete either Item **A** or Item **B** (as applicable) and Item **C**.

A If this is an annual report, specify whether it is for:
(*1*) ❑ The 2002 calendar year; or
(*2*) ❑ The fiscal year beginning _____ and ending _____.
mm/dd/yyyy mm/dd/yyyy

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.

C If this is a final report, check here . . . . . ➔ ❑

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 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	
	❑ Yes ❑ No		❑ Yes ❑ No		❑ Yes ❑ No	

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 (Part 7) 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 or Federal litigation or enforcement proceeding (including any administrative 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 (if applicable): (1) the case number, (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 name of the MEWA or ECE, the disposition of the case, and the phrase "Item 8b Attachment," noted in the upper right corner.

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 coverage provided by 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 coverage provided by 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 coverage provided by 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 coverage provided by 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, YOU MAY ATTACH ADDITIONAL PAGES.
(SEE INSTRUCTIONS SECTION 2.4)

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 and correct. Under penalty of perjury and other penalties set forth in the instructions, I also declare that, unless this is an extension request, this report is complete.

Signature of administrator ➔ _____ Date ➔ _____

Type or print name of administrator ➔ _____

Department of Labor
Pension and Welfare Benefits Administration

Year 2002
Instructions for Form M-1

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

ERISA refers to the Employee Retirement Income Security Act of 1974, as amended

Notes on the 2002 Form M-1

- This year's Form M-1 is substantively identical to the 2001 Form M-1.
- A minor procedural change was made to the Report Identification Information in Part I of the form. A new Item C was added to indicate whether this is a final report. For more information on new Item C, see the line-by-line instructions in Section 3.1.
- The Year 2002 Form M-1 is generally due March 1, 2003, with an extension until May 1, 2003, available.

Introduction

This form is required to be filed under sections 101(g) and 734 of 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. Additional copies of the Form M-1 are available by calling the **PWBA toll-free hotline** at **1-866-275-7922** and on the Internet at: **www.dol.gov/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) 693-8360.**

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

Contents

The instructions are divided into three main sections.

SECTION 1

1.1 Definitions

"Administrator"
For purposes of this report, 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" is the administrator. ("Plan sponsor" 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.) 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.

"Employer Identification Number" or "EIN"
An EIN is a nine-digit employer identification number. For example, 00-1234567. Entities who do not have an EIN can apply for one on Form SS-4, Application for Employer Identification Number. This form can be obtained at most IRS or Social Security Administration offices. PWBA does NOT issue EINs.

"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 3 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.)

"Employee Welfare Benefit Plan"
In general, an employee welfare benefit plan means any plan, fund, or program established or maintained by an employer or by an employee organization, or by both, to the extent such plan, fund, or program provides its participants or beneficiaries the benefits listed in section 3(1) of ERISA (including benefits for medical care).

"Excepted Benefits"
Part 7 of Subtitle B of Title I (Part 7) of ERISA does not apply to any group health plan or group health insurance issuer in relation to its provision of excepted benefits.

Certain benefits that are generally not health coverage are excepted in all circumstances. These benefits are: coverage only for accident (including accidental death and dismemberment), disability income insurance, liability insurance (including general liability insurance and automobile liability insurance), coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, automobile medical payment insurance, credit-only insurance (for example, mortgage insurance), and coverage for on-site medical clinics.

Other benefits that generally are health coverage are excepted if certain conditions are met. Specifically, limited scope dental benefits, limited scope vision benefits, and long-term care benefits are excepted if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the group health plan. For more information on these limited excepted benefits, see the Department of Labor's regulations at 29 CFR 2590.732(b)(3).

In addition, noncoordinated benefits may be excepted benefits. The term "noncoordinated benefits" refers to coverage for a specified disease or illness (such as cancer-only coverage) or hospital indemnity or other fixed dollar indemnity insurance (such as insurance that pays $100/day for a hospital stay as its only insurance benefit), if three conditions are met. First, the benefits must be provided under a separate policy, certificate, or contract of insurance. Second, there can be no coordination between the provision of these benefits and another exclusion of benefits under a group health plan maintained by the same plan sponsor. Third, benefits must be paid without regard to whether benefits are provided with respect to the same event under a group health plan maintained by the same plan sponsor. For more information on these noncoordinated excepted benefits, see the Department of Labor's regulations at 29 CFR 2590.732(b)(4).

