Form 5500

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6057(b) and 6058(a) of the Internal Revenue Code (the Code).

▶ **Complete all entries in accordance with the instructions to the Form 5500.**

OMB Nos. 1210-0110
1210-0089

2022

This Form is Open to Public Inspection

Part I Annual Report Identification Information

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022

A This return/report is for:
- [ ] a multiemployer plan
- [X] a multiple-employer plan (Filers checking this box must attach a list of participating employer information in accordance with the form instructions.)
- [ ] a single-employer plan
- [ ] a DFE (specify) ____

B This return/report is:
- [X] the first return/report
- [ ] the final return/report
- [X] an amended return/report
- [ ] a short plan year return/report (less than 12 months)

C If the plan is a collectively-bargained plan, check here. . . . . ▶ [ ]

D Check box if filing under:
- [X] Form 5558
- [ ] automatic extension
- [ ] the DFVC program
- [ ] special extension (enter description)

E If this is a retroactively adopted plan permitted by SECURE Act section 201, check here. . . . . ▶ [ ]

Part II Basic Plan Information—enter all requested information

1a Name of plan
INTEGRATIVE EMERGENCY SERVICES HEALTH PLAN

1b Three-digit plan number (PN) ▶ 504

1c Effective date of plan 01/01/2016

2a Plan sponsor's name (employer, if for a single-employer plan)
Mailing address (include room, apt., suite no. and street, or P.O. Box)
City or town, state or province, country, and ZIP or foreign postal code (if foreign, see instructions)
INTEGRATIVE EMERGENCY SERVICES

4835 LBJ FREEWAY SUITE 900
DALLAS, TX 75244

2b Employer Identification Number (EIN) 61-1778177

2c Plan Sponsor's telephone number 469-420-5512

2d Business code (see instructions) 622000

Caution: A penalty for the late or incomplete filing of this return/report will be assessed unless reasonable cause is established.

Under penalties of perjury and other penalties set forth in the instructions, I declare that I have examined this return/report, including accompanying schedules, statements and attachments, as well as the electronic version of this return/report, and to the best of my knowledge and belief, it is true, correct, and complete.

SIGN HERE	Filed with authorized/valid electronic signature.	10/13/2023	INTEGRATIVE EMERGENCY SERVICES
	Signature of plan administrator	Date	Enter name of individual signing as plan administrator
SIGN HERE			
	Signature of employer/plan sponsor	Date	Enter name of individual signing as employer or plan sponsor
SIGN HERE			
	Signature of DFE	Date	Enter name of individual signing as DFE

3a	Plan administrator's name and address [X] Same as Plan Sponsor	**3b**	Administrator's EIN
		3c	Administrator's telephone number
4	If the name and/or EIN of the plan sponsor or the plan name has changed since the last return/report filed for this plan, enter the plan sponsor's name, EIN, the plan name and the plan number from the last return/report:	**4b**	EIN
a	Sponsor's name	**4d**	PN
c	Plan Name		
5	Total number of participants at the beginning of the plan year	**5**	1057
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines **6a(1), 6a(2), 6b, 6c,** and **6d**).		
a(1)	Total number of active participants at the beginning of the plan year	**6a(1)**	1057
a(2)	Total number of active participants at the end of the plan year	**6a(2)**	539
b	Retired or separated participants receiving benefits	**6b**	0
c	Other retired or separated participants entitled to future benefits	**6c**	0
d	Subtotal. Add lines **6a(2)**, **6b**, and **6c**	**6d**	539
e	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits.	**6e**	
f	Total. Add lines **6d** and **6e**.	**6f**	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	**6g**	
h	Number of participants who terminated employment during the plan year with accrued benefits that were less than 100% vested	**6h**	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	**7**	

8a If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Codes in the instructions:

b If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Codes in the instructions:

4A 4D

9a Plan funding arrangement (check all that apply)		**9b** Plan benefit arrangement (check all that apply)	
(1)	[ ] Insurance	**(1)**	[X] Insurance
(2)	[ ] Code section 412(e)(3) insurance contracts	**(2)**	[ ] Code section 412(e)(3) insurance contracts
(3)	[ ] Trust	**(3)**	[ ] Trust
(4)	[X] General assets of the sponsor	**(4)**	[X] General assets of the sponsor

