From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Wednesday, December 29, 2010 2:59 PM
To: DaleT@benefitsystems.info
Subject: Carpenters Local No. 491 Health & Welfare Plan Waiver of the Annual Limits Requirements 12-29-2010

Importance: High

Follow Up Flag: Follow up
Flag Status: Green

Attachments: Updated Jan 1 Approval Letter .pdf
Good Afternoon,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section 2711 for Carpenters Local No. 491 Health & Welfare Plan. HHS has reviewed your application and made its determination. Please see the attached letter.

Please confirm receipt of this letter by replying to this e-mail.

Please let me know if I can be of further assistance.

Sincerely,

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov

Pages 2 through 145 redacted for the following reasons:
- -
(b)(4)

12/06/10 AM

CARPENTER'S LOCAL 491 HEALTH & WELFARE FUND

6650 Belair Road - Suite One
Baltimore, Maryland 21206

November 24, 2010

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED AND VIA EMAIL
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Office of Oversight
Room 737-F-04
200 Independence Avenue, SW
Washington, D.C. 20201

Attention: James Mayhew, Room 737-F-04

Re: Application for Waiver of Annual Limits Requirements of Public Health Service Act Section 2711

Dear Mr. Mayhew:

The Carpenters Local No. 491 Health & Welfare Plan (the "Plan") is a Taft-Hartley self-insured multi-employer Welfare Fund governed by the Employee Retirement Income Security Act of 1974, as amended and qualified under Section 501(c)(9) of the Internal Revenue Code of 1986, as amended. The Plan provides a program of health benefits covering participants of employers who have Collective Bargaining Agreements (CBAs) with Local 491, which represents the participants of this Plan. **Please note that the Plan's plan year begins January 1, 2011.**

In accordance with the instructions issued by HHS relative to group health plans applying for a waiver from the restricted annual limits, we are supplying the information below:

1. **The terms of the plan or policy form(s) for which a waiver is sought:**
The Plan is funded by employer contributions, which are paid into a Trust Fund. Employer contribution rates are set forth in the applicable Collective Bargaining Agreements. The terms of the Plan can be found in the Summary Plan Description attached hereto as Attachment 1 as well as all relevant Summary of Material Modifications issued since the SPD was prepared. The relevant sections of the Plan document for which the waiver is requested are also attached hereto as Attachment 2.

2. **The number of individuals covered by the plan or policy form(s) submitted:**
There are approximately (b)(4) participants currently covered by the Plan (b)(4) employees/retirees and (b)(4) dependents).

3. **The annual limit(s) and rates applicable to the plan or policy form(s) submitted:** The Plan is applying for a waiver of the annual limits requirements of PHS Act Section 2711 as they apply to the employees/retirees and their eligible dependents. The Plan currently has

the following annual limits: a) an annual medical benefit limit set at (b)(4) per covered participant: b) a (b)(4) annual limit on prescription drug coverage per participant; c) a separate (b)(4) annual limit on injectable prescription drugs per participant; d) and a (b)(4) annual limit on basic benefits for diagnostic x-ray and laboratory benefits (note the excess goes to major medical, paid at (b)(4) for basic). In addition, the Plan has certain lifetime maximums which we request be converted to annual limits, as follows: a) a lifetime major medical maximum of (b)(4) and b) a lifetime (b)(4) maximum for orthodontia for children.

4. **A brief description of why compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation:**
For the most current completed plan year, ending December 2009, the Plan expenses were (b)(4) and for that year, the Plan experienced a gain of (b)(4) . For the first half of 2010, expenses were (b)(4) and the Plan experienced a loss of (b)(4) .

If the change to the statutory and regulatory maximums were to be implemented, the Trustees anticipate that it would increase costs by between (b)(4) and (b)(4) . This is based on projections of claim utilization for the medical and drug benefits and on standard actuarial factors, as performed by the Plan's consultant, Bolton Partners. This represents an increase to the baseline costs of between (b)(4) and (b)(4) .

Removing the annual and lifetime limits as described above will undoubtedly increase expenses. In addition, without even taking into consideration these changes, the projected annual trend increase for health plans is (b)(4) to (b)(4) . Further, complying with the other requirements under the Acts (i.e. Age 26 dependent coverage) is projected to increase the Plan's cost by up to 5%. Therefore, compliance with these rules would result in a significant increase in the contribution amount needed to properly fund the Plan.

