From: Vincent F. O'Hara [v.ohara@hohlaw.com]
Sent: Wednesday, November 10, 2010 10:30 AM
To: HHS HealthInsurance (HHS)
Cc: 'Gloria Johnson'; MORETTIV@hpd.nyc.gov; 'Aguiar, Sandra'; 'Timothy Klimpl'
Subject: Waiver

Attachments: CSBA SBF Annual Limits Waiver Application.pdf; Letter for Waiver Application for CSBA SBF.pdf

Dear HHS:

Enclosed please find a letter dated November 9,2010 and application for Waiver from the Civil Service Bar Association Security Benefit Fund for your attention.

Very truly yours,

Vincent F. O'Hara
Holm & O'Hara LLP
3 West 35th Street- 9th Floor
New York, New York 10001
Tel (212)682-2280, Fax (212)682-2153
www.hohlaw.com

CIVIL SERVICE BAR ASSOCIATION SECURITY BENEFIT FUND

APPLICATION FOR WAIVER OF THE ANNUAL LIMITS REQUIREMENT OF PUBLIC HEALTH SERVICE ACT SECTION 2711

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

   Please see attached "Your Plan at a Glance" and Summary Plan Description.

2. **The number of individuals covered by the plan or policy form(s) submitted.**

   Active Members: (b)(4) Total: (b)(4)

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

   Prescription Drug Plan: (b)(4) maximum payment per family per calendar year. Co-payments between (b)(4) and (b)(4) percent.

   Dental Program: $(b)(4) maximum payment per person per calendar year. Deductible of $(b)(4) per person and $(b)(4) per family per calendar year.

   Optical Benefit: For use of non-participating provider, $(b)(4) maximum reimbursement per person per calendar year.

   Life-Style Benefit: $(b)(4) maximum reimbursement per family per year for prescriptions for sexual dysfunction drugs.

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.**

Governmental Plan Offering Limited Supplemental Benefits

The Civil Service Bar Association Security Benefit Fund (the "Plan") is a self-funded limited benefit plan established by a collective bargaining agreement ("CBA") between the City of New York (the "City") and the Civil Service Bar Association. The Plan is funded through contributions made by the City for covered members based on an annual rate per participant, paid on 28-day cycles at the rate of $(b)(4). The CBA that governs the Plan is currently expired. Thus, the contribution rate will continue to be in force until a new CBA is reached. In many instances in bargaining with New York City, no new CBA is reached for two to three years after a CBA's expiration.

The Plan provides supplemental health and other benefits to full-time and part-time members and their covered dependents that supplement members' and dependents' major medical coverage, which is provided by the City of New York. The supplemental benefits provided by the Plan include Dental, Prescription Drug, Optical, Life-Style, Newborn, 24-Hour Nurse Helpline, Hearing Aid, Short Term Disability, Long Term Disability and Life Insurance.

Financial Condition of the Plan

In 2009, the Plan paid out $ (b)(4) in disbursements, including benefits and administrative costs. In the same year, the Plan had total receipts of $ (b)(4) including $ (b)(4) in employer contributions. Thus, the Plan had a difference of $ (b)(4) between its total receipts and disbursements for 2009. Since 2006, (b)(4) members have reached annual limits under the Plan, including (b)(4) for 2009 and 2010 year to date. Because the Plan is funded through predetermined contributions from the City under the terms of a collective bargaining agreement, an increase in the Plan's benefit obligations may quickly force the Plan into deficit spending and jeopardize its future solvency. Additionally, the restricted annual limits for each participant and beneficiary set forth in the interim final regulations approach and within (b)(4) years exceed the Plan's net assets available for benefits. If only one participant or beneficiary makes a claim that reaches the annual limit of $750,000 during the 2011 Plan Year, this claim would represent (b)(4) % of the Plan's 2009 net assets available for benefits over benefit obligations. Thus, only (b)(4) such claims would effectively render the Plan insolvent.

5. **An attestation, signed by the plan administrator or Chief Executive Officer of the issuer of 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, Carol Henrich-Herrera, the administrator for the Civil Service Bar Association Security Benefit Fund certify that: 1) 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 plan or policies.

