

Bricklayers Fringe Benefit Funds Office

BAC Local Union #1, NY
66-05 Woodhaven Boulevard
Rego Park, NY 11374
Phone: (718) 459-5800

COPY

Jeremiah Sullivan
Administrator

November 23, 2010

James Mayhew
HHS Office of Consumer Information and Insurance Oversight, Office of Oversight
Room 737-F-04
200 Independence Ave. SW
Washington, DC 20201

Dear Mr. Mayhew:

Please accept this application from the Bricklayers Insurance and Welfare Fund for a waiver from the restricted annual limits set forth in the Interim Final Regulations for the plan year January 1, 2011 to December 31, 2011. The plan was offered prior to September 23, 2010. This letter and its attachments include the following information as required by OCIO Sub-Regulatory Guidance 2010-1: Process for Obtaining Waivers of the Annual Limits Requirements of PHS Act Section 2711.

The Bricklayers Insurance and Welfare Fund provides hospital, medical, prescription drug, dental, vision, and life benefits. The Fund covers 1,748 members (actives and retirees) and 2,249 estimated dependents. In order for Active Employees to attain and maintain eligibility for health benefits in the Fund they must work a minimum number of hours. Based on hours of employment during a Plan Year, the Fund grants Active coverage under one of three levels of benefits, Benefit Levels A, B, or C as follows:

Hours Worked in Benefit Accrual Period	Benefit Level
(b)(4)	Plan A
	Plan B
	Plan C
	None

The Fund also maintains a plan for Retirees. Eligible Retirees maintain coverage for life on a non-contributory basis.

The Fund is self-insured and is administered by a joint board of employer and union trustees and the Fund Office.

The Fund is requesting a waiver of the annual maximums for the following benefits:

➤ Prescription drugs (Actives):

Benefit Level A

Benefit Level B

Benefit Level C

Prescription drugs (Retirees): (b)(4)

Participant Only

Participant and One Dependent

Participant and 2 or more Dependents

➤ Annual maximum of (b)(4) for Physical Examinations for all Actives, Retirees and their eligible dependents.

➤ Annual Maximum on Dental Benefits of (b)(4) for eligible pediatric Dependents of Actives under benefit level A, and (b)(4) for eligible pediatric Dependents of Actives under benefit level B and Retirees.

➤ Semi-Annual Maximum on Optical Benefits for eligible pediatric Dependents of Actives as follows:

	Benefit Levels A and B	Benefit Level C
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Examination

Single lens prescription

Bifocal or trifocal lens prescription (b)(4)

Frames

➤ Semi-Annual Maximum on Optical Benefits for eligible pediatric Dependents of Retirees as follows:

Examination

Single lens prescription (b)(4)

Bifocal or trifocal lens prescription

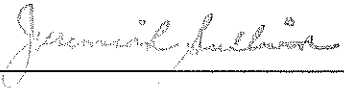
➤ Annual maximum in Benefit Level A of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to (b)(4) consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.

➤ Annual maximum in Benefit Level B of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to four consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.

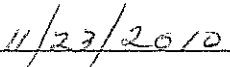
➤ Annual maximum in Benefit Level C and the Retiree Group of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to (b)(4) consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.

Attestation

I hereby attest to the following: I am the plan administrator of the Bricklayers Insurance and Welfare Fund. I certify that (1) the plan was in force prior to September 23, 2010 and (2) 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 a significant increase in premiums paid by the plan's participants and covered dependents.



Jeremiah Sullivan, Administrator



Date

Attachment A-Annual Dollar Limit Waiver Certification

Name of Plan: Bricklayers Insurance and Welfare Fund

Plan Year: January 1, 2011 to December 31, 2011

The Segal Company has reviewed the Plan's request for a Waiver of the Restricted Annual Dollar Limits in the Affordable Care Act, and has the following findings.

1. The terms of the plan or policy form(s) for which a waiver is sought.
 - See Attachment B
 - The employers currently pay (b)(4) per hour into the fund to cover all benefits offered to the members.
 2. The number of individuals covered by the plan submitted.
 - There are approximately (b)(4) covered active participants and retirees and (b)(4) estimated dependents
 3. The annual limit(s) and rates applicable to the plan or policy form(s) submitted.
 - The waiver is being sought for the annual limits on the medical benefits and the prescription drug benefits as follows:
 - Prescription drugs (Actives):
 - Benefit Level A
 - Benefit level B
 - Benefit Level C
 - Prescription drugs (Retirees):
 - Participant Only
 - Participant and One Dependent
 - Participant and 2 or more Dependents
- Annual maximum of (b)(4) for Physical Examinations for all Actives, Retirees and their eligible dependents.
- Annual Maximum on Dental Benefits of (b)(4) for eligible pediatric Dependents of Actives under benefit level A, and (b)(4) for eligible pediatric Dependents of Actives under benefit level B and Retirees.
- Semi-Annual Maximum on Optical Benefits for eligible pediatric Dependents of Actives as follows:

Benefit Levels Benefit Level C
A and B

Examination	
Single lens prescription	
Bifocal or trifocal lens prescription	(b)(4)
Frames	

- Semi-Annual Maximum on Optical Benefits for eligible pediatric Dependents of Retirees as follows:

Examination	
Single lens prescription	(b)(4)
Bifocal or trifocal lens prescription	

- Annual maximum in Benefit Level A of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to (b)(4) consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.
- Annual maximum in Benefit Level B of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to (b)(4) consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.
- Annual maximum in the Retiree Plan of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to (b)(4) consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.
 - The “rates” applicable to the current plan are: (b)(4) per member per month for January 1, 2011 through December 31, 2011.
 - The “rate” applicable to the plan for January 1, 2011 through December 31, 2011, if the annual maximums are increased to \$750,000 is (b)(4) per member per month, which is an increase in cost of (b)(4) per month or (b)(4) percent.
 - “Rate(s)” refers to the premium equivalent cost of the self-funded hospital/medical benefits on a per-active-member-per-month basis.