10 Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number attached. (See instructions)

a Pension Schedules

- **(1)** [ ] **R** (Retirement Plan Information)
- **(2)** [ ] **MB** (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary
- **(3)** [ ] **SB** (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary

b General Schedules

- **(1)** [ ] **H** (Financial Information)
- **(2)** [ ] **I** (Financial Information – Small Plan)
- **(3)** [X] **A** (Insurance Information) 1
- **(4)** [ ] **C** (Service Provider Information)
- **(5)** [ ] **D** (DFE/Participating Plan Information)
- **(6)** [ ] **G** (Financial Transaction Schedules)

Part III Form M-1 Compliance Information (to be completed by welfare benefit plans)

11a If the plan provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2520.101-2.) ..... [X] Yes [ ] No

If "Yes" is checked, complete lines 11b and 11c.

11b Is the plan currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.) ..... [X] Yes [ ] No

11c Enter the Receipt Confirmation Code for the 2022 Form M-1 annual report. If the plan was not required to file the 2022 Form M-1 annual report, enter the Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure to enter a valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)

Receipt Confirmation Code 132962478

SCHEDULE A (Form 5500)

Department of the Treasury
Internal Revenue Service

Department of Labor
Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

▶ **File as an attachment to Form 5500.**

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2022

This Form is Open to Public Inspection

For calendar plan year 2022 or fiscal plan year beginning 01/01/2022 and ending 12/31/2022

A Name of plan
INTEGRATIVE EMERGENCY SERVICES HEALTH PLAN

B Three-digit plan number (PN) ▶ 504

C Plan sponsor's name as shown on line 2a of Form 5500
INTEGRATIVE EMERGENCY SERVICES

D Employer Identification Number (EIN)
61-1778177

Part I Information Concerning Insurance Contract Coverage, Fees, and Commissions

Provide information for each contract on a separate Schedule A. Individual contracts grouped as a unit in Parts II and III can be reported on a single Schedule A.

1 Coverage Information:

(a) Name of insurance carrier
BLUECROSS BLUESHIELD OF TEXAS

(b) EIN	(c) NAIC code	(d) Contract or identification number	(e) Approximate number of persons covered at end of policy or contract year	Policy or contract year	
				(f) From	(g) To
36-1236610	70670	249034	1279	01/01/2022	12/31/2022

2 Insurance fee and commission information. Enter the total fees and total commissions paid. List in line 3 the agents, brokers, and other persons in descending order of the amount paid.

(a) Total amount of commissions paid	(b) Total amount of fees paid
176718	15072

3 Persons receiving commissions and fees. (Complete as many entries as needed to report all persons).

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

LOCKTON COMPANIES LLC

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
176718	5784	SPECIAL PROGRAMS	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

LOCKTON COMPANIES LLC TEXAS

(b) Amount of sales and base commissions paid	Fees and other commissions paid		(e) Organization code
	(c) Amount	(d) Purpose	
0	9288	SPECIAL PROGRAMS	3

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid

(b) Amount of sales and base commissions paid	Fees and other commissions paid		**(e)** Organization code
	(c) Amount	**(d)** Purpose	

Part II Investment and Annuity Contract Information

Where individual contracts are provided, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

4	Current value of plan's interest under this contract in the general account at year end	**4**	
5	Current value of plan's interest under this contract in separate accounts at year end	**5**	

6 Contracts With Allocated Funds:

a State the basis of premium rates ▶

b	Premiums paid to carrier	**6b**	
c	Premiums due but unpaid at the end of the year	**6c**	
d	If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, enter amount. Specify nature of costs ▶	**6d**	

e Type of contract: (1) ☐ individual policies (2) ☐ group deferred annuity (3) ☐ other (specify) ▶

f If contract purchased, in whole or in part, to distribute benefits from a terminating plan, check here ▶ ☐