Finally, supplemental benefits may be excepted if certain conditions are met. Specifically, the benefits are excepted only if they are provided under a separate policy, certificate or contract of insurance, and the benefits are medicare supplemental (commonly known as "Medigap" or "MedSupp") policies, TRICARE supplements, or supplements to certain employer group health plans. Such supplemental coverage cannot duplicate primary coverage and must be specifically designed to fill gaps in primary

coverage, coinsurance, or deductibles. Note that retiree coverage under a group health plan that coordinates with Medicare may serve a supplemental function similar to that of a Medigap policy. However, such employer-provided retiree "wrap around" benefits are not excepted benefits (because they are expressly excluded from the definition of a Medicare supplemental policy in section 1882(g)(1) of the Social Security Act). For more information on supplemental excepted benefits, see the Department of Labor's regulations at 29 CFR 2590.732(b)(5).

"Group Health Plan"
In general, a group health plan means an employee welfare benefit plan to the extent that the plan provides benefits for medical care to employees or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise. See ERISA section 733(a).

"Health Insurance Issuer" or "Issuer"
The term "health insurance issuer" or "issuer" is defined, in pertinent part, in 2590.701-2 of the Department's regulations as "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."

"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). (Note: Many States regulate entities as MEWAs using their own, State definition of the term. Whether or not an entity meets a State's definition of a MEWA for purposes of regulation under State law is a matter of State law.)

For more information on MEWAs, visit PWBA's Web site at **www.dol.gov/pwba** or call the **PWBA's toll-free hotline** at **1-866-275-7922** and ask for the booklet entitled, "MEWAs: Multiple Employer Welfare Arrangements Under the Employee Retirement Income Security Act: A Guide to Federal and State Regulation."

For information on State MEWA regulation, contact your State Insurance Department.

"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 merger were last originated at least 3 years prior to the merger); 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 3 years prior to the merger).

Therefore, a MEWA or ECE may be originated more than once.

"Plan Number" or "PN"
A PN is a three-digit number assigned to a plan or other entity by an employer or plan administrator. For plans or other entities providing welfare benefits, the first plan number should be number 501 and additional plans should be numbered consecutively.

"Sponsor"
For purposes of this report, the "sponsor" means:

(1) 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; or

(2) If the MEWA or ECE is not a group health plan, the sponsor is the entity that establishes or maintains the MEWA or ECE.

1.2 Who Must File

General Rules
The administrator of a multiple employer welfare arrangement (MEWA) 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) must file the report if the ECE was last originated at any time within 3 years before the annual filing due date. (See the definition of "originated" in Section 1.1 and the discussion of when to file in Section 1.3.) (**Caution:** An ECE may be "originated" more than once. Each time an ECE is "originated," more filings are triggered.)

Exception
Irrespective of the general rules (described above), 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 (or to their beneficiaries).

Additional Guidance
(1) In response to comments, and consistent with the question-and-answer guidance published in April and June of 2000, no penalties will be assessed against the administrator of a MEWA or ECE if the MEWA or ECE meets any of the following conditions:

(i) It provides coverage that consists solely of excepted benefits (defined above), which are not subject to Part 7 of ERISA. (However, if the MEWA or ECE provides coverage that consists both of excepted benefits and other benefits for medical care that are not excepted benefits, the administrator of the MEWA or ECE is required to file the Form M-1.)

(ii) It is an employee welfare benefit plan that is not subject to ERISA, including a governmental plan, church plan, or plan maintained only for the purpose of complying with workers' compensation laws, within the meaning of sections 4(b)(1), 4(b)(2), or 4(b)(3) of ERISA, respectively.

(iii) It provides coverage only through employee welfare benefit plans that are not covered by ERISA, including governmental plans, church plans, and plans maintained only for the purpose of complying with workers' compensation laws, within the meaning of sections 4(b)(1), 4(b)(2), and 4(b)(3) of ERISA, respectively.

(2) In addition, in response to comments, and consistent with the question-and-answer guidance published in April and June of 2000, no penalties will be assessed against the administrator of an entity that would not constitute a MEWA or ECE but for the following circumstances:

(i) It provides coverage to the employees of two or more trades or businesses that share a common control interest of at least 25 percent at any time during the plan year, applying principles similar to the principles applied under section 414 of the Internal Revenue Code.

(ii) It is created by a change in control of businesses (such as a merger or acquisition) that is for a bona fide business purpose (that is, for a purpose other than avoiding Form M-1 filing) and is temporary in nature (that is, it does not extend beyond the end of the plan year following the year in which the change in control occurs).

(iii) It is a group health plan that covers a very small number of participants who are not employees (or former employees) of the plan sponsor, such as non-employee members of the board of directors or independent contractors. The number of non-employee participants covered by the plan is very small if it does not exceed one percent of the total number of participants, determined as of the last day of the year to be reported (or, in the case of a 90-day origination report, determined as of the 60th day following the origination date).