Carol Henrich-Herrera
Administrator

Sworn to me on this 9 day
of November, 2010

Michelle M. Mendez
Notary Public

MICHELLE M. MENDEZ
Notary Public, State of New York
No. 01ME6086173
Qualified in Kings County,
Commission Expires 1/13/2011

VINCENT F. O'HARA
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CONNECTICUT OFFICE
73 MAIN STREET
P.O. BOX 215
SHARON, CT 06069
(860) 364-0627

November 9, 2010

Via Email and Certified Mail
RRR #
HHS, Office of Consumer Information and Insurance Oversight
Office of Oversight
Room 737-F-04
200 Independence Ave. SW
Washington, DC 20201

Attn: James Mayhew

Re: Waiver of the Annual Limits Requirement
Civil Service Bar Association Security Benefit Fund
Our File No. 4217

Dear Mr. Mayhew:

Please be advised that the law firm of Holm & O'Hara LLP represents the Civil Service Bar Association Security Benefit Fund (the "Fund"). Enclosed is the Fund's application for a waiver of the Annual Limits Requirement of Public Health Service Act Section 2711.

Please note that the Fund is a New York City collectively-bargained, governmental plan offering limited benefits that are intended to supplement members' and their families' major medical coverage, which is provided by the City of New York. As such, the Fund has annual limits well below the restricted annual limits set forth in the Interim Final Rules and contributions cannot be increased to meet the additional cost of increasing the annual limits. Accordingly, the Fund respectfully requests a waiver of these restricted annual limits.

If you require any additional information in connection with this application, please feel free to contact me at (212) 682-2280, ext. 36. Thank you for your courtesy and cooperation in this matter.

Very truly yours,

Vincent F. O'Hara

VFO/tsk

Enclosures
cc: Trustees

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From: Habit, Sandra (HHS/OCIIO)
Sent: Wednesday, November 17, 2010 3:41 PM
To: v.ohara@hohlaw.com
Subject: Waiver Application - Civil Service Bar Association Security Benefit Fund

Mr. O'Hara,

Thank you for your application for the Waiver of the Annual Limits Requirements of the PHS Act Section 2711. In order to complete your application, please provide the following information regading CSBA SBF:

(The premium amounts is the total cost to the employer and the employee)

	Premium (current level)	Premium (renewal)	Premium (if $750,000 annual limit was applied)	% increase if the $750,000 was implemented
EE				
EE + Child (if applicable or other appropriate tier)				
EE + Spouse (if applicable or other appropriate tier)				
Family (if applicable or other appropriate tier)				

In addition, please provide the effective renewel date of this plan.

Please provide this information by 5:00 pm, November 19, 2010. We look forward to receiving your completed application. Thank you.

Sandy

From: Vincent F. O'Hara [v.ohara@hohlaw.com]
Sent: Friday, November 19, 2010 4:41 PM
To: Habit, Sandra (HHS/OCIIO)
Cc: 'Timothy Klimpl'; 'Aguiar, Sandra'; 'Gloria Johnson'
Subject: Response to Questions Regarding Waiver Application for CSBA SBF

Attachments: Response to Questions Regarding Waiver Application- CSBA SBF.pdf

Dear Ms. Habit:

Enclosed please find a response to your email dated November 17, 2010, requesting information relating to the Civil Service Bar Association Security Benefit Fund's application for Waiver.

Very truly yours,

Vincent F. O'Hara
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New York, New York 10001
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November 19, 2010

Via Email
HHS, Office of Consumer Information and Insurance Oversight
Office of Oversight

Attn: Sandra Habit

Re: Waiver of the PHS Act Section 2711 Annual Limits Requirement
Civil Service Bar Association Security Benefit Fund
Our File No. 4217

Dear Ms. Habit:

As you know, the law firm of Holm & O'Hara LLP represents the Civil Service Bar Association Security Benefit Fund (the "Fund"). In response to your email dated November 17, 2010, please note that the Fund is a governmental plan offering supplemental benefits under a collective bargaining agreement ("CBA") between the City of New York and the Civil Service Bar Association. As such, covered members and their eligible dependents do not pay premiums into the Fund. Instead, the Fund receives contributions made by the City for covered members based on an annual rate per participant, paid on 28-day cycles at the rate of $ (b)(4) . The Fund is self-insured for prescription drug, dental and optical, but it is fully insured for disability and life insurance. The contribution rate applies to each participant regardless of whether the Fund provides single or family coverage. COBRA beneficiaries pay this same contribution rate to continue their coverage. Because the CBA is currently expired, this contribution rate will remain in effect until a new CBA is reached. In many instances in bargaining with New York City, no new CBA is reached for two to three years after a CBA's expiration. Due to the Fund's financial condition as set forth in the Fund's application, in order to ensure its solvency, the Fund may need to eliminate benefits subject to the restricted annual limits of PHS Act 2711.

Please let me know if you have any further questions or concerns regarding the Fund or its waiver application. Thank you for your courtesy and cooperation in this matter.

Very truly yours,

Vincent F. O'Hara

VFO/tsk

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Your Plan At A Glance

Dental Program (For Full Time And Part Time Members And Their Covered Dependents)

(b)(4) per person, (b)(4) per family calendar year deductible, then covered per fee schedule which is accepted as payment in full by participating dentists to (b)(4) maximum payment per person per calendar year. Lifetime maximum of (b)(4) per person for orthodontics.

Prescription Drug Plan (For Full Time Members And Their Covered Dependents)

Card program with a (b)(4)% co-payment for generic drugs, a (b)(4)% copayment for preferred brand name drugs, and (b)(4)% co-payment for non-preferred brand name drugs, to a $ (b)(4) maximum payment per family per calendar year. Mail order available for a 90-day supply of maintenance drugs with a (b)(4)% co-payment for generic drugs, a (b)(4)% co-payment for preferred brand name drugs, and a (b)(4)% co-payment for non-preferred brand name drugs. In addition, member will be responsible to pay the difference between the cost of the brand name and the generic equivalent plus the generic co-pay when brand name medications have a direct generic equivalent available.

The Plan requires Prior Authorization for the **Proton Pump Inhibitors (PPIs)** therapeutic drug class.

Quantity limitation on **Sleep Aids.** In compliance with the guidelines issued by the FDA, coverage of Sleep Aids are limited to 10 pills/month.

Mandatory Step Therapy or Prior Authorization on all new or refill prescriptions for brand name **Statin** class drug.[1]

Two Incentives to using First Line Generic Drugs

A) First Line generic drugs listed above will be available to you **Free of Charge.**
B) The Semiannual (b)(4) Deductible is waived on all First Line generic drugs filled.

Life-Style Benefit (For Full Time Members and Their Covered Dependents)

Up to (b)(4) per family per year reimbursed for prescriptions for sexual dysfunction drugs

Newborn Benefit (For Full Time Members And Their Covered Dependents)

(b)(4) benefit for birth of a child or adoption of a child who is up to 18 years of age

24 Hour Nurse HelpLine (For Full Time and Part Time Members And Their Covered Dependents)

Contact registered nurses to assist with health questions and/or listen to over 1000 pre-recorded tapes dealing with medical topics.

[1] Step therapy/prior authorization will not apply to prescriptions presented for Lipitor 80 mg.

Your Plan At A Glance (Contd.)

Hearing Aid Benefit (For Full Time Members And Their Covered Dependents)

Up to (b)(4) per device per person once every three years and up to (b)(4) per mold once every three years.

Optical Benefit (For Full Time Members And Their Covered Dependents And For Part Time Employees)

Eye exam and one pair of eyeglasses or contact lenses or a supply of disposable lenses per person once per calendar year through participating providers; up to (b)(4) per person per calendar year reimbursement if using a non-participating provider.

Short Term Disability Coverage (For Full Time Members)

(b)(4)% of gross weekly earning to $(b)(4) maximum benefit for 13 weeks.

Long Term Disability Coverage (For Full Time Members)

(b)(4)% of gross salary to $ (b)(4) maximum per month to age 65.