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 significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation.

Complying with the restricted annual dollar limits, i.e., increasing the annual limit to \$750,000 for the 2011 plan year, would result in a significant decrease in access to benefits for current participants and dependents for the following reasons:

- The estimated additional cost of at least (b)(4) associated with the increase or elimination of the current maximum would not be offset by the ability to obtain

additional employer contributions due to existing collective bargaining agreements and other employer economic constraints.

- Due to the downturn in the economy, the number of hours worked per active member has declined. Therefore, the Fund is receiving less money per member to provide benefits.
- The hourly employer contribution rate of (b)(4) for 2011 would have to increase by (b)(4) to raise the maximum to \$750,000. Obtaining this increase in 2011 is not feasible because collective bargaining agreements are already in place.
- In order to absorb the estimated additional cost of at least (b)(4) associated with the increase or elimination of the current maximum, the Trustees will have to cut or eliminate benefits thereby limiting access to benefits for members due to higher cost sharing requirements.
- Specifically, order to absorb the overall increase in costs of (b)(4) per member per month, the Trustees will have to cut or eliminate benefits thereby limiting access to benefits for members due to higher cost sharing requirements. For example, the prescription drug benefits may be eliminated completely. The other alternative that the Fund may consider is to pass on these additional costs entirely to the members in the form of higher copayments, coinsurance, and deductibles...
- Due to low contributions hours, the Fund is projected to incur a deficit of (b)(4) in calendar year 2011. If the Fund were to absorb an additional (b)(4) expense due to the higher annual limit, the Fund's ability to provide future benefits will be significantly limited.

Pages 7 through 16 redacted for the following reasons:

Exemption 4

From: Keels, Lisa (HHS/OCIIO)
Sent: Friday, December 17, 2010 5:25 PM
To: Habit, Sandra (HHS/OCIIO)
Subject: FW: Application for 2011 Waiver of Plans Annual Benefit Limits

Attachments: doc20101217125740.pdf

FYI, Sandy. This is an application for Bricklayers Insurance and Welfare fund of New York. It is not one of my applications. Erica said it belongs to Veronica Morales (in OCS), and we have contacted Veronica about it. I'm forwarding this email to you anyway.

Thanks!

Lisa

-----Original Message-----

From: Sandi Justus [mailto:sandi@bricklayers1ny.org]
Sent: Friday, December 17, 2010 1:02 PM
To: Keels, Lisa (HHS/OCIIO); OCIIO Oversight
Cc: 'Ressegue, Robert'
Subject: FW: Application for 2011 Waiver of Plans Annual Benefit Limits

Dear Ms. Keels;

The attached is in reference to the Bricklayers Insurance and Welfare fund of New York. An application for a 2011 waiver of our Plan's annual benefit limits was sent directly to Mr. James Mayhew via US Postal Service and was postmarked November 24, 2010. To date we have not received a confirmation of its receipt so, for your convenience, we have attached the application to this email with a copy to the HHS Oversight e-mail address. Please let us know if there is any additional information you will need for us to assist in your determination.

Thank you. Ms. Sandra Justus, Office Manager

This an AUTOMATED EMAIL being sent to you from BRICKLAYERS.

***** DO NOT REPLY TO THIS MESSAGE *****

From: Sandi Justus [sandi@bricklayers1ny.org]

Sent: Friday, December 31, 2010 11:09 AM

To: Habit, Sandra (HHS/OCIIO)

Subject: RE: Bricklayers Insurance & Welfare Fund Approval Letter for a Waiver of the Annual Limits Requirements 12-30-2010

Dear Ms. Habit: This will confirm receipt of your approval letter. Thank you and Happy New Year. Sandra Justus, Office Mgr. Bricklayers Insurance & Welfare Fund.

From: Habit, Sandra (HHS/OCIIO) [mailto:Sandra.Habit@hhs.gov]

Sent: Thursday, December 30, 2010 3:27 PM

To: 'sandi@bricklayers1ny.org'

Subject: Bricklayers Insurance & Welfare Fund Approval Letter for a Waiver of the Annual Limits Requirements 12-30-2010

Importance: High

Good Afternoon,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section 2711 for **Bricklayers Insurance & Welfare Fund**. HHS has reviewed your application and made its determination. Please see the attached letter. The following plans have been approved:

Actives Plan A

BRICK I&W:000009

Actives Plan B
Actives Plan C
Retiress

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

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

Sincerely

Sandy Habit
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
301-492-4175
Sandra.Habit@hhs.gov

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosures may result in prosecution to the full extent of the law.

BRICK I&W:000010

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 significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation.

Complying with the restricted annual dollar limits, i.e., increasing the annual limit to \$750,000 for the 2011 plan year, would result in a significant decrease in access to benefits for current participants and dependents for the following reasons:

- The estimated additional cost of at least (b)(4) associated with the increase or elimination of the current maximum w (b)(4) offset by the ability to obtain additional employer contributions due to existing collective bargaining agreements and other employer economic constraints.
- Due to the downturn in the economy, the number of hours worked per active member has declined. Therefore, the Fund is receiving less money per member to provide benefits.
- The hourly employer contribution rate of (b)(4) for 2011 would have to increase by (b)(4) to raise the maximum t (b)(4) 000. Obtaining this increase in 2011 use collective bargaining agreements are already in place.
- In order to absorb the estimated additional cost of at least (b)(4) associated with the increase or elimination of the current maximum, the (b)(4) I have to cut or eliminate benefits thereby limiting access to benefits for members due to higher cost sharing requirements.
- Specifically, order to absorb the overall increase in costs of (b)(4) per member per month, the Trustees will have to cut or eliminate benefits t (b)(4) miting access to benefits for members due to higher cost sharing requirements. For example, the prescription drug benefits may be eliminated completely. The other alternative that the Fund may consider is to pass on these additional costs entirely to the members in the form of higher copayments, coinsurance, and deductibles...