Good Faith Determinations Regarding Whether an Entity is an ECE
Accordingly, subject to the exceptions described above, the administrator of a MEWA is required to file annually. By contrast, the administrator of an ECE is required to file for 3 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, then the entity is an ECE. Moreover, if the administrator makes a further good faith determination at the time of the filing that the ECE is not required to file because its most recent origination was more than 3 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 the 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 3 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.

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 (unless March 1 is a Saturday, Sunday, or Federal holiday, in which case the form must be filed no later than the following business day).

90-Day Origination Report
In general, an expedited filing is also 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).

Exception to the 90-Day Origination Report Requirement
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: (1) complete Parts I and II of the Form M-1 (and check Box B(3) in Part I); (2) sign, date, and type the administrator's name at the end of the form; and (3) file this request for extension 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 this 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, PWBA
Room N-1513, U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, DC 20210

1.5 Penalties

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 (or a higher amount if adjusted pursuant to the Federal Civil Penalties Inflation Adjustment Act of 1990, as amended by the Debt Collection Improvement Act of 1996). 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. (For example, for a filing due by March 1, 2003, calendar year 2002 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 6 continuous months of fiscal year information to report. (Thus, for example, for a filing that is due by March 1, 2003, fiscal year 2002 information may be used if the administrator has at least 6 continuous months of fiscal year 2002 information to report.) In this case, the administrator should check Box A(2) in Part I 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 is an exception to the 90-Day Origination Report requirement. 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 Attaching Additional Pages

If more space is needed to complete any item on the Form M-1, additional pages may be attached. Additional pages must be the same size as this form ($8^1/_2$" x 11") and should include the name of the MEWA or ECE, the Item number, and the word "Attachment" in the upper right corner. In addition, the attachment for any item should be in a format similar to that item on the form.

2.5 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 - Report Identification Information
Complete either Item A or Item B, as applicable.

Annual Reports: If this is an annual report, check either box A(1) or box A(2).

Box A(1): Check this box if calendar year information is being used to complete this report. (See Section 2.1 on Year to be Reported.)

Box A(2): Check this box if fiscal year information is being used to complete this report. Also specify the fiscal year. (For example, if fiscal year 2002 information is being used instead of calendar year 2002 information, specify the dates the fiscal year begins and ends.) (See Section 2.1 on Year to be Reported.)

Special Filings: If this is a special filing, check either box B(1), box B(2), or box B(3).

Box B(1): Check this box if the filing 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.)

Box B(2): Check this box if the filing is an Amended Report. (See Section 2.5 on Amended Reports.)

Box B(3): Check this box if the administrator of the MEWA or ECE is requesting an extension. (See Section 1.3 on When to File.)

Final Reports: Check the box in Item C if the administrator does not intend to file a Form M-1 next year. For example, if this is the third filing following an origination for an ECE, or if a MEWA has ceased operations, the administrator should check this box.

Part II – MEWA or ECE Identification Information

Items 1a through 1d: Enter the name, address, and 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 those used by group health plans or employers that purchase coverage through the MEWA or ECE. For more information on EINs or PNs, see Section 1.1 on Definitions.

Items 2a through 2c: Enter the name, address, and telephone number of the administrator of the MEWA or ECE, and the 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. For more information on the definition of "administrator," and on EINs or PNs, see Section 1.1 on Definitions.

Items 3a through 3c: Enter the name, address, and telephone number of the entity sponsoring the MEWA or ECE, and any 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. For more information on the definition of "sponsor," and on EINs or PNs, see Section 1.1 on Definitions. 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, see the definition of "originated" in Section 1.1.

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.) When completing the chart, complete Item 5a first. Then for each row, complete Item 5b through Item 5g as it applies to the State listed in Item 5a.

Item 5a. Enter all States in which the MEWA or ECE provides benefits for medical coverage. For this purpose, list the State(s) where the employers (of the employees receiving coverage) are domiciled. 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, and the Northern Mariana Islands. Enter one State per row.

Item 5b. For each State listed in Item 5a, specify whether the MEWA or ECE is licensed or otherwise authorized to operate as a health insurance issuer in the State listed in that row. (For a definition of the term "health insurance issuer," see Section 1.1.) For more information on whether an entity that is a licensed or registered MEWA in a State meets the definition of a health insurance issuer in that State, contact the State Insurance Department.

Item 5c. For each "yes" answer in Item 5b, enter the National Association of Insurance Commissioners (NAIC) number.