Life Insurance Coverage (For Full Time and Part Time Members)

$ (b)(4) up to age 65; (b)(4) ages 65-69; (b)(4) ages 70 and over.
(b)(4) of the benefit is paid from the first through the twelfth month of employment as a member, with full coverage thereafter.

[1] Step therapy/prior authorization will not apply to prescriptions presented for Lipitor 80 mg.

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Your Plan At A Glance

Dental Program (For Full Time And Part Time Members And Their Covered Dependents)

(b)(4) per person, (b)(4) per family calendar year deductible, then covered per fee schedule which is accepted as payment in full by participating dentists to (b)(4) maximum payment per person per calendar year. Lifetime maximum of (b)(4) per person for orthodontics.

Prescription Drug Plan (For Full Time Members And Their Covered Dependents)

Card program with a (b)(4) copayment for generic drugs, a (b)(4) copayment for preferred brand name drugs, and a (b)(4) copayment for non preferred brand name drugs, to a (b)(4) maximum payment per family per calendar year. Mail order available for a 90-day supply of maintenance drugs with a (b)(4) copayment for generic drugs, a (b)(4) copayment for preferred brand name drugs, and a (b)(4) copayment for non preferred brand name drugs.

Life-Style Benefit (For Full Time Members And Their Covered Dependents)

Up to (b)(4) per family per year reimbursed for prescriptions for sexual dysfunction drugs.

(b)(4)

Optical Benefit (For Full Time Members And Their Covered Dependents And For Part Time Employees)

Eye exam and one pair of eyeglasses or contact lenses or a supply of disposable lenses per person once per calendar year at no cost through participating providers; up to (b)(4) per person per calendar year reimbursement if using a non participating provider.

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Dental Program

The Dental Program is provided for full time members and part time members and their eligible dependents.

The Dental plan is administered through Self-Insured Dental Services (S.I.D.S), based on a schedule of payments.

The dental program offers two dental options:

- You may select one or more dentists from the listing of S.I.D.S' MetroDent Premier Participating Provider Organization participating providers. These dentists agree to accept the schedule as payment in full for all covered dental services after the deductible is paid. A fee would be charged for any service provided which is considered a non-covered service. Contact S.I.D.S. at 516-396-5500 or 718-204-7172 for a listing of participating providers.
- You may utilize a dentist(s) of your choice. Upon receipt of a completed claim form, reimbursement will be made to you or you may assign benefits to your dentist for all services which are covered under the dental program.

Covered Expenses

Covered expenses include charges made by a dentist for the performance of dental services when the service is performed by or under the direction of a dentist, is essential dental care, and begins and is completed while the individual is covered for benefits.

A service is deemed to start when the actual performance of the service starts except that:

- for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared;
- for a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved;
- for root canal therapy, it starts when the pulp chamber of the tooth is opened.

Maximum Amount Payable

There is a (b)(4) maximum payment for each individual covered by the Plan per calendar year for other than orthodontics.

There is a (b)(4) lifetime maximum benefit for orthodontic treatment. Orthodontic treatment is not subject to the (b)(4) annual maximum.

There is a (b)(4) lifetime maximum payment for surgical implants.

Annual Deductible

Each individual covered under the Plan is subject to a (b)(4) deductible, with a (b)(4) maximum family deductible per calendar year. Orthodontic services are not subject to the deductible.

How Benefits Are Paid

After dental work is performed, send completed claim form to:

S.I.D.S. Dept. 33, P.O. Box 9005, Lynbrook, NY 11563

Claim forms are available from the Fund Office. All claims must be filed within 12 months of the date ~~if~~ of service. Claims filed later than 12 months after the date of service may not be reimbursed. If you would like the payment made directly to your dentist, sign the "Assignment of Benefits" section on the claim form. Payment will be at the rate of 100% of the amounts listed in the Schedule of Covered Dental Expenses, not to exceed actual dentist charges.

Pre-treatment Authorizations

If you require substantial dental work be sure to have your dentist submit a pre-treatment authorization so you will know if you have and out-of-pocket expense at the onset of treatment. Pre-treatment authorizations are required for inlays, crowns, laminate veneers, bridges, dentures, periodontal surgery, or when expenses will exceed $300 in a 90 day period.