Due to low contributions hours, the Fund is projected to incu (b)(4) in calendar year 2011. If the Fund were to absorb an additional (b)(4) to the higher annual limit, the Fund's ability to provide future bene (b)(4) gnificantly limited.

From: Habit, Sandra (HHS/OCIIO)

Sent: Thursday, December 30, 2010 3:27 PM

To: 'sandi@bricklayers1ny.org'

Subject: Bricklayers Insurance & Welfare Fund Approval Letter for a Waiver of the Annual Limits Requirements 12-30-2010

Importance: High

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 **Bricklayers Insurance & Welfare Fund**. HHS has reviewed your application and made its determination. Please see the attached letter. The following plans have been approved:

Actives Plan A
Actives Plan B

BRICK I&W:000012

Actives
Plan C

Retiress

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

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

Sincerely

Sandy Habit
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
301-492-4175
Sandra.Habit@hhs.gov

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW: This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosures may result in prosecution to the full extent of the law.

BRICK I&W:000013

From: Morales, Veronica (HHS/OCIIO)
Sent: Monday, December 20, 2010 12:34 PM
To: 'sandi@bricklayers1ny.org'
Cc: Sheer, Jennifer (HHS/OCIIO); Keels, Lisa (HHS/OCIIO)
Subject: Bricklayers Insurance & Welfare Fund, Waiver Application
Attachments: Waiver Application Form.xls

Dear Lisa:

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, [attached to the email] [and 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 the plan was created pursuant to the Taft-Hartley Act. If yes:
 - Please confirm the Collective Bargaining Agreement was ratified prior to October 3, 2008.
 - Please provide the date for which the Collective Bargaining Agreement will expire.

In order to complete your application, please provide this information by 5:00 pm, December 21, 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.

Veronica W. Morales, J.D.
U.S. Department of Health & Human Services
Office of Consumer Information & Insurance Oversight
Office of Consumer Support
Phone# (301) 492-4249
Email: veronica.morales@hhs.gov

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

BRICK I&W:000014

ANNUAL LIMIT WAIVER APPLICATION 2010

Current Essential Benefits Annual Limits (Annual Limit for Each Essential Benefit)

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)	Current Essential Benefits Annual Limits (Annual Limit for Each Essential Benefit)																							
																	Ambulatory	Emergency	Hospitalization	Laboratory	Pediatric	Maternity/Newborn	Mental Health/Substance Abuse	Rehabilitative/Devices	Preventive/Wellness	Prescription														
Bricklayers Insurance & Welfare Fund	Actives Plan A	New York	NY	01/01/2011	Sandra Justus	60-05 Woodhaven Blvd	Rego Park	NY	11374	1-718-459-5800	sandi@bricklayers1ny.org	Limited Benefit	Yes	Group																										
Bricklayers Insurance & Welfare Fund	Actives Plan B	New York	NY	01/01/2011	Sandra Justus	60-05 Woodhaven Blvd	Rego Park	NY	11374	1-718-459-58--	sandi@bricklayers1ny.org	Limited Benefit	Yes	Group																									(b)(4)	
Bricklayers Insurance & Welfare Fund	Actives Plan C	New York	NY	01/01/2011	Sandra Justus	60-05 Woodhaven Blvd	Rego Park	NY	11374	1-718-459-5800	sandi@bricklayers1ny.org	Limited Benefit	Yes	Group																									(b)(4)	
Bricklayers Insurance & Welfare Fund	Retirees	New York	NY	01/01/2011	Sandra Justus	60-05 Woodhaven Blvd	Rego Park	NY	11374	1-718-459-5800	sandi@bricklayers1ny.org	Limited Benefit	Yes	Group																										

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

Plan Deductible	Office Visit Copays/Coinsurance	Hospital Inpatient Copay/Coinsurance	Emergency Room Copay/Coinsurance	Rx Copay/Coninsurance	Individual/Employee Tier*	Current Monthly Premium Rates or Premium Equivalent Rates (in dollars):			Renewal Monthly Premium Rates or Premium Equivalent Rates if Waiver Granted (in dollars)*			Projected Rate Increase that would result from compliance with \$750,000 Annual Limit Restriction (in dollars) (Average Premium by Individual)*			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 Column AQ)	Decrease in Access to Benefits that would result from compliance with \$750,000 Annual Limit Restriction (describe briefly in cell or in a	Plan Administrator/CEO of Health Insurance Issuer Name	Title of Individual Providing Attestation
						Employee contribution (if applicable)	Employer contribution (if applicable)	Total	Employee contribution (if applicable)	Employer contribution (if applicable)	Total	Employee contribution (if applicable)	Employer contribution (if applicable)	Total				
					Employee									Please see Attachment	Santo Lanzafame	Plan Administrator		
					Employee	(b)(4)							Please see Attachment	Santo Lanzafame	Plan Administrator			
					Employee									Please see Attachment	Santo Lanzafame	Plan Administrator		
					Employee									Please see Attachment	Santo Lanzafame	Plan Administrator		
					Employee									Please see Attachment	Santo Lanzafame	Plan Administrator		
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					Employee									Please see Attachment	Santo Lanzafame	Plan Administrator		
					Employee									Please see Attachment	Santo Lanzafame	Plan Administrator		
					Employee									Please see Attachment	Santo Lanzafame	Plan Administrator		

(b)(4)

(b)(4)

* 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).