Item 5d. For each "no" answer in Item 5b, specify whether the MEWA or ECE is fully insured through one or more health insurance issuers in each State.

Item 5e. For each "yes" answer in Item 5d, enter the name of the insurer and its NAIC number (if available). If there is more than one insurer, enter all insurers and their NAIC numbers (if applicable).

Item 5f. In each State listed in Item 5a, 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 and excess loss insurance.

Item 5g. For each "yes" answer in Item 5f, enter the name of the stop-loss insurer and its NAIC number (if available). If there is more than one stop-loss insurer, enter all stop-loss insurers and their NAIC numbers (if applicable).

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 participants in the MEWA receive coverage through these two employers. Three employers are located in State Y and 30 participants in the MEWA receive coverage through these three employers. Finally, one employer is located in State Z and

200 participants in the MEWA receive coverage through this employer. In this example, the administrator of the MEWA should specify State X and State Z under Item 6 because the MEWA conducts $23^1/_3$ percent of its business in State X (70/300 = $23^1/_3$ percent) and $66^2/_3$ percent of its business in State Z (200/300 = $66^2/_3$ percent). However, the administrator should not specify State Y because the MEWA conducts only 10 percent of its business in State Y (30/300 = 10 percent).

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 covered under the MEWA or ECE. For more information on determining the number of participants, see the Department of Labor's regulations at 29 CFR 2510.3-3(d).

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 Subtitle B of Title I (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 the Newborns' Act were published in the Federal Register 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 of Labor's summary plan description content regulations at 2520.102-3(u). Finally, the Department of Labor has published two sets of informal, question-and-answer guidance on WHCRA. These sets of question-and-answer guidance are available on the Department's website at **www.dol.gov/pwba** and from **PWBA's toll-free hotline** at **1-866-275-7922**.

General Information Regarding the Applicability of Part 7: In general, the foregoing provisions apply to group health plans and health insurance issuers in connection with a group health plan.

Many MEWAs and ECEs are group health plans or health insurance issuers. However, even if a MEWA or ECE is neither a group health plan nor a health insurance issuer, if the MEWA or ECE offers or provides benefits for medical care through one or more group health plans, the coverage is required to comply with Part 7 of ERISA and the MEWA or ECE is required to complete Items 8a through 9d.

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 that State's Insurance Department.

For More Information: PWBA has published two compliance assistance publications on these recent health care laws. The first, "Compliance Assistance Guide: Recent Changes in Health Care Law," includes comprehensive information on HIPAA, MHPA, the Newborns' Act, and WHCRA. The second, "Compliance Assistance for Group Health Plans: HIPAA and Other Recent Health Care Laws" provides key compliance considerations for group health plans. You may obtain these publications, or speak to a benefits advisor about these laws, by calling the **PWBA toll-free hotline** at **1-866-275-7922**. These booklets are also available on the Internet at: **www.dol.gov/pwba**.

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.

Item 9a: The HIPAA portability requirements added sections 701, 702, and 703 of ERISA.

General Applicability. 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 benefits for medical care to employees through one or more group health plans.

Exceptions. You may answer "N/A" if either of the following paragraphs apply:

(1) The MEWA or ECE is a small health plan (as described in section 732(a) of ERISA and 2590.732(a) of the Department's regulations).

(2) The MEWA or ECE offers coverage only to small group health plans (as described in section 732(a) of ERISA and 2590.732(a) of the Department's regulations).

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

Item 9b: MHPA added section 712 of ERISA.

General Applicability. 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 benefits for medical care to employees through one or more group health plans.

Exceptions. You may answer "N/A" if any of the following paragraphs apply:

(1) The MEWA or ECE is a small group health plan (as described in section 732(a) of ERISA and 2590.732(a) of the Department's regulations).

(2) The MEWA or ECE offers coverage only to small group health plans (as described in section 732(a) of ERISA and 2590.732(a) of the Department's regulations).

(3) The MEWA or ECE does not provide both medical/surgical benefits and mental health benefits.

(4) The MEWA or ECE offers or provides coverage only to small employers (as described in the small employer exemption contained in section 712(c)(1) of ERISA and 2590.712(e) of the Department's regulations).

(5) The coverage has 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).

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

Item 9c: The Newborns' Act added section 711 of ERISA.

General Applicability. 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 benefits for medical care to employees through one or more group health plans.

Exceptions. You may answer "N/A" if either of the following paragraphs apply:

(1) The MEWA or ECE does not provide benefits for hospital lengths of stay in connection with childbirth.