7 Contracts With Unallocated Funds (Do not include portions of these contracts maintained in separate accounts)

a Type of contract: (1) ☐ deposit administration (2) ☐ immediate participation guarantee (3) ☐ guaranteed investment (4) ☐ other ▶

b	Balance at the end of the previous year			**7b**	
c	Additions: (1) Contributions deposited during the year	**7c(1)**			
	(2) Dividends and credits	**7c(2)**			
	(3) Interest credited during the year	**7c(3)**			
	(4) Transferred from separate account	**7c(4)**			
	(5) Other (specify below) ▶	**7c(5)**			
	(6) Total additions			**7c(6)**	
d	Total of balance and additions (add lines **7b** and **7c(6)**)			**7d**	0
e	Deductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	**7e(1)**			
	(2) Administration charge made by carrier	**7e(2)**			
	(3) Transferred to separate account	**7e(3)**			
	(4) Other (specify below) ▶	**7e(4)**			
	(5) Total deductions			**7e(5)**	
f	Balance at the end of the current year (subtract line **7e(5)** from line **7d**)			**7f**	0

Part III Welfare Benefit Contract Information

If more than one contract covers the same group of employees of the same employer(s) or members of the same employee organizations(s), the information may be combined for reporting purposes if such contracts are experience-rated as a unit. Where contracts cover individual employees, the entire group of such individual contracts with each carrier may be treated as a unit for purposes of this report.

8 Benefit and contract type (check all applicable boxes)

- **a** [X] Health (other than dental or vision)
- **b** [X] Dental
- **c** [ ] Vision
- **d** [ ] Life insurance
- **e** [ ] Temporary disability (accident and sickness)
- **f** [ ] Long-term disability
- **g** [ ] Supplemental unemployment
- **h** [ ] Prescription drug
- **i** [ ] Stop loss (large deductible)
- **j** [ ] HMO contract
- **k** [ ] PPO contract
- **l** [ ] Indemnity contract
- **m** [ ] Other (specify) ▶

9 Experience-rated contracts:				
a Premiums: (1) Amount received	9a(1)			
(2) Increase (decrease) in amount due but unpaid	9a(2)			
(3) Increase (decrease) in unearned premium reserve	9a(3)			
(4) Earned ((1) + (2) - (3))			9a(4)	0
b Benefit charges (1) Claims paid	9b(1)			
(2) Increase (decrease) in claim reserves	9b(2)			
(3) Incurred claims (add **(1)** and **(2)**)			9b(3)	0
(4) Claims charged			9b(4)	
c Remainder of premium: (1) Retention charges (on an accrual basis) --				
(A) Commissions	9c(1)(A)			
(B) Administrative service or other fees	9c(1)(B)			
(C) Other specific acquisition costs	9c(1)(C)			
(D) Other expenses	9c(1)(D)			
(E) Taxes	9c(1)(E)			
(F) Charges for risks or other contingencies	9c(1)(F)			
(G) Other retention charges	9c(1)(G)			
(H) Total retention			9c(1)(H)	0
(2) Dividends or retroactive rate refunds. (These amounts were [ ] paid in cash, or [ ] credited.)			9c(2)	
d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement			9d(1)	
(2) Claim reserves			9d(2)	
(3) Other reserves			9d(3)	
e Dividends or retroactive rate refunds due. (Do not include amount entered in line **9c(2)**.)			9e	
10 Nonexperience-rated contracts:				
a Total premiums or subscription charges paid to carrier			10a	7516692
b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or retention of the contract or policy, other than reported in Part I, line 2 above, report amount.			10b	0

Specify nature of costs.

N/A

Part IV Provision of Information

11 Did the insurance company fail to provide any information necessary to complete Schedule A? [ ] Yes [X] No

12 If the answer to line 11 is "Yes," specify the information not provided. ▶

Receipt Confirmation Code: 00013296-2478

2022 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 filing is required to be filed under section 101(g) of the Employee Retirement Income Security Act of 1974, as amended by the Patient Protection and Affordable Care Act.