11/29/10

Bricklayers Fringe Benefit Funds Office

BAC Local Union #1, NY
66-05 Woodhaven Boulevard
Rego Park, NY 11374
Phone: (718) 459-5800

Jeremiah Sullivan
Administrator

November 23, 2010

James Mayhew
HHS Office of Consumer Information and Insurance Oversight, Office of Oversight
Room 737-F-04
200 Independence Ave. SW
Washington, DC 20201

Dear Mr. Mayhew:

Please accept this application from the Bricklayers Insurance and Welfare Fund for a waiver from the restricted annual limits set forth in the Interim Final Regulations for the plan year January 1, 2011 to December 31, 2011. The plan was offered prior to September 23, 2010. This letter and its attachments include the following information as required by OCIO Sub-Regulatory Guidance 2010-1: Process for Obtaining Waivers of the Annual Limits Requirements of PHS Act Section 2711.

The Bricklayers Insurance and Welfare Fund provides hospital, medical, prescription drug, dental, vision, and life benefits. The Fund covers (b)(4) members (actives and retirees) and (b)(4) estimated dependents. In order for Active Employees to attain and maintain eligibility for health benefits in the Fund they must work a minimum number of hours. Based on hours of employment during a Plan Year, the Fund grants Active coverage under one of three levels of benefits, Benefit Levels A, B, or C as follows:

Hours Worked in Benefit Accrual Period	Benefit Level
(b)(4)	Plan A
	Plan B
	Plan C
	None

The Fund also maintains a plan for Retirees. Eligible Retirees maintain coverage for life on a non-contributory basis.

The Fund is self-insured and is administered by a joint board of employer and union trustees and the Fund Office.

The Fund is requesting a waiver of the annual maximums for the following benefits:

➤ Prescription drugs (Actives):

Benefit Level A

Benefit Level B (b)(4)

Benefit Level C

Prescription drugs (Retirees):

Participant Only

Participant and One Dependent (b)(4)

Participant and 2 or more Dependents

- Annual maximum of (b)(4) for Physical Examinations for all Actives, Retirees and their eligible dependents.
- Annual Maximum on Dental Benefits of (b)(4) for eligible pediatric Dependents of Actives under benefit level A, and (b)(4) for eligible pediatric Dependents of Actives under benefit level B and Retirees.
- Semi-Annual Maximum on Optical Benefits for eligible pediatric Dependents of Actives as follows:

	Benefit Levels A and B	Benefit Level C
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Examination		
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Single lens prescription		
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Bifocal or trifocal lens prescription	(b)(4)	
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Frames		
--------	--	--

- Semi-Annual Maximum on Optical Benefits for eligible pediatric Dependents of Retirees as follows:

Examination		
-------------	--	--

Single lens prescription	(b)(4)	
--------------------------	--------	--

Bifocal or trifocal lens prescription		
---------------------------------------	--	--

- Annual maximum in Benefit Level A of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to six consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.
- Annual maximum in Benefit Level B of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to four consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.
- Annual maximum in Benefit Level C and the Retiree Group of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to two consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.

Attestation

I hereby attest to the following: I am the plan administrator of the Bricklayers Insurance and Welfare Fund. I certify that (1) the plan was in force prior to September 23, 2010 and (2) 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 a significant increase in premiums paid by the plan's participants and covered dependents.

Jeremiah Sullivan 11-23-10
Jeremiah Sullivan, Administrator Date

Attachment A-Annual Dollar Limit Waiver Certification

Name of Plan: Bricklayers Insurance and Welfare Fund

Plan Year: January 1, 2011 to December 31, 2011

The Segal Company has reviewed the Plan's request for a Waiver of the Restricted Annual Dollar Limits in the Affordable Care Act, and has the following findings.

1. The terms of the plan or policy form(s) for which a waiver is sought.

- See Attachment B
- The employers currently pay (b)(4) per hour into the fund to cover all benefits offered to the members.

2. The number of individuals covered by the plan submitted.

- There are approximately (b)(4) covered active participants and retirees and (b)(4) estimated dependents

3. The annual limit(s) and rates applicable to the plan or policy form(s) submitted.

- The waiver is being sought for the annual limits on the medical benefits and the prescription drug benefits as follows:

- Prescription drugs (Actives):

- Benefit Level A
- Benefit level B (b)(4)
- Benefit Level C

- Prescription drugs (Retirees):

- Participant Only
- Participant and One Dependent (b)(4)
- Participant and 2 or more Dependents

➤ Annual maximum of (b)(4) for Physical Examinations for all Actives, Retirees and their eligible dependents.

➤ Annual Maximum on Dental Benefits of (b)(4) for eligible pediatric Dependents of Actives under benefit level A, and (b)(4) for eligible pediatric Dependents of Actives under benefit level B and Retirees.

➤ Semi-Annual Maximum on Optical Benefits for eligible pediatric Dependents of Actives as follows:

Benefit Levels Benefit Level C
A and B

Examination	
Single lens prescription	(b)(4)
Bifocal or trifocal lens prescription	
Frames	

- Semi-Annual Maximum on Optical Benefits for eligible pediatric Dependents of Retirees as follows:

Examination	
Single lens prescription	(b)(4)
Bifocal or trifocal lens prescription	

- Annual maximum in Benefit Level A of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to six consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.
- Annual maximum in Benefit Level B of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to four consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.
- Annual maximum in the Retiree Plan of up to (b)(4) office visits per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit; and up to two consultations per family, per benefit period, with a scheduled maximum reimbursement of (b)(4) per visit.