(2) The MEWA or ECE 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.

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

Item 9d: WHCRA added section 713 of ERISA.

General Applicability. 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 benefits for medical care to employees through one or more group health plans.

Exceptions. You may answer "N/A" if any of the following paragraphs apply:

(1) The MEWA or ECE is a small health plan (as described in section 732(a) of ERISA and 2590.732(a) of the Department's regulations).

(2) The MEWA or ECE offers coverage only to small group health plans (as described in section 732(a) of ERISA and 2590.732(a) of the Department's regulations).

(3) The MEWA or ECE does not provide medical/surgical benefits with respect to a mastectomy.

Worksheet. 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.

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: 2 hrs.

Preparing the form: 50 min. - 1 hr. and 35 min.

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 (Part 7) 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's Pension and Welfare Benefits Administration (PWBA) office in your region or consult with legal counsel or a professional employee benefits advisor.

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

- Section 701(e) of ERISA and § 2590.701-5 of the Department's regulations 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.
- To be complete, the certificate must include: the date, the name of the plan, the participant and/or beneficiary's name and identification information, the plan administrator's contact information (name, address, and telephone number, a telephone number to call for further information (if different than the plan administrator's number)), and the individual's creditable coverage information, as described below. (****TIP:** Don't forget dependent information.)
- With respect to an individual's creditable coverage information, the certificate must reflect either: (1) that an individual has at least 18 months of creditable coverage; or (2) the date any waiting period (or affiliation period) began and the date creditable coverage began. In addition, the certificate must reflect either: (1) the date creditable coverage ended; or (2) that coverage is continuing. (****TIP:** Don't forget waiting period information.)
- For a certificate issued automatically upon loss of coverage, the certificate should reflect the last continuous period of coverage. For a certificate issued upon request, the certificate should reflect each period of continuous coverage that the individual had in the 24 months prior to the date of request (up to 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 about whether health coverage offered by a MEWA or ECE is creditable coverage or is coverage consisting solely of excepted benefits, contact **PWBA toll-free** at **1-866-275-7922.**

(2) Does the coverage provided by the MEWA or ECE make available a procedure for individuals to request and receive certificates? . . . . . ❑ Yes ❑ No

- Section 2590.701-5(a)(4)(ii) of the Department's regulations requires group health plans and group health insurance issuers to establish a procedure for individuals to request and receive certificates.

(3) If the coverage provided by the MEWA or ECE imposes a preexisting condition exclusion period, are notices provided 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? . . . . . ❑ Yes ❑ No ❑ N/A

- Section 2590.701-3(c) of the Department's regulations prohibits a group health plan, and a group health insurance issuer, from imposing 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.

Question # 3 is continued on the next page.

- **<u>**TIP**</u>: Check for "hidden" preexisting condition exclusion periods. Coverage or exclusion provisions that limit benefits based on the fact that a condition was present before an individual's effective date of coverage are preexisting condition exclusions and must either be eliminated, or must comply with HIPAA's limitations on preexisting condition exclusion periods, including this general notice provision, the individual notice provision described in Question #4, and HIPAA's other limits on preexisting condition exclusion periods, described in Question #5.

- 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.

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

- Section 2590.701-5(d) of the Department's regulations 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 coverage provided by the MEWA or ECE imposes a preexisting condition exclusion, does it comport with HIPAA's other limitations on preexisting condition exclusions? . . . . . ❑ Yes ❑ No ❑ N/A

- **<u>**TIP**</u>: Again, check for "hidden" preexisting condition exclusion periods. Coverage or exclusion provisions that limit benefits based on the fact that a condition was present before an individual's effective date of coverage are preexisting condition exclusions and must either be eliminated or must comply with HIPAA's limitations on preexisting condition exclusion periods.

- Section 701(a)(1) of ERISA and § 2590.701-3(a)(1)(i) of the Department's regulations 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.) (In addition, for health insurance issuers, State law may prescribe a shorter period than the 6-month period that generally applies.)

- 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. (**<u>**TIP**</u>: If the MEWA or ECE imposes a waiting period, ensure that the 6-month look-back period ends on the first day of the waiting period, not the first day of coverage.)

- Section 701(a)(2) of ERISA and § 2590.701-3(a)(1)(ii) of the Department's regulations 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.) (**<u>**TIP**</u>: If the MEWA or ECE imposes a waiting period, ensure that the 12-month (or 18-month for late enrollees) maximum preexisting condition exclusion period begins on the first day of the waiting period, not the first day of coverage.)