OMB No. 1210-0116

Department of Labor
Employee Benefits Security Administration

PART I PURPOSE OF FILING

Complete as applicable:

A
Identify the type of filing:
(1) ☑ Annual Report:
- ○ Calendar Year
- ◉ or the fiscal year beginning 01/01/2022 and ending 12/31/2022

(2) ☐ MEWA Registration
Date:
(3) ☐ ECE Origination
Date:
(4) ☐ ECE Special Filing
Date:

B Check if any of the following:
Check here if this is a final report ☐
Check here if this is an amended report ☐
Check here if this is a request for an extension ☐

C Identify the type of entity:
(1) ◉ A Plan MEWA
(2) ○ A Non-Plan MEWA
(3) ○ An Entity Claiming Exception (ECE)

D Enter the most recent date the MEWA or ECE filed the Form M-1:
☑ Check the box if this is the first filing or enter the date below:
02/23/2023

PART II CUSTODIAL & FINANCIAL INFORMATION

1a Name and address of the MEWA or ECE
Integrative Emergency Services Health Plan

Heritage Square One
4835 LBJ Freewar, Suite 900
Dallas, TX 75244

1b Telephone number of the MEWA or ECE (469) 420-5512

1c Employer Identification Number (EIN) 61-1778177

1d Plan Number (PN) 501

2a Name and address of the administrator of the MEWA or ECE
Integrative Emergency Services

Heritage Square One
4835 LBJ Freeway, Suite 900
Dallas, TX 75244

2b Telephone number of the administrator (469) 420-5512

2c EIN 61-1778177

2d E-mail address of the administrator
humanresources@ies.healthcare

3a Name and address of the entity or entities sponsoring the MEWA or ECE
Integrative Emergency Services

Heritage Square One
4835 LBJ Freeway, Suite 900
Dallas, TX 75244

3b Telephone number of the sponsor (469) 420-5545

3c EIN 61-1778177

4a Name and address of the agent for service of process or registered agent
Matt C. Innes
Integrative Emergency Services
Heritage Square One
4835 LBJ Freewar, Suite 900
Dallas, TX 75244

4b Telephone number of such person (469) 420-5545

4c E-mail address of such person
minnes@ies.healthcare

5a Name and address of each member of the Board, officer, trustee, or custodian of the MEWA or ECE

5b Telephone number of each such person

5c E-mail address of such person

6a Name and address of all promoters and/or agents responsible for marketing the MEWA or ECE

6b Telephone number of each promoter or agent

6c E-mail address of such person

6d EIN of each promotor or agent

7a Name and address of any person, financial institution(s), or other entity holding assets for the MEWA or ECE

7b Telephone Number of person, financial institution, or entity

8a Name and address of any actuary(ies) providing services to the MEWA or ECE

8b Telephone number of each actuary

8c E-mail address of each actuary

8d EIN of each actuary

9a If the MEWA or ECE has a contract with a third party administrator (TPA) the name and address of the third party administrator(s)

9b Telephone number of each TPA

9c E-mail address of each TPA

9d EIN of each TPA

10a Name and address of any person or entity that has authority or control over the MEWA's or ECE's assets or over assets paid to the entity by plans or employers for the provision of benefits

10b Telephone number of each such person or entity

10c E-mail address of such person or entity

10d EIN of each such person or entity

11a Name and address of any person or entity that has discretionary authority, control, or responsibility with respect to the administration of the MEWA or ECE or any benefit program offered by it

Integrative Emergency Services

Heritage Square One
4835 LBJ Freeway, Suite 900
Dallas, TX 75244

11b Telephone number of each such person or entity (469) 420-5512

11c E-mail address of such person or entity
humanresources@ies.healthcare

11d EIN of each such person or entity 61-1778177

12a Names and addresses of the MEWAs or ECEs that merged

12b Telephone number of the entities

12c EINs

12d PNs

13 Do you have an opinion from an actuary assessing the MEWA's or ECE's actuarial soundness, including the adequacy of contribution rates? No

14a Are you, your entity, and/or its officers, directors, and employees covered by fiduciary liability policies? Please identify the carrier that issued the fiduciary liability policy(ies) in the space provided. Yes

Continental Casualty Insurance Co.

14b Are the fiduciaries of each of the plans whose participants are receiving benefits from the entity covered by a fiduciary liability policy? Yes

15 Are all assets in the possession of the MEWA or ECE maintained consistent with section 403 of ERISA and 29 CFR 2550.403a-1 and 2550.403b-1? Yes

If no, please explain.

16a Within the past five years, has any litigation or other enforcement proceeding (including any administrative proceeding) regarding any MEWA, ECE, or Group Health Plan been instituted by a Federal or State agency against the MEWA or ECE, a trustee, or a director, owner, partner, senior manager, or officer of the sponsoring entity? No

If yes, please identify each litigation or enforcement proceeding to 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.