If you fail to comply with the pre-authorization requirements, you run the risk of your claim not being paid by the Fund.

Alternate Benefit Provision

Due to the element of choice available in the treatment of some dental conditions, there may be more than one course of treatment that could provide a suitable result based on accepted dental standards. In these instances, S.I.D.S. will determine the alternate course of treatment on which payment will be based and the expenses that will be included as covered expenses. You may elect to follow the original course of treatment and be responsible for charges which exceed Plan allowances for alternate treatment.

Limitations

Examination - (b)(4) in a calendar year
X-ray - (b)(4) maximum per calendar year
Prophylaxis - (b)(4) in a calendar year
Replacement of crowns, bridges and dentures - not more than (b)(4) in 5 years
Palliative treatment - (b)(4) given that same visit
Topical fluoride treatment - to age 19, (b)(4) application per year
Root scalling, curettage, bite correction, any combination - (b)(4) in a calendar year
Sealants - (b)(4) on molars of children under age 19 with lifetime maximum of (b)(4)
Denture adjustment - (b)(4) in a calendar year
Orthodontic treatment - maximum (b)(4) months; limited to eligible dependent children and non-cosmetic adult

Implants - (b)(4) in a life time
Specialist Consultation - includes allowance for examination, maximum (b)(4) per calendar year

Extension Of Benefits

An expense incurred in connection with a dental service that is completed after a person's benefits cease will be deemed to be incurred while that person was eligible if:

- for crowns, inlays, fixed bridgework and full or partial dentures, a pre-treatment authorization was issued and impressions were taken and/or teeth were prepared while that person was an eligible beneficiary and the device was installed or delivered within one month after the date the pre-treatment authorization was issued;
- for root canal therapy, the pulp chamber of the tooth was opened while that person was eligible for benefits and the treatment was completed within one month after that person's eligibility terminated.

There is no extension for any dental service not shown above.

Expenses Not Covered

Covered expenses will not include, and no payment will be made for expenses incurred for:

- cosmetic restoration
- replacement of a lost or stolen appliance
- replacement of a bridge, crown or denture within five years after the date it was originally installed
- any replacement of a bridge, crown or denture which is or can be made usable according to common dental standards
- procedures, appliances or restorations (except full dentures) whose main purpose is to:
  (a) change vertical dimension, or
  (b) diagnose or treat conditions or dysfunctions of the tempor mandibular joint, or
  (c) stabilize periodontally involved teeth
- multiple bridge abutments
- dental services that do not meet common dental standards
- services that are provisional or temporary
- services not included as covered dental services in the Civil Service Bar Association Dental Schedule
- services for which benefits are not payable according to the "General Limitations" section.

General Limitations

No payment will be made for expenses incurred for you or any one of your dependents:

- for or in connection with an injury arising out of, or in the course of, any employment for wage or profit
- for or in connection with a sickness which is covered under any workers' compensation or similar law
- for charges made by a hospital owned or run by the United States Government unless there is a legal obligation to pay such charges whether or not there is any insurance
- to the extent that payment is unlawful where the person resides when the expenses are incurred
- for charges which would not have been made if the person had no insurance, including services provided by the member's spouse
- to the extent that they exceed the amounts shown in the schedule of allowances
- for charges for unnecessary care, treatment or surgery
- to the extent that you or any of your dependents is in any way paid or entitled to payment for those expenses by or through a public program
- for or in connection with experimental procedures or treatment methods
- for or in connection with an injury caused by an accident covered by an automobile no-fault or financial responsibility law.

Claim Submission

You may use computer generated or universal claim forms, however, signature on file and signature trips are not acceptable. For more information contact S.I.D.S. at 516-396-5500.

Mail claims to:

Self Insured Dental Services
P.O. Box 9005, Dept. 33
Lynbrook, NY 11563

Claim forms are available at Alicare.