- Section 701(a)(3) of ERISA and § 2590.701-3(a)(1)(iii) of the Department's regulations 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) of the Department's regulations 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.)

(6) Does the coverage provided by the MEWA or ECE provide notices of special enrollment rights to employees who are eligible to enroll in the plan or coverage? . . . . . ❑ Yes ❑ No

- Section 2590.701-6(c) of the Department's regulations 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.

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(7) Does the coverage provided by 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? ❑ Yes ❑ No

- Section 701(f) of ERISA and § 2590.701-6 of the Department's regulations 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 either: (1) has a new dependent through marriage, birth, adoption, or placement for adoption; or (2) loses eligibility for other group health plan or health insurance coverage or employer contributions towards the other coverage terminate.

- **__**TIP**__**: Ensure that the MEWA or ECE provides special enrollment to all individuals who qualify. Among others, this includes individuals who lose eligibility for individual market coverage, individuals who voluntarily terminate employment and lose group health plan coverage (even if they are eligible for COBRA continuation coverage), individuals who exhaust COBRA, children who "age out" of eligibility under another parent's group health plan, individuals who move out of a group health plan's HMO service area, and individuals whose employers cease contributing towards their group health plan coverage (even if coverage does not cease).

- For individuals who special enroll after marriage or loss of other coverage, coverage must be made effective no later than on the first day of the first calendar month following the date the completed request for enrollment is received. For individuals who special enroll after birth, adoption, or placement for adoption, coverage must be made effective no later than the date of such birth, adoption, or placement for adoption. (**__**TIP**__**: Ensure that effective dates of coverage for special enrollees are correct.)

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

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(8) Does the coverage provided by the MEWA or ECE have rules for eligibility (including continued eligibility) that comply with the nondiscrimination requirements that prohibit discrimination against any individual or a dependent based on any health factor? . . . . . ❑ Yes ❑ No

- Section 702(a) of ERISA and § 2590.702(a) of the Department's regulations 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 participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities), and disability.

Question #8 is continued on the next page.

- These rules prohibit discrimination within a group of similarly situated individuals. Under §2590.702(d) of the Department's regulations, plans may treat distinct groups of similarly situated individuals differently, if the distinctions between or among the group are not based on a health factor. If distinguishing among groups of participants, plans and issuers must base distinctions on bona fide employment-based classifications consistent with the employer's usual business practice. Whether an employment-based classification is bona fide is based on relevant facts and circumstances, such as whether the employer uses the classification for purposes independent of qualification for health coverage. Bona fide employment-based classifications might include: full-time versus part-time employee status; different geographic location; membership in a collective bargaining unit; date of hire or length of service; or differing occupations. In addition, plans may treat participants and beneficiaries as two separate groups of similarly situated individuals. Plans may also distinguish among beneficiaries. Distinctions among groups of beneficiaries may be based on bona fide employment-based classifications of the participant through whom the beneficiary is receiving coverage, relationship to the participant (such as spouse or dependent), marital status, age or student status of dependent children, or any other factor that is not a health factor.

- Also, nothing prohibits a plan from establishing more favorable rules for eligibility for individuals with an adverse health factor, such as disability.

- ****TIP**: Ensure that the plan does not require individuals to present evidence of insurability, such as passing a physical exam, providing a certificate of good health, or demonstrating good health through answers to a health care questionnaire, in order to enroll in the plan. (This is a violation, even if the plan provision is imposed only at late enrollment.)

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(9) Does the coverage provided by the MEWA or ECE comply with the nondiscrimination rules by providing benefits uniformly to participants and beneficiaries? . . . . . ❑ Yes ❑ No

- Under § 2590.702(b)(2) of the Department's regulations, a plan is not required to provide any benefits, but benefits provided must be uniformly available and any benefit restrictions must be applied uniformly to all similarly situated individuals and cannot be directed at any individual participants or beneficiaries based on a health factor. (A plan amendment applicable to all similarly situated individuals and made effective no earlier than the first day of the next plan year is not considered directed at individual participants and beneficiaries.)

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(10) If the coverage provided by the MEWA or ECE imposes a source-of-injury restriction, does it comply with the nondiscrimination provisions? . . . . . ❑ Yes ❑ No ❑ N/A

- Under § 2590.702(b)(2)(iii) of the Department's regulations, plans may exclude benefits for treatment of certain injuries based on the source of that injury, except that plans may not exclude benefits otherwise provided for treatment of an injury if that injury results from an act of domestic violence or a medical condition.