- The "rates" applicable to the current plan are: (b)(4) per member per month for January 1, 2011 through December 31, 2011.
- The "rate" applicable to the plan for January 1, 2011 through December 31, 2011, if the annual maximums are increased to \$750,000 is (b)(4) per member per month, which is an increase in cost of (b)(4) per month or (b)(4) percent.
- "Rate(s)" refers to the premium equivalent cost of the self-funded hospital/medical benefits on a per-active-member-per-month basis.

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 significant increase in premiums paid by those covered by such plans or policies, along with any supporting documentation.

Complying with the restricted annual dollar limits, i.e., increasing the annual limit to \$750,000 for the 2011 plan year, would result in a significant decrease in access to benefits for current participants and dependents for the following reasons:

- The estimated additional cost of at least (b)(4) associated with the increase or elimination of the current maximum would not be offset by the ability to obtain

additional employer contributions due to existing collective bargaining agreements and other employer economic constraints.

- Due to the downturn in the economy, the number of hours worked per active member has declined. Therefore, the Fund is receiving less money per member to provide benefits.
- The hourly employer contribution rate of (b)(4) for 2011 would have to increase by (b)(4) to raise the maximum to \$750,000. Obtaining this increase in 2011 is not feasible because collective bargaining agreements are already in place.
- In order to absorb the estimated additional cost of at least (b)(4) associated with the increase or elimination of the current maximum, the Trustees will have to cut or eliminate benefits thereby limiting access to benefits for members due to higher cost sharing requirements.
- Specifically, order to absorb the overall increase in costs of (b)(4) per member per month, the Trustees will have to cut or eliminate benefits thereby limiting access to benefits for members due to higher cost sharing requirements. For example, the prescription drug benefits may be eliminated completely. The other alternative that the Fund may consider is to pass on these additional costs entirely to the members in the form of higher copayments, coinsurance, and deductibles...
- Due to low contributions hours, the Fund is projected to incur a deficit of (b)(4) in calendar year 2011. If the Fund were to absorb an additional (b)(4) expense due to the higher annual limit, the Fund's ability to provide future benefits will be significantly limited.

Attachment B

SUMMARY OF BENEFITS (ACTIVES)

Your benefits are provided either directly from the Fund or through a contract the Fund holds with Empire HealthChoice.

Benefits paid by the Fund through Empire HealthChoice:

Hospital Benefits for Non-Occupational Disabilities, for Participants and Dependents:

Up to (b)(4) paid-in-full days in semi-private accommodations provided by Empire HealthChoice. See the Hospital section of this SPD for a summary of benefits. Refer to the attached Empire BlueCross BlueShield booklet for a complete description of your benefits.

Maternity Hospital Benefits - for Female Participants and Female Dependents:

Provided by Empire HealthChoice. See the Hospital section of this SPD for a summary of benefits. Refer to the attached Empire BlueCross BlueShield booklet for a complete description of your benefits.

Benefits paid directly by the Fund:

Anesthesia Benefits - for Participants and Dependents:

Up to (b)(4) will be paid for anesthesia charges when Surgical Benefits are payable by the Fund.

Annual Physical Examination - for Participants and Dependents:

Up to (b)(4) will be paid toward the cost of an annual physical examination.

Assistant Surgeon Benefits - for Participants and Dependents:

Up to (b)(4) will be paid for one or more operations performed as the result of any one accident or sickness.

Death Benefits - for Participants Only:

Up to (b)(4) will be paid in the event of death from any cause.

Dental Care Benefits - for Participants and Dependents:

Up to scheduled allowances

Optical Care Benefits - for Participants and Dependents:

Up to scheduled allowances for biannual exam and lenses.

Physician Visits - for Participants and Dependents:

Up to (b)(4) will be paid toward the cost of a physician visit.

Post-Surgical Visits Benefits - for Participants and Dependents:

Up to (b)(4) will be paid for post-operative visits by the surgeon while you are still hospitalized on account of an operation.

Prescription Drug Benefits - for Participants and Dependents:

Up to annual maximum benefits will be paid in accordance with the Drug Schedule.

Benefit Level A

Benefit Level B

(b)(4)

Benefit Level C

Special Benefits - for Participants and Dependents:

Up to (b)(4) per family unit will be paid during any calendar year.

Surgical Benefits - for Participants and Dependents:

Up to (b)(4) will be paid for one or more operations performed as the result of any one accident or sickness.

X-ray and Laboratory Expense Benefits - for Participants and Dependents:

Up to (b)(4) per procedure, in accordance with a Schedule of X-Ray and Laboratory procedures, will be paid for x-ray and laboratory examinations.

Ambulance Service Payment:

Equal to (b)(4) of usual, customary and reasonable charges will be provided for local licensed ambulance service, to and from the nearest hospital with medical facilities adequate for the subscriber's treatment, in connection with an in-patient admission or emergency out-patient care.

BENEFITS PAID DIRECTLY BY THE FUND

DENTAL CARE BENEFITS

If you or an eligible dependent requires dental care, you may be eligible for Dental Care Benefits. Participants covered under Benefit Levels A or B and their eligible dependents may receive dental services from a Self-Insured Dental Services/Metrodent Network provider or a provider of your choice. For a complete description of the Metrodent PPO and/or the location of a Metrodent National Doctor, please contact the Fund Office or S.I.D.S./Metrodent at 516-396-5500 or 718-204-7172.