As an additional consideration, economic conditions in this industry have been deteriorating over the last three years. Plan participants worked a total of (b)(4) hours in 2008, but this dropped to (b)(4) in 2009. The projected hours worked for 2010 reflect a further drop to (b)(4) . This is resulting in lower revenues, and a much greater likelihood that a large claim would produce a significant loss to the Plan.

As the contribution amounts are set forth in Collective Bargaining Agreements, and based on the current economy, it is not likely that the employers will agree to increase their required contributions in order to further subsidize coverage.

Accordingly, the Trustees would have no alternative but to give up the Plan's grandfathered status and eliminate or reduce benefits currently being provided to equalize the Plan's expenses with the contributions received. Therefore, compliance with these rules would result in a significant decrease in access to benefits for those currently covered by the Plan as the Plan would be eliminated and replaced with a lower cost plan that would provide lesser benefits to those currently covered by the Plan.

5. **An attestation signed by the plan administrator or Chief Executive Office of the issuer or the coverage, certifying 1) that the plan was in force prior to September 23, 2010; and 2) that the application of restricted annual limits to such plans or policies**

would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies:
I do hereby attest that I am the Plan Administrator and that the above Plan was in force prior to September 23, 2010, and that based upon the above information, the application of restricted annual limits to the Plan would result in a significant decrease in access to benefits for those currently covered by the Plan and/or a significant increase in the premium needed to cover the cost of the Plan without the Plan's current annual limits.

Very truly yours,

Dale O. Troll, CEBS
Fund Administrator

Pages 149 through 196 redacted for the following reasons:
- -
(b)(4)

ANNUAL LIMIT WAIVER APPLICATION 2010

Annual Limit Waiver Request Applicant Name	Policy Name (use a new row for each policy application)	Applicant (Plan/ Policy Situs) City	Applicant (Plan/ Policy Situs) State	Plan/ Policy Effective Date (mm/dd/yyyy)	Contact Name	Street Address	City	State	Zip Code	Phone Number (including area code)	Email Address	Type of Coverage (e.g., Limited Benefit, HRA, Rx only, Other)	Self-Insured (Yes/No)	Individual or Group Policy	Total Number of Individuals Covered by Policy (include all dependents covered)	Current Plan Overall Annual Limit (in dollars)
Carpenters Local No. 491 Health & Welfare Plan	Plan 1	Baltimore	MD	01/01/2011	Dale O. Troll	6650 Belair Rd. Suite One	Baltimore	MD	21206	410-254-4800	DaleT@benefitsystems.info	Limited Benefit	Yes	Group	(b)(4)	

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1105. The time required to complete this information collection is estimated to average (8 hours) or (240 minutes) per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

ANNUAL LIMIT WAIVER APPLICATION 2010

Current Essential Benefits Annual Limits (Annual Limit for Each Essential Benefit)										Office Visit Copays/Coinsurance		Hospital Inpatient Copay/Coinsurance		Emergency Room Copay/Coinsurance		Rx Copay/Coninsurance	
Ambulatory	Emergency	Hospitalization	Laboratory	Pediatric	Maternity/ Newborn	Mental Health/ Substance Abuse	Rehabilitative/ Devices	Preventive/ Wellness	Prescription	Plan Deductible	Copay (if applicable)	Coinsurance (if applicable)	Copay (if applicable)	Coinsurance (if applicable)	Copay (if applicable)	Coinsurance (if applicable)	Copay (if applicable)	Coinsurance (if applicable)
(b)(4)																		

ANNUAL LIMIT WAIVER APPLICATION 2010

Individual/ Employee Tier*	Current Monthly Premium Rates or Premium Equivalent Rates (in dollars)*: Employee contribution	Current Monthly Premium Rates or Premium Equivalent Rates (in dollars)*: Employer contribution	Renewal Monthly Premium Rates or Premium Equivalent Rates if Waiver Granted (in dollars)* Employee contribution	Renewal Monthly Premium Rates or Premium Equivalent Rates if Waiver Granted (in dollars)* Employer contribution	Projected Rate Increase that would result from compliance with $750,000 Annual Limit Restriction (in dollars) (Average Premium by Individual)* Employee contribution	Projected Rate Increase that would result from compliance with $750,000 Annual Limit Restriction (in dollars) (Average Premium by Individual)* Employer contribution	Projected Rate Increase that would result from compliance with $750,000 Annual Limit Restriction (in dollars)(Average Premium by Individual) (Difference of Column AT and AQ divided by	Decrease in Access to Benefits that would result from compliance with $750,000 Annual Limit Restriction (describe briefly in cell	Plan Administrator/ CEO of Health Insurance Issuer Name	Title of Individual Providing Attestation
					(b)(4)					
Employee									Dale O. Troll	Plan Administrator