- ****TIP**: An example of a permissible source-of-injury exclusion would include a plan provision that provides benefits for head injuries generally, but excludes benefits for head injuries sustained while participating in bungee jumping, as long as the injuries do not result from a medical condition or domestic violence. However, an example of an impermissible source-of-injury exclusion would include a plan provision that excludes coverage for self-inflicted injuries (or injuries resulting from attempted suicide) if the injuries are otherwise covered by the plan and if the injuries are the result of a medical condition, such as depression.

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(11) Does the coverage provided by 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? ❑ Yes ❑ No

- Section 702(b) of ERISA and § 2590.702(b) of the Department's regulations 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.

- 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. On January 8, 2001, the Department published proposed rules describing bona fide wellness programs under § 2590.702(f). Essentially, these proposed rules permit rewards that are not contingent on an individual meeting a standard related to a health factor. In addition, these proposed rules permit rewards that are contingent on an individual meeting a standard related to a health factor if:

Question #11 is continued on the next page.

- The reward does not exceed a specified percentage of the total employee-only premium. (Comments were invited as to whether a 10 percent, 15 percent, or 20 percent limitation might be appropriate.)
- The program is reasonably designed to promote good health or prevent disease. (For this purpose, a program must allow individuals an opportunity to qualify for the reward at least once each year.)
- The reward is available to all similarly situated individuals. In particular, the program must allow a reasonable alternative standard for individuals for whom it is unreasonably difficult due to a medical condition to satisfy the original program standard or for whom it is medically inadvisable to attempt to satisfy the original program standard during that time period. (The plan must also disclose the availability of a reasonable alternative standard in all plan materials describing the terms of the program.)

• (Note: Nothing prohibits a plan from establishing more favorable premium rates for indivduals with an adverse health factor, such as disability.)

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(12) Does the coverage provided by the MEWA or ECE comply with the rules prohibiting list billing? . . . . ❑ Yes ❑ No

• Section 2590.702(c)(2)(ii) of the Department's regulations prohibits charging or quoting group health plans separate rates that vary for individuals based on health factors. This practice is commonly referred to as list billing. This does not prevent MEWAs or ECEs from taking the health factors of each individual into account in establishing a blended/aggregate rate for providing coverage to the plan.

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(13) Does the coverage provided by the MEWA or ECE comply with the nondiscrimination regulations by providing coverage without any nonconfinement clauses? . . . . . ❑ Yes ❑ No

• Typically, a nonconfinement clause will deny or delay eligibility for some or all benefits if an individual is confined to a hospital or other health care institution. Sometimes nonconfinement clauses also deny or delay eligibility if an individual cannot perform ordinary life activities. Section 2590.702(e)(1) of the Department's regulations explains that these clauses violate ERISA sections 702(a) (if the clause delays or denies eligibility) and 702(b) (if the clause raises individual premiums).

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(14) Does the coverage provided by the MEWA or ECE comply with the nondiscrimination regulations by providing coverage without any impermissible actively-at-work clauses? . . . . . ❑ Yes ❑ No

• Typically, actively-at-work provisions delay eligibility for benefits based on an individual being absent from work. Section 2590.702(e)(2) of the Department's regulations explains that actively-at-work provisions generally violate ERISA sections 702(a) (if the clause delays or denies eligibility) and 702(b) (if the clause raises individual premiums or contributions), unless absence from work due to a health factor is treated, for purposes of the plan, as if the individual is at work. Nonetheless, an exception provides that a plan may establish a rule for eligibility that requires an individual to begin work for the employer sponsoring the plan before eligibility commences. Further, plans may establish rules for eligibility or set an individual's premium or contribution rate in accordance with the rules relating to similarly situated individuals in § 2590.702(d) of the Department's regulations. For example, a plan that treats full-time and part-time employees differently for other employment-based purposes, such as eligibility for other employee benefits, may distinguish, in rules for eligibility under the plan, between full-time and part-time employees.

• **TIP: An impermissible actively-at-work provision would include a plan provision under which employees generally become eligible to enroll 30 days after the first day of employment. However, if an employee is not actively at work on the first day after the end of the 30-day period, then eligibility is delayed until the first day the employee is actively at work. Note: If the plan treated any employee absent from work due to a health factor as being actively at work, then the provision would not violate § 2590.702(e)(2) and section 702(a) of ERISA.

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(15) If the entity is a group health plan which 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? . . ❑ Yes ❑ No ❑ N/A

• Section 703 of ERISA provides that a group health plan that is a multiemployer 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 Department in your State.

Worksheet B

(Form M-1)

Determining Compliance with the 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 (Part 7) 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's Pension and Welfare Benefits Administration (PWBA) office in your region or consult with legal counsel or a professional employee benefits advisor.