When you need to file a claim, notify the Fund Office or your local Union Office and you will be sent the required Dental Care claim form. All claims forms must be completed and returned to Metrodent within (b)(4) days after all dental work is completed.

Dental Care Benefits will be paid in accordance with the Self-Insured Dental Services/Metrodent Schedule of Dental Care Benefits. However, benefits will not be paid in excess of the amount actually charged, nor will benefits be paid if the patient does not incur an actual charge by a licensed dentist, nor will reimbursement be made for any amounts for which you are not legally liable in the absence of coverage by this Fund. Contact the Fund Office or Metrodent in order to determine if a specific procedure is covered and for the Plan's allowance.

There are no Dental Care Benefits payable under Benefit Level C, but Level C participants may share in the discounted prices offered through the Self-Insured Dental Services/Metrodent Network when they utilize the services of a Metrodent Network provider.

The overall maximum amount payable for Dental Care Benefits for a covered individual during a full year Benefit Period is (b)(4) for Benefit Level A, and (b)(4) for Benefit Level B.

Note: Oral Surgery

Claims for oral surgery that requires hospitalization are covered by the general surgical schedule. There will not be additional payments made under the Dental Benefit. If you must be hospitalized for oral surgery, contact the Fund Office for the surgical allowances. Also note that the surgery must be performed by a legally qualified medical doctor, physician or surgeon.

OPTICAL CARE BENEFITS

Optical benefits are provided for participants and their eligible dependents covered under Benefit Levels A, B, and C.

You and your dependents may go to a licensed Optometrist or Ophthalmologist of your choice for an examination once every year. Optical Prescription benefits are covered only if at least 1 calendar year has elapsed since the last reimbursement from this Fund for optical prescriptions.

No Optical Care Benefits will be paid for accidents or illnesses covered by Workers' Compensation legislation or for treatments received in hospitals or clinics operated by the federal government, a state government or by the Veteran's Administration.

You will be reimbursed for Optical care according to the schedule shown below for covered optical expenses you submit to the Fund Office:

SCHEDULE OF OPTICAL CARE BENEFITS

	Benefit levels A and B	Benefit Levels C
Examination		
Single lens prescription		(b)(4)
Bifocal or trifocal lens prescription		
Frames		

Participants covered under Benefit Levels A or B may also receive benefits from a Vision Screening provider by requesting a Vision Screening Coupon from the Fund Office. This coupon entitles the Bricklayer or his eligible dependents to a paid in full eye exam, lenses and frames at a participating vision care center. However, only select lens frame models are provided at no cost. Each participant and dependent may use one coupon per year. Please note that participants covered under Benefit Levels C are not eligible for the coupon program.

PRESCRIPTION DRUG BENEFITS

Prescription drug benefits are provided under the ULLICARE Rx prescription card program for participants covered under Benefit Levels A, B or C and their eligible dependents.

If a licensed medical doctor, dentist or osteopathic physician prescribes drugs for you or an eligible dependent, you may be eligible for Prescription Drug Benefits.

Benefits under this section are limited to the following Prescription Drugs only:

1. Prescriptions which require compounding;
2. Prescriptions for Legend Drugs (drugs which cannot be dispensed without a prescription);
3. Insulin on prescription.

The Plan will pay for insulin but will not pay for companion implements such as hypodermic syringes, needles, etc. The Plan will not cover any drugs, vitamins, diet supplements, etc. which can be purchased without a prescription. The fact that a physician may give you a written prescription for items of this type will make no difference.

The combined maximum prescription drug benefit payable per family for a Benefit Program is as follows:

Benefit Level A	
Benefit Level B	(b)(4)
Benefit Level C	

ULLICARE provides a nationwide network of retail pharmacies that will fill your prescriptions as a *participating* pharmacy. You receive prescription drug coverage when you go to a pharmacy that is not participating in this network, but you may have to make a higher out-of-pocket payment than if you use a participating pharmacy. Your identification card and your

prescription are all you need to obtain prescription service at a participating pharmacy. All participating pharmacies have the necessary claim forms. If you obtain prescription drugs at a non-participating pharmacy, you will have to pay the charge, then complete a claim form to receive reimbursement. You may obtain a claim form from the Fund Office. Complete a claim form for each prescription and attach the receipt and mail it to ULLICARE Rx/Medco, PO Box 69, Lees Summit, MO 64063-0009.

In addition, if you are covered under another prescription plan you may submit your co-payments for reimbursement.

Immunizations

The Fund will cover immunizations as follows:

Benefit Level A – Up to (b)(4) immunizations per benefit period, per family, at maximum of (b)(4) per immunization

Benefit Level B – Up to (b)(4) immunizations per benefit period, per family, at maximum of (b)(4) per immunization

Benefit Level C – Up to (b)(4) immunizations per benefit period, per family, at maximum of (b)(4) per immunization

ANNUAL PHYSICAL EXAMINATION

For participants covered under Benefit Levels A or B and their eligible dependents the Fund will pay (b)(4) towards the cost of an annual physical examination. This includes all necessary diagnostic x-ray and laboratory tests which will be paid according to Plan Schedules.

A participant or eligible dependent may select a legally qualified medical diagnostic facility of his own choice and, upon presentation of a claim form, the Fund will reimburse the participant up to the amount of benefit set forth in the Plan Schedule. There are no benefits payable under Benefit Level C for an annual physical examination.

You may also use the services of PMEG for your physicals. In order to make an appointment for an Annual Physical, contact PMEG at 800-811-7364.