Schedule

Diagnostic Services	Plan Pays
Oral Examination	(b)(4)
Periodic Oral Examination	
maximum two in a calendar year	
Full Mouth Series X-Rays	
10 to 14 periapical & bitewing films	
Panoramic Film	
Intraoral Film	
periapical or bitewing-each film	
X-ray maximum-$90 per calendar yea	
Occlusal Film	
Extraoral-each film	
posterior-Anterior, Lateral Film 20.00	
Saliography	
TMJ Film	
Cephalometric Film	
Pulp Vitality Test	
Diagnostic Casts	
Palliative Treatment	
no other treatment that same visit	
Preventive services	
Prophylaxis	
Adult	
Child	
including scaling & polishing	
maximum-two ier calendar year	
Fluoride Excl. Prophy	
to age 19, maximum one application per year	
Sealant	(b)(4)
to age 19, $120 lifetime maximum	
Space Maintainer	
Restorative Services	
Silver Amalgam Fillings	
one surface	
two surfaces	
three surfaces	
four or more surfaces	
Sedative Filling	
Composite Resin Fillings	
one surface	
two surfaces	

Restorative Services (contd.)	Plan Pays
three or more surfaces	(b)(4)
incisal edge	
Composite Inlay	
one surface	
two surfaces	
three surfaces	
Ceramic Inlay	
one surface	
two surfaces	
three surfaces	
Metallic Inlay	
one surface	
two surfaces	
three surfaces	
Pin Retention-Per Tooth	
Crowns	
acrylic jacket, laboratory	
porcelain jacket	
resin fused to metal	
full cast & 3/4 cast	
porcelain fused to metal	
Porcelain Laminate Veneer, Lab	
Prefab SS Crown-primary tooth	
Post & Core, pre-fabricated	
Post & Core, laboratory cast	
Prosthodontics	
Complete Denture	
immediate or permanent	
Partial Denture-unilateral	
Partial Denture-bilateral	
acrylic base	
cast metal base	
Reline Denture-chair side	
Reline Denture-lab	
Bridge Abutments	
inlay-two surface	
inlay-three surface	
porcelain fused to metal	
resin fused to metal	
full cast and 3/4 cast	

Prosthodontics (contd.)	Plan Pays
Bridge Pontic	
porcelain fused to metal	
Precision Attachment	
Recement Bridge	
Recement inlay or crown	
Repair Comp Dent Base	
Replc Miss/Brkn TTN-Com Dent	
Repair Part Acrylic Saddle/Base	(b)(4)
90.00	
Repair Cast Framework	
Repair or Replace Crown Facing	
Denture Adjustment	
Oral Surgery	
Simple Extraction	
Surgical Extractions	
must be demonstrated by pre-operative x-ray	
surgical extraction	
soft tissue impaction	
partial bony impaction	
complete bony impaction	
root recovery	
Surgical Exposure Imp/Unerup	
Surgical Exp Imp/Unerup-Ortho	
Removal Of A Cyst	
<1/2 inch in diameter	(b)(4)
>1/2 inch in diameter	
Alveoplasty per quad	
Incision & Drainage	
Endosseous Implant per fixture	
Subperiosteal Implant	
Biopsy or Oral Tissue	
Removal of Frenum	

Periodontic Services

Although eight teeth constitute the anatomic compliment of a quadrant, for purposes of settling claims for periodontal treatment, payment will be based on five teeth per quadrant. Accordingly, if at least five teeth are treated in a quadrant, payment will be based on the allowance for a full quadrant. If fewer than five teeth are treated, payment will be pro-rated on the basis of five teeth per quadrant. When more than one periodontal procedure is performed on the same day, claims for services will be combined and payment will be based on the most costly procedure.