Q. If the MEWA or ECE offers or provides coverage for both mental health benefits and medical/surgical benefits, does the coverage comply with the requirements of the MHPA provisions, which are contained in section 712 of ERISA? . . . . . ❑ Yes ❑ No ❑ N/A

- Section 712 of ERISA and § 2590.712 of the Department's regulations 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.
- These provisions do not require a group health plan or group health insurance coverage to provide any mental health coverage. Further, MHPA does not apply to benefits for treatment of substance abuse or chemical dependency.
- There are also exemptions for small employers and certain plans or coverage with increased costs. For more information on these exemptions, contact **PWBA toll free** at **1-866-275-7922**.

Worksheet C

(Form M-1)

Determining Compliance with the 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 (Part 7) 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 either of 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's Pension and Welfare Benefits Administration (PWBA) office in your region or consult with legal counsel or a professional employee benefits advisor.

(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 coverage comply with the Newborns' Act's substantive requirements, which are contained in section 711 of ERISA? . . . . . ❑ Yes ❑ No ❑ N/A

- Section 711 of ERISA and § 2590.711 of the Department's regulations 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 providing care in a manner consistent 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.

- **__**TIP**__**: Check whether the Federal Newborns' Act's requirements in section 711 of ERISA apply, or whether the coverage is instead subject to State law regulating such coverage. For this purpose, the following information is helpful:

  (A) __Self-insured coverage__: The Federal Newborns' Act's requirements in section 711 of ERISA apply to self-insured benefits offered in connection with childbirth.

  (B) __Insured coverage__: On the other hand, State law (rather than Federal law) applies to health insurance coverage offered in connection with childbirth if the State law meets certain criteria specified in ERISA section 711(f). Based on a preliminary review of State laws as of July 1, 2002, State law rather than Federal law applies to health insurance coverage offered in connection with childbirth in all States and other U.S. jurisdictions __except__:

  Wisconsin, Puerto Rico, the Virgin Islands, American Samoa, Wake Island, and the Northern Mariana Islands.

  Therefore, the Federal Newborns' Act provisions appear to apply to health insurance coverage in these States and jurisdictions.

(2) If the MEWA or ECE offers or provides benefits in connection with childbirth, are the disclosure requirements under the Newborns' Act satisfied? . . . . . ❑ Yes ❑ No ❑ N/A

- Section 2520.102-3(u) of the Department's regulations requires all group health plans providing maternity benefits to include a statement in their summary plan descriptions (SPDs) advising of the requirements under Federal or State law applicable to the coverage relating to hospital lengths of stay in connection with childbirth for a mother or newborn child. If the Federal law applies in some areas and State law applies in other areas, the SPD should describe the different areas and the Federal or State requirements applicable in each. (Note: Parallel disclosure requirements are contained in section 711(d) of ERISA, if applicable (see discussion of federal Newborns' Act applicability above under Question 1).)

- For this purpose, a MEWA or ECE that is subject to the Newborns' Act's 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).

- A similar disclosure requirement applies to nonfederal governmental plans. For mandated language required to be used with respect to such plans, see 45 CFR 146.130(d)(2) (published in the Federal Register at 63 FR 57561 on October 27, 1998).

Worksheet D

(Form M-1)

Determining Compliance with the 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 (Part 7) 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 either of 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's Pension and Welfare Benefits Administration (PWBA) office in your region or consult with legal counsel or a professional employee benefits advisor.

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

- Section 713 of ERISA 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 all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications 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, prostheses, and treatment of physical complications 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, are the disclosure requirements under WHCRA satisfied? . . . . . ❑ Yes ❑ No ❑ N/A

- Section 713(a) of ERISA establishes a disclosure requirement under which group health plans, and their health insurance issuers, must describe the benefits required under WHCRA. The notice is to be provided to participants upon enrollment in the plan and annually thereafter.

- The enrollment notice must describe the benefits that WHCRA requires group health plans and issuers to cover. If the following information is provided, then the group health plan is in compliance with this requirement:

  If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Heallth and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

  ◦ All stages of reconstruction of the breast on which the mastectomy was performed;

Question #2 is continued on the next page.

- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan. Therefore, the following deductibles and coinsurance apply: [insert deductibles and coinsurance applicable to these benefits].

If you would like more information on WHCRA benefits, call your Plan Administrator [insert phone number].

- WHCRA's annual notice must be provided once each year. The following language may be used to satisfy the annual notice requirement:

  Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas? Call your Plan Administrator [insert phone number] for more information.