SPECIAL BENEFITS

Special Benefits are available for participants covered under Benefit Level A and B and their eligible dependents. Reimbursement will be made for the Special Benefits set forth below.

There are no special benefits payable under Benefit Level C.

The total benefits payable for Special Benefits, for any one accident or illness, shall not exceed (b)(4). The maximum reimbursement is (b)(4) per family unit.

Special Benefits include:

- The cost of a Physician authorized hearing aid device.
- The cost of replacement of blood and its transfusion when not covered by Empire HealthChoice. No benefits are payable for the replacement of blood, if blood has been donated in exchange for payment.

Ambulance service

Payment equal to (b)(4) of usual, customary and reasonable charges will be provided for local licensed ambulance service, to and from the nearest hospital with medical facilities adequate for the subscriber's treatment, in connection with an in-patient admission or emergency out-patient care.

Special Benefits - for Retirees and Dependents:

The maximum total benefit payable for Special benefits for any one illness or accident is (b)(4).

Surgical Benefits - for Retirees and Dependents:

Up to (b)(4) will be paid for an operation performed as the result of any one accident or sickness.

X-Ray and Laboratory Expense Benefits - for Retirees and Dependents:

Benefits in accordance with a Schedule of X-Ray and Laboratory procedures will be paid for x-ray and laboratory examinations.

Hospital Benefits for those not eligible for Medicare:

For complete details about Hospital benefits see the attached Empire BlueCross BlueShield booklet.

DENTAL CARE BENEFITS

Dental benefits are provided for Retired Participants and their Eligible Dependents by a Self-Insured Dental Services/Metrodent Network provider or a provider of your choice. For a complete description of the Metrodent PPO and/or the location of a Metrodent National Doctor, please contact the Fund Office or S.I.D.S./Metrodent at 516-396-5500 or 718-204-7172.

Dental Care Benefits will be paid in accordance with the Self-Insured Dental Services/Metrodent Schedule of Dental Care Benefits. However, benefits will not be paid in excess of the amount actually charged, nor will benefits be paid if the patient does not incur an actual charge by a licensed dentist, nor will reimbursement be made for any amounts for which you are not legally liable in the absence of coverage by this Fund. Contact the Fund Office or Metrodent in order to determine if a specific procedure is covered and for the Plan's allowance.

Note: Oral Surgery

In those cases of oral surgery which require hospitalization, and which are covered by the general surgical schedule, there are no additional payments made under the Self-Insured Dental Services/Metrodent Network benefit (e.g.: cysts, fractured jaws, etc.). If you must be hospitalized for oral surgery, contact the Fund Office for the surgical allowances. Also note that the surgery must be performed by a legally qualified medical doctor, physician or surgeon.

OPTICAL CARE BENEFITS

If you or an eligible dependent requires optical care, you may be eligible for Optical Care Benefits. You and your dependents may go to a licensed Optometrist or Ophthalmologist of your choice for an examination once every 2 years. Optical prescription benefits are covered only if at least 2 calendar years have elapsed since the last reimbursement from this Fund for optical prescriptions.

No Optical Care Benefits will be paid for accidents or illnesses covered as per Workers' Compensation legislation or for treatments received in hospitals or clinics operated by the federal government, a state government or by the Veteran's Administration.

Optical Care Benefits are provided to you in one of two ways.

(1) you will be reimbursed according to the schedule shown below for any covered optical expense you submit to the Fund Office.

SCHEDULE OF OPTICAL CARE BENEFITS

Examination

Single lens prescription

(b)(4)

Bifocal or trifocal lens prescription

(2) you may request an optical coupon from the fund office. This coupon entitles you or an eligible dependent to a free eye exam, glasses and frames at a participating optical care center. However, only certain lens frame models are provided at no cost. You and each of your dependents may use one coupon every two years. These benefits are provided by a Vision

and Chiropractic office visits. These visits will count against the maximum number of office visits allowed in your eligible plan.

Consultations

The Retiree Plan provides up to (b)(4) consultations per family, per benefit period with a scheduled maximum reimbursement of (b)(4) per visit.

From: Morales, Veronica (HHS/OCIO)
Sent: Wednesday, December 22, 2010 5:01 PM
To: 'Sandi Justus'
Cc: Sheer, Jennifer (HHS/OCIO)
Subject: RE: Bricklayers Insurance & Welfare Fund, Waiver Application

Dear Ms. Justus:

Thank you for your information. Your application is now complete and you should receive a determination of your application within 30 days.

Thank you.

Veronica W. Morales, J.D.
U.S. Department of Health & Human Services
Office of Consumer Information & Insurance Oversight
Office of Consumer Support
Phone# (301) 492-4249
Email: veronica.morales@hhs.gov

INFORMATION NOT RELEASABLE TO THE PUBLIC UNLESS AUTHORIZED BY LAW:

This information has not been publicly disclosed and may be privileged and confidential. It is for internal government use only and must not be disseminated, distributed, or copied to persons not authorized to receive the information. Unauthorized disclosure may result in prosecution to the full extent of the law.

From: Sandi Justus [<mailto:sandi@bricklayers1ny.org>]
Sent: Tuesday, December 21, 2010 12:44 PM
To: Morales, Veronica (HHS/OCIO)
Cc: Keels, Lisa (HHS/OCIO); 'local1'; Sandra Justus
Subject: FW: Bricklayers Insurance & Welfare Fund, Waiver Application

Dear Ms. Morales: Attached is the Bricklayers Insurance & Welfare Fund Waiver Application Attachment DOC (43 KB) and the Bricklayers Waiver Application Form 2010. Please note that the answers to your questions are completed below in blue. If you need further information please do not hesitate to contact me at (718)459-5800. Thank you for your consideration. Sandra Justus, Office Manager.