	Plan Pays
Root Scaling & Gingival Curettage,	
Bite Correction, including prophylaxis	
per visit	
full mouth	(b)(4)
perio maintenance procedure	
maximum allowance on any combination of the above services- (b)(4) **per calendar year**	
Periodontal Surgery	
confirmation by charting and/or x-rays required per quadrant of at least 5 teeth	
Gingivectomy-per quad	
Osseous Surgery-per quad	
Osseous Graft-per site	
Osseous Graft-per quad	(b)(4)
Occlusal Adjustment-Complete	
Occlusal Adjustment-Limited	
Free Soft Tissue Graft-per quad	
Endodontics	
x-ray of satisfactory completion required	
Pulp-Cap, direct	
Vital Pulpotomy	
Root Canal Therapy	
one canal	
two canals	(b)(4)
three canals	
four canals	
Apicoectomy, 1st root	

Endodontics (contd.)	Plan Pays
Apicoectomy, maximum per tooth	(b)(4)
Root Resection/Hemisection	
Retrograde Root Filling	
Adjunctive Services	
General Anesthesia	
plan pays 1st 30 min. only	
Specialist Consultation	
maximum two in a calendar year	
Therapeutic Injection	
Orthodontic Services	
Diagnosis & Initial Appliance	
Active Treatment, per month	
Passive Treatment, per 3 months	
Post-Txstabilization Device	

Localized delivery of Chemo-Therapeutic Agents (such as Perio-Chip Implants) annual allowance (b)(4) per year, (b)(4) per tooth. Annual maximum (b)(4).

Prescription Drug Plan

The Prescription Drug Plan is provided for full time members and their eligible dependents. Part time members and their dependents are not covered.

How The Plan Works

The Prescription Drug Plan is administered by Express Scripts. All active full time members receive one plastic prescription drug identification card per family.

When you need to have a prescription filled or refilled, present your prescription drug identification card to a participating pharmacy. As long as you use a participating pharmacy, all you have to pay is a copayment amount, regardless of the total cost of the prescription or refill.

The copayments are as follows:

- If a prescription or refill is dispensed using a generic drug the copayment is $ (b)(4)
- If a prescription or refill is dispensed using a preferred brand name (formulary) drug the copayment is $ (b)(4)
- If a prescription or refill is dispensed using a non-preferred brand name (non-formulary) drug, the copayment is $ (b)(4)

The Fund will pay up to a maximum of $ (b)(4) per family per calendar year. Any member who expects to exceed the maximum of $ (b)(4) in any one calendar year must call Alicare at 212-539-5117.

The card plan allows you to receive up to a 30-day supply at Retail. However, you will be able to obtain up to a 90-day supply of a maintenance medication from CFI, the Plan's mail order pharmacy.

Mail order pharmacy copayments are as follows: a (b)(4) copayment for generic drugs, a $(b)(4) copayment for preferred brand name drugs, and a (b)(4) copayment for non-preferred brand name drugs for each prescription or refill ordered through Central Fill. A maximum 90-day supply will be dispensed.

The mail order prescription should be mailed to: Express Scripts, 4415 Lewis Road, P.O. Box 69301, Harrisburg, PA 17106-9301. Fill out the information on the provided envelope along with the doctor's prescription for a three-month supply of medication. Please make sure to enclose the copayment for each prescription. Once you have filled an original prescription through mail order, you can easily order refills through Central Fill's automated Interactive Voice Response (IVR) system at 1-800-233-7139, or by logging on to the Express Scripts web site, www.express.scripts.com.

If your pharmacy is non-participating, either contact Alicare for a participating Express Scripts pharmacy in your area or pay for your prescription in full and you will be reimbursed through the drug plan on a direct payment basis. Direct reimbursement can be more costly. If you are unable to use your card or have forgotten your card when filling a prescription, either you or your pharmacy should contact Express Scripts or Alicare immediately. There are steps which can be taken to assist you in acquiring the medication without having to submit on a direct reimbursement basis at a higher out-of-pocket cost. To receive direct reimbursement claim forms, contact Alicare.