16b Have any of the persons or entities listed in this Part II ever been the subject of any criminal or civil investigation or action involving dishonesty or breach of trust or been convicted of a felony? No

If yes, please explain.

16c Have any cease and desist orders been issued by a Federal or State agency against any of the entities listed in this Part II? No

If so, please list the issuing entities and the year in which each order was issued.

Entity	Year

17 Complete a separate row for each state in which the entity operates in the following chart. (Note: Only entities that provide medical care (within the meaning of ERISA section 733(a) (2)) are required to file the Form M-1.):

17a	17b	17c	17d	17e	17f	17g	17h	17i	17j
Enter all States where the MEWA or ECE is operating.	**Is coverage provided?**	**State registration number.**	**Name of state agent or entity for service of process.**	**Is the entity a licensed health insurer in this State?**	**If yes to 17e, enter NAIC number.**	**If no to 17e, is the entity fully insured?**	**If yes to 17g, enter name and NAIC number of insurer.**	**Does the entity purchase stop loss coverage?**	**If yes to 17i, enter the name and NAIC number of insurer.**
AZ ☐ **New State**	Yes		IES	No		Yes	BCBSX (524114)	No	
FL ☐ **New State**	Yes		IES	No		Yes	BCBSTX (524114)	No	
IN ☐ **New State**	Yes		IES	No		Yes	BCBSTX (524114)	No	
TX ☐ **New State**	Yes		IES	No		Yes	BCBSTX (524114)	No	
AR ☑ **New State**	Yes		IES	No		Yes	BCBSTX (524114)	No	

18 Of the States identified in box 17a, identify those States in which the entity conducted 20 percent or more of its business (based on the number of participants receiving coverage for medical care). `TX`

19 Total number of participants covered under the entity. `527`

PART III
INFORMATION FOR COMPLIANCE WITH PART 7 OF ERISA

20 If you answered yes to box 16a, in reference to any State or Federal litigation or other enforcement proceeding (including any administrative proceeding), check yes below if 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. `N/A`

21 Is the MEWA subject to part 7 of ERISA on the date of the filing? (Note: The Self-Compliance Tool at www.dol.gov/ebsa/pdf/cagappa.pdf may be helpful in answering Boxes 21-21f.) If "yes," complete the following. `Yes`

21a Is the coverage provided by the MEWA or ECE in compliance with the portability and nondiscrimination provisions of the Health Insurance Portability and Accountability Act of 1996, including Title I of the Genetic Information Nondiscrimination Act of 2008, and the Department of Labor's (Department's) regulations issued thereunder? `Yes`

21b Is the coverage provided by the MEWA or ECE in compliance with the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 and the Department's regulations issued thereunder? `Yes`

21c 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? `Yes`

21d Is the coverage provided by the MEWA or ECE in compliance with the Women's Health and Cancer Rights Act of 1998? `Yes`

21e Is the coverage provided by the MEWA or ECE in compliance with Michelle's Law? `Yes`

21f Is the coverage provided by the MEWA or ECE in compliance with the Patient Protection and Affordable Care Act of 2010 and the Department's regulations issued thereunder that are applicable as of the date signed at the bottom of this form? `Yes`

ATTACHMENTS

IES 2022 M-1 Filing - Health (Signed).pdf

SIGNATURE

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: Filed with Electronic Sigr

Address of Administrator:

Date: 02/23/2023

Receipt Confirmation Code: 00013297-4521

2022 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 filing is required to be filed under section 101(g) of the Employee Retirement Income Security Act of 1974, as amended by the Patient Protection and Affordable Care Act.