From: Morales, Veronica (HHS/OCIO) [<mailto:Veronica.Morales@hhs.gov>]
Sent: Monday, December 20, 2010 12:34 PM
To: 'sandi@bricklayers1ny.org'
Cc: Sheer, Jennifer (HHS/OCIO); Keels, Lisa (HHS/OCIO)
Subject: Bricklayers Insurance & Welfare Fund, Waiver Application

Dear Lisa:

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, [attached to the email] [and 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

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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?

Yes, the Plan was in existence prior to March 23, 2010 and is in compliance with the grandfathering provisions, pursuant to 45 CFR 147.140.

- Confirm whether the plan was created pursuant to the Taft-Hartley Act. If yes:
 - Please confirm the Collective Bargaining Agreement was ratified prior to October 3, 2008.

Yes, the Plan was created pursuant to the Taft-Hartley Act and the current Collective Bargaining Agreement was ratified as of July 1, 2008.

- Please provide the date for which the Collective Bargaining Agreement will expire.

The current Collective Bargaining will expire as of June 30, 2011.

In order to complete your application, please provide this information by 5:00 pm, December 21, 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.

Veronica W. Morales, J.D.
U.S. Department of Health & Human Services
Office of Consumer Information & Insurance Oversight
Office of Consumer Support
Phone# (301) 492-4249
Email: veronica.morales@hhs.gov

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Thank you.

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From: Morales, Veronica (HHS/OCIO)
Sent: Monday, December 20, 2010 2:46 PM
To: 'Sandi Justus'
Cc: Sheer, Jennifer (HHS/OCIO)
Subject: RE: Bricklayers Insurance & Welfare Fund, Waiver Application

Ms. Justus,

Please note that the sooner we get your completed waiver application, the sooner we will be able to process it.

As per my previous email, "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."

I look forward to receiving your completed application.

Should you have any questions, please feel free to contact me via phone or email.

Regards,

Veronica W. Morales, J.D.
U.S. Department of Health & Human Services
Office of Consumer Information & Insurance Oversight
Office of Consumer Support
Phone# (301) 492-4249
Email: veronica.morales@hhs.gov

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From: Sandi Justus [<mailto:sandi@bricklayers1ny.org>]
Sent: Monday, December 20, 2010 1:32 PM
To: Morales, Veronica (HHS/OCIO)
Cc: 'Ressegue, Robert'
Subject: RE: Bricklayers Insurance & Welfare Fund, Waiver Application

Dear Ms. Morales: my name is Sandra Justus and I am the Office Manager for the Bricklayers Insurance & Welfare Plan. I have just received your email requesting the completion of the waiver application. Would it be at all possible to get an extension beyond the 12/21/10 5pm deadline ? Thank you for your consideration to this request. I await your reply.

From: Morales, Veronica (HHS/OCIO) [<mailto:Veronica.Morales@hhs.gov>]
Sent: Monday, December 20, 2010 12:34 PM
To: 'sandi@bricklayers1ny.org'
Cc: Sheer, Jennifer (HHS/OCIO); Keels, Lisa (HHS/OCIO)
Subject: Bricklayers Insurance & Welfare Fund, Waiver Application

Dear Lisa:

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:

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- I. Please complete the entire annual limits spreadsheet, [attached to the email] [and 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 the plan was created pursuant to the Taft-Hartley Act. If yes:
 - Please confirm the Collective Bargaining Agreement was ratified prior to October 3, 2008.

 - Please provide the date for which the Collective Bargaining Agreement will expire.

In order to complete your application, please provide this information by 5:00 pm, December 21, 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.

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From: Morales, Veronica (HHS/OCIIO)
Sent: Tuesday, December 21, 2010 2:06 PM
To: Sheer, Jennifer (HHS/OCIIO)
Subject: FW: Bricklayers Insurance & Welfare Fund, Waiver Application
Attachments: Bricklayers 1 Waiver Application Form Attachment.DOC; Bricklayers 1 Waiver Application Form 2010.xls.XLS

Veronica W. Morales, J.D.
U.S. Department of Health & Human Services
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Sent: Tuesday, December 21, 2010 12:44 PM
To: Morales, Veronica (HHS/OCIIO)
Cc: Keels, Lisa (HHS/OCIIO); 'local1'; Sandra Justus
Subject: FW: Bricklayers Insurance & Welfare Fund, Waiver Application

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From: Morales, Veronica (HHS/OCIIO) [\[mailto:Veronica.Morales@hhs.gov\]](mailto:Veronica.Morales@hhs.gov)
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Cc: Sheer, Jennifer (HHS/OCIIO); Keels, Lisa (HHS/OCIIO)
Subject: Bricklayers Insurance & Welfare Fund, Waiver Application

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- I. Please complete the entire annual limits spreadsheet, [attached to the email] [and 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

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grandfathering provisions, pursuant to 45 CFR 147.140?

Yes, the Plan was in existence prior to March 23, 2010 and is in compliance with the grandfathering provisions, pursuant to 45 CFR 147.140.

- Confirm whether the plan was created pursuant to the Taft-Hartley Act. If yes:
 - Please confirm the Collective Bargaining Agreement was ratified prior to October 3, 2008.

Yes, the Plan was created pursuant to the Taft-Hartley Act and the current Collective Bargaining Agreement was ratified as of July 1, 2008.

- Please provide the date for which the Collective Bargaining Agreement will expire.

The current Collective Bargaining will expire as of June 30, 2011.

In order to complete your application, please provide this information by 5:00 pm, December 21, 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.

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Thank you.



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.