* When completing the columns requesting premium rate information, please express the premium rates as a composite rate (if premiums are a range based on years of service or age) and by tier (Employee, Employee + Spouse, Employee + Child, Family, etc.) as applicable. If you are an issuer, please provide the premium amount in the column titled, "Total" (Column AN, AQ and AT).

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Sent: Thursday, December 16, 2010 12:42 PM
To: Troll, Dale
Cc: Steve Batoff (sbatoff@batoffassociates.com); Habit, Sandra (HHS/OCIIO)
Subject: RE: Waiver Application for Carpenter's Local 491 Health and Welfare Fund

Hi,

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Thank you,

Cam Moultrie

Cam Lynne Moultrie
Office of Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
(301) 492-4174
cam.moultrie@hhs.gov

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Subject: RE: Waiver Application for Carpenter's Local 491 Health and Welfare Fund

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Thank you for all your help.

Dale Troll

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an annual limit of (b)(4)

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U.S. Department of Health and Human Services

(301) 492-4174
cam.moultrie@hhs.gov

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Sent: Thursday, December 02, 2010 10:19 AM
To: HHS HealthInsurance (HHS)
Cc: Steve Batoff (sbatoff@batoffassociates.com)
Subject: Waiver

Dear Sir

Attached please find copy of Application for Waiver of Annual Limits, also sent by certified mail

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Attachments: Copy of Waiver_application_form Carpenters Local No 491 (3).xls

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Office of Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
(301) 492-4174
cam.moultrie@hhs.gov

From: Troll, Dale [mailto:DaleT@benefitsystems.info]
Sent: Friday, December 17, 2010 9:45 AM
To: Moultrie, Cam (HHS/OCIIO)
Cc: 'Steve Batoff (sbatoff@batoffassociates.com)'
Subject: RE: Waiver Application for Carpenter's Local 491 Health and Welfare Fund

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Cc: Steve Batoff (sbatoff@batoffassociates.com)
Subject: RE: Waiver Application for Carpenter's Local 491 Health and Welfare Fund

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Attachments: Waiver Relief Application - Carpenters 491 (11-23-10).docx

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A lifetime maximum of (b)(4) per person for orthodontia benefits. The Plan is applying to convert this lifetime limit for children only into an annual limit of (b)(4) for children only.

A lifetime maximu (b)(4) per person for major medical benefits. The Plan is applying to convert this lifetime limit into an annual limit of (b)(4)

The Plan was created pursuant to the Taft-Hartley Act. There are two collective bargaining agreements with regard to the Plan. The Show Site Agreement between Trade Show Contractors Association of Washington D.C. and Vicinity and Mid-Atlantic Regional Council of Carpenters United Brotherhood of Carpenters and Joiners of America is effective on March 1,

2006, and will expire on February 28, 2011.

From: Moultrie, Cam (HHS/OCIIO) [mailto:Cam.Moultrie@hhs.gov]
Sent: Monday, December 13, 2010 7:14 PM
To: Troll, Dale
Cc: Steve Batoff (sbatoff@batoffassociates.com); Habit, Sandra (HHS/OCIIO)
Subject: RE: Waiver Application for Carpenter's Local 491 Health and Welfare Fund

Dear Mr. Troll,

Thank you for your application for the Waiver of the Annual Limits Requirements of the Public Health Service Act (PHS Act) Section 2711. In order to expedite your application, please provide the following information:

I. Please complete the entire annual limits spreadsheet available at: http://www.hhs.gov/ociio/regulations/annual_limit_waivers.html. Please return the completed spreadsheet to this email address as an attachment. We will only be able to process spreadsheets that are fully complete (i.e., every cell should contain the information requested). If a cell on the spreadsheet does not pertain to your plan, please write "None," and/or provide an explanation regarding why you are unable to complete that particular cell in a separate document.