OMB No. 1210-0116

Department of Labor
Employee Benefits Security Administration

PART I PURPOSE OF FILING

Complete as applicable:

A
Identify the type of filing:
(1) ☑ Annual Report:
- ○ Calendar Year
- ◉ or the fiscal year beginning 01/01/2022 and ending 12/31/2022

(2) ☐ MEWA Registration
Date:
(3) ☐ ECE Origination
Date:
(4) ☐ ECE Special Filing
Date:

B Check if any of the following:
Check here if this is a final report ☐
Check here if this is an amended report ☐
Check here if this is a request for an extension ☐

C Identify the type of entity:
(1) ◉ A Plan MEWA
(2) ○ A Non-Plan MEWA
(3) ○ An Entity Claiming Exception (ECE)

D Enter the most recent date the MEWA or ECE filed the Form M-1:
☐ Check the box if this is the first filing or enter the date below:
03/03/2022

PART II CUSTODIAL & FINANCIAL INFORMATION

1a Name and address of the MEWA or ECE
Integrative Emergency Services Life, AD&D, STD, LTD Plan

Heritage Square One
4835 LBJ Freeway, Suite 900
Dallas, TX 75244

1b Telephone number of the MEWA or ECE (469) 420-5512

1c Employer Identification Number (EIN) 61-1778177

1d Plan Number (PN) 503

2a Name and address of the administrator of the MEWA or ECE
Integrative Emergency Services

Heritage Square One
4835 LBJ Freeway, Suite 900
Dallas, TX 75244

2b Telephone number of the administrator (469) 420-5512

2c EIN 61-1778177

2d E-mail address of the administrator
humanresources@ies.healthcare

3a Name and address of the entity or entities sponsoring the MEWA or ECE
Integrative Emergency Services

Heritage Square One
4835 LBJ Freeway, Suite 900
Dallas, TX 75244

3b Telephone number of the sponsor (469) 420-5545

3c EIN 61-1778177

4a Name and address of the agent for service of process or registered agent
Matt C. Innes
Integrative Emergency Services
Heritage Square One
4835 LBJ Freeway, Suite 900
Dallas, TX 75244

4b Telephone number of such person (469) 420-5512

4c E-mail address of such person
minnes@ies.healthcare

5a Name and address of each member of the Board, officer, trustee, or custodian of the MEWA or ECE

5b Telephone number of each such person

5c E-mail address of such person

6a Name and address of all promoters and/or agents responsible for marketing the MEWA or ECE

6b Telephone number of each promoter or agent

6c E-mail address of such person

6d EIN of each promotor or agent

7a Name and address of any person, financial institution(s), or other entity holding assets for the MEWA or ECE

7b Telephone Number of person, financial institution, or entity

8a Name and address of any actuary(ies) providing services to the MEWA or ECE

8b Telephone number of each actuary

8c E-mail address of each actuary

8d EIN of each actuary

9a If the MEWA or ECE has a contract with a third party administrator (TPA) the name and address of the third party administrator(s)

9b Telephone number of each TPA

9c E-mail address of each TPA

9d EIN of each TPA

10a Name and address of any person or entity that has authority or control over the MEWA's or ECE's assets or over assets paid to the entity by plans or employers for the provision of benefits

10b Telephone number of each such person or entity

10c E-mail address of such person or entity

10d EIN of each such person or entity

11a Name and address of any person or entity that has discretionary authority, control, or responsibility with respect to the administration of the MEWA or ECE or any benefit program offered by it

Integrative Emergency Services

Heritage Square One
4835 LBJ Freeway, Suite 900
Dallas, TX 75244

11b Telephone number of each such person or entity (469) 420-5512

11c E-mail address of such person or entity
humanresources@ies.healthcare

11d EIN of each such person or entity 61-1778177

12a Names and addresses of the MEWAs or ECEs that merged

12b Telephone number of the entities

12c EINs

12d PNs

13 Do you have an opinion from an actuary assessing the MEWA's or ECE's actuarial soundness, including the adequacy of contribution rates? No

14a Are you, your entity, and/or its officers, directors, and employees covered by fiduciary liability policies? Please identify the carrier that issued the fiduciary liability policy(ies) in the space provided. Yes

Continental Casualty Insurance Co.

14b Are the fiduciaries of each of the plans whose participants are receiving benefits from the entity covered by a fiduciary liability policy? Yes

15 Are all assets in the possession of the MEWA or ECE maintained consistent with section 403 of ERISA and 29 CFR 2550.403a-1 and 2550.403b-1? Yes

If no, please explain.

16a Within the past five years, has any litigation or other enforcement proceeding (including any administrative proceeding) regarding any MEWA, ECE, or Group Health Plan been instituted by a Federal or State agency against the MEWA or ECE, a trustee, or a director, owner, partner, senior manager, or officer of the sponsoring entity? No

If yes, please identify each litigation or enforcement proceeding to 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.

16b Have any of the persons or entities listed in this Part II ever been the subject of any criminal or civil investigation or action involving dishonesty or breach of trust or been convicted of a felony? No

If yes, please explain.

16c Have any cease and desist orders been issued by a Federal or State agency against any of the entities listed in this Part II? No

If so, please list the issuing entities and the year in which each order was issued.

Entity	Year

17 Complete a separate row for each state in which the entity operates in the following chart. (Note: Only entities that provide medical care (within the meaning of ERISA section 733(a) (2)) are required to file the Form M-1.):

17a	17b	17c	17d	17e	17f	17g	17h	17i	17j
Enter all States where the MEWA or ECE is operating.	**Is coverage provided?**	**State registration number.**	**Name of state agent or entity for service of process.**	**Is the entity a licensed health insurer in this State?**	**If yes to 17e, enter NAIC number.**	**If no to 17e, is the entity fully insured?**	**If yes to 17g, enter name and NAIC number of insurer.**	**Does the entity purchase stop loss coverage?**	**If yes to 17i, enter the name and NAIC number of insurer.**
TX ☐ **New State**	Yes		IES	No		Yes	New York Life (524113)	No	
AZ ☐ **New State**	Yes		IES	No		Yes	New York Life (524113)	No	
FL ☐ **New State**	Yes		IES	No		Yes	New York Life (524113)	No	
IN ☐ **New State**	Yes		IES	No		Yes	New York Life (524113)	No	
AR ☑ **New State**	Yes		IES	No		Yes	New York Life (524113)	No	

18 Of the States identified in box 17a, identify those States in which the entity conducted 20 percent or more of its business (based on the number of participants receiving coverage for medical care). TX

19 Total number of participants covered under the entity. 567

PART III
INFORMATION FOR COMPLIANCE WITH PART 7 OF ERISA

20 If you answered yes to box 16a, in reference to any State or Federal litigation or other enforcement proceeding (including any administrative proceeding), check yes below if 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. N/A

21 Is the MEWA subject to part 7 of ERISA on the date of the filing? (Note: The Self-Compliance Tool at www.dol.gov/ebsa/pdf/cagappa.pdf may be helpful in answering Boxes 21-21f.) If "yes," complete the following. Yes

21a Is the coverage provided by the MEWA or ECE in compliance with the portability and nondiscrimination provisions of the Health Insurance Portability and Accountability Act of 1996, including Title I of the Genetic Information Nondiscrimination Act of 2008, and the Department of Labor's (Department's) regulations issued thereunder? Yes

21b Is the coverage provided by the MEWA or ECE in compliance with the Mental Health Parity Act of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 and the Department's regulations issued thereunder? Yes

21c 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? Yes

21d Is the coverage provided by the MEWA or ECE in compliance with the Women's Health and Cancer Rights Act of 1998? Yes

21e Is the coverage provided by the MEWA or ECE in compliance with Michelle's Law? Yes

21f Is the coverage provided by the MEWA or ECE in compliance with the Patient Protection and Affordable Care Act of 2010 and the Department's regulations issued thereunder that are applicable as of the date signed at the bottom of this form? Yes

ATTACHMENTS

IES 2022 M-1 Filing - Life and Disability (Signed).pdf

SIGNATURE

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: Filed with Electronic Sigr

Address of Administrator:

Date: 02/23/2023

Multiple-Employer Plan / Participating Employee Participation

Integrative Emergency Services Health Plan

61-1778177, Plan 504

1/1/22-12/31/22

Employer Name	Tax- Identification	Plan
Integrative Emergency Services LLC	61-1778177	504
MYDAS, PA	46-3481190	504
Integrative Emergency Services Physician Group PA	45-2317041	504
Beacon Emergency Services Team, PA	46-3466558	504
Healthcare Observation Services Team, PA	81-3670231	504
Integrative Emergency Services Physician Group - Houston, PLLC	84-1832545	504
Integrative Emergency Services Carrollton PLLC	84-2988873	504

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