II. In addition, please provide the following information:

- Confirm whether the plan was in existence prior to March 23, 2010. If so, is the plan in compliance with grandfathering provisions, pursuant to 45 CFR 147.140?
- Confirm whether your plan provides any lifetime limits.
- Confirm whether the plan was created pursuant to the Taft-Hartley Act and, if applicable, the effective and expiration dates of the collective bargaining agreement.

In order to complete your application, please provide this information by 5:00 pm, December 17, 2010. Once this information is received and the application is complete, it will be processed by the Department of Health and Human Services (HHS). As stated in our September 3, 2010 Sub-Regulatory Guidance, HHS will issue a decision within 30 days of receiving a complete application. You will receive an e-mail from HHS notifying you of the waiver decision.

Thank you.

Cam Lynne Moultrie
Office of Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
(301) 492-4174
cam.moultrie@hhs.gov

From: Troll, Dale [mailto:DaleT@benefitsystems.info]
Sent: Thursday, December 02, 2010 10:19 AM
To: HHS HealthInsurance (HHS)
Cc: Steve Batoff (sbatoff@batoffassociates.com)
Subject: Waiver

Dear Sir

Attached please find copy of Application for Waiver of Annual Limits, also sent by certified mail

Dale Troll
Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201

Date: October 2010

From: Steve Larsen, Director, Office of Oversight

Subject: Application for Waiver of the Annual Limits Requirements of PHS Act Section 2711

Dear Waiver Applicant:

Section 2711(a)(2) of the Public Health Service Act (PHS Act), as added by the Patient Protection and Affordable Care Act (Affordable Care Act), requires the Secretary to impose restrictions on the imposition of annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for any participant or beneficiary in a new or existing group health plan or a new policy in the individual market for plan or policy years beginning on or after September 23, 2010 and prior to January 1, 2014. Specifically, the Secretary is granted the authority to determine what constitutes a "restricted annual limit" that can still be imposed under such plans or policies prior to January 1, 2014.

The interim final regulations published on June 28, 2010 (codified at 26 CFR § 54.9815-2719T; 29 CFR § 2590.715-2719; and 45 CFR §147.126) established such restricted annual limits. The regulations also provided that these restricted annual limits may be waived by the Secretary of Health and Human Services (HHS) if compliance with the interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. Pursuant to the regulation, HHS issued guidance on September 3 regarding the scope and process for applying for a waiver.

The Office of Consumer Information and Insurance Oversight, Office of Insurance Oversight received and processed your application for the plan(s) or policy(ies) year beginning January 1, 2011. We have determined that your application has met the criteria to obtain a waiver of the restricted annual limits requirements because compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies. To the extent you make any change to your benefit package after March 23, 2010, you must determine whether the change(s) will trigger loss of grandfathering status pursuant to 45 CFR §147.140(g)(1).

An approval of your request for waiver of the restricted annual limits requirements granted under this process applies only to the annual limit(s) provided in your application for the plan or policy year beginning between September 23, 2010 and September 23, 2011. This waiver only applies to the annual limits requirements in Section 2711 of the ACA and does not apply to any other requirement of the Affordable Care Act, ERISA, the IRS Code or the PHS Act. Further, a group

health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when this waiver expires in accordance with future guidance from HHS. HHS may modify this waiver approval process memorandum and other relevant information.

If you have any questions regarding this letter, please email OCIIOOversight@hhs.gov.

CARPENTER'S LOCAL 491 HEALTH & WELFARE FUND

6650 Belair Road - Suite One
Baltimore, Maryland 21206

November 24, 2010

VIA CERTIFIED MAIL, RETURN RECEIPT REQUESTED AND VIA EMAIL
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Office of Oversight
Room 737-F-04
200 Independence Avenue, SW
Washington, D.C. 20201

Attention: James Mayhew, Room 737-F-04

Re: Application for Waiver of Annual Limits Requirements of Public Health Service Act Section 2711

Dear Mr. Mayhew:

The Carpenters Local No. 491 Health & Welfare Plan (the "Plan") is a Taft-Hartley self-insured multi-employer Welfare Fund governed by the Employee Retirement Income Security Act of 1974, as amended and qualified under Section 501(c)(9) of the Internal Revenue Code of 1986, as amended. The Plan provides a program of health benefits covering participants of employers who have Collective Bargaining Agreements (CBAs) with Local 491, which represents the participants of this Plan. **Please note that the Plan's plan year begins January 1, 2011.**

In accordance with the instructions issued by HHS relative to group health plans applying for a waiver from the restricted annual limits, we are supplying the information below:

1. **The terms of the plan or policy form(s) for which a waiver is sought:**
   The Plan is funded by employer contributions, which are paid into a Trust Fund. Employer contribution rates are set forth in the applicable Collective Bargaining Agreements. The terms of the Plan can be found in the Summary Plan Description attached hereto as Attachment 1 as well as all relevant Summary of Material Modifications issued since the SPD was prepared. The relevant sections of the Plan document for which the waiver is requested are also attached hereto as Attachment 2.

2. **The number of individuals d by the plan or policy form(s) submitted:**
   There are approxima (b)(4) participants currently covered by the Plan ((b)(4) employees/retirees and (b)(4) ents).

3. **The annual limit(s) and rates applicable to the plan or policy form(s) submitted:** The Plan is applying for a waiver of the annual limits requirements of PHS Act Section 2711 as they apply to the employees/retirees and their eligible dependents. The Plan currently has

the following an : a) an annual medical benefit limit set at (b)(4) per covered participa (b)(4) annual limit on prescription drug coverag icipant separate (b)(4) imit on injectable prescription drugs per participant; d) and a (b)(4) annual limit on basic benefits f ray and laboratory benefits (note the excess goes to major medical, paid at (b)(4) for basic). In addition, the Plan has certain lifetime maximums which w rted to limits, as follows: a) a lifetime major medical maximum of (b)(4) ; and b) a lifetime (b)(4) maximum for orthodontia for children.

4. **A brief description of why compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation:**

t current completed plan year, ending December Plan expenses were (b)(4) and for th Plan experienced a gain of (b)(4) For the first half of ses were (b)(4) and the Plan experienced a (b)(4)

If the change to the statutory and regulatory maximum be ed, the Trustees anticipate that it would increase costs by between (b)(4) and (b)(4) This is based on projections of claim utilization for the medical an efits tandard actuarial factors, as performed by the Plan's consultant, Bolton Partners. This represents an increase to the baseline costs of between (b)(4) .

Removing the annual and lifetime limits as described above will undoubtedly increase expenses. In addition, without even taking ation these changes, the projected annual trend increase for health plans is (b)(4) . Further, complying with the other requirements under Acts (i.e. Age 26 dependent coverage) is projected to increase the Plan's cost by up to (b)(4). Therefore, compliance with these rules would result in a significant increase in the contr ion amount needed to properly fund the Plan.

As an additional consideration, economic conditions in this ind been deteriorating over the last th s. Plan participants worked a total of (b)(4) hours in 2008, but thi d to (b)(4) in 2009. The projected hours worked for 2010 reflect a further drop to (b)(4) Thi lting in lower revenues, and a much greater likelihood that a large claim would produce a significant loss to the Plan.

As the contribution amounts are set forth in Collective Bargaining Agreements, and based on the current economy, it is not likely that the employers will agree to increase their required contributions in order to further subsidize coverage.

Accordingly, the Trustees would have no alternative but to give up the Plan's grandfathered status and eliminate or reduce benefits currently being provided to equalize the Plan's expenses with the contributions received. Therefore, compliance with these rules would result in a significant decrease in access to benefits for those currently covered by the Plan as the Plan would be eliminated and replaced with a lower cost plan that would provide lesser benefits to those currently covered by the Plan.

5. **An attestation signed by the plan administrator or Chief Executive Office of the issuer or the coverage, certifying 1) that the plan was in force prior to September 23, 2010; and 2) that the application of restricted annual limits to such plans or policies**

would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies:
I do hereby attest that I am the Plan Administrator and that the above Plan was in force prior to September 23, 2010, and that based upon the above information, the application of restricted annual limits to the Plan would result in a significant decrease in access to benefits for those currently covered by the Plan and/or a significant increase in the premium needed to cover the cost of the Plan without the Plan's current annual limits.

Very truly yours,

Dale O. Troll, CEBS
Fund Administrator