Covered Items

- Federal Legend Drugs (including oral contraceptives)
- State Restricted Drugs
- Compounded Prescriptions
- Prescription Birth Control
- Diabetic Pills

Exclusions

The following items are not covered:

- Fertility Drugs (with the following exception: Fertility drugs are covered only for the maintenance of a pregnancy.)
- Sexual Dysfunction Drugs (e.g. Viagra, Muse, etc.)-for this coverage see page D1
- Items lawfully obtainable without prescription
- Syringes and Needles (covered through NYC Contract)
- Devices and Appliances
- Insulin, Diabetic Agents (covered through NYC Contract)
- Chemotherapy Drugs (covered through NYC Contract)
- Prescriptions covered without charge under Federal, State, or Local Programs, to include Workers" Compensation
- Any charge for administration of a drug
- Investigational or experimental drugs
- Unauthorized refills
- Immunizational agents, biological sera, blood or plasma
- Medication for an eligible person confined to a rest home, sanitarium, extended care facility, hospital, etc.
- Any charge where the usual and customary charge is less than the Plan's deductible
- Any charge above the usual and customary, advertised or posted price, whichever is less than the scheduled amount
- Genetically Engineered Drugs (e.g. Protropin)
- Asthma Drugs (covered through NYC Contract)
- Psychotropic Drugs (covered through NYC Contract)

Effective July 1, 2001, the Citywide PICA Drug Program (Psychotropic/Injectable/Chemotherapy/Asthma) was established.

IMPORTANT — ONLY MEMBERS COVERED UNDER A CITY-SPONSORED HEALTH PLAN ARE ELIGIBLE. THESE DRUGS ARE NO LONGER COVERED UNDER THIS CURRENT CIVIL SERVICE BAR ASSOCIATION PROGRAM.

Copayment Exceptions

Can you get a non-formulary drug at a formulary copayment?

If your physician concludes that for medical reasons you are unable to take the formulary drug, he/she can call the Express Scripts prior authorization department at (866) 374-5549. If authorization is granted, you will be able to fill the prescription in question at the preferred copayment ($15). The doctor also has the option of faxing in the request to (866) 374-5547. Your doctor should have a response within 48 hours.

Life-Style Benefit

The Life-Style Benefit is provided for full time members and their eligible dependents. Part time members and their dependents are not covered.

Effective January 1, 2001, up to (b)(4) per family per year will be reimbursed for prescriptions for sexual dysfunction drugs (e.g. Viagra). Reimbursement is made after your primary care reimbursement.

Submit a completed claim form along with your prescription drug receipt to Alicare.

(b)(4)

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Optical Benefit

The Optical Benefit provides full or partial payment for an eye exam and/or one pair of eyeglasses/contact lenses for full time members and their eligible dependents and for part time members, once per calendar year.

Contact Alicare at 212-539-5117 or 5118 or e-mail CSBAinfo@Alicare.com prior to your appointment to request an optical voucher or if you have any questions.

You may choose one of the following options:

- You may use your own optometrist.

  If you elect to use an optician/optometrist of your choice, the voucher will entitle you to up to a $ (b)(4) reimbursement for glasses and/or exam or contact lenses and/or exam. An itemized sales receipt must be attached to the completed voucher when submitting for reimbursement.

OR

- You may use a participating provider.

  A list of participating providers will be sent to you with your optical voucher. These vendors provide a selection of private optical centers in many convenient New York locations as well as out of state locations. In addition to an eye examination, a selection of lenses with tint, oversize, as well as an array of boutique frames from which to choose are also available. Additional discounts are available on non-covered items.

GHI Subscribers

IMPORTANT: If you are a GHI subscriber and utilize a GHI participating physician, the cost of your exam will be excluded from your benefit. If you are a GHI subscriber and utilize a non-GHI provider, you must first submit your claim to GHI. Attach a copy of the GHI Explanation of reimbursement. The benefit paid by GHI will be deducted from the amount you claim.

VDT Program

Civil Service Bar Association members may also be eligible for an additional exam and/or glasses or contacts every 24 months from NYC's VDT program if he or she uses a video display terminal for more than 20 hours a week. A participating optician must be used for this service. Board of Education, CUNY, Transit Authority and OTB employees are <u>not</u> eligible for the VDT program.

A booklet is available from Alicare describing this benefit in greater detail.

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From: Timothy Klimpl [t.klimpl@hohlaw.com]
Sent: Tuesday, November 30, 2010 2:40 PM
To: Habit, Sandra (HHS/OCIIO)
Cc: v.ohara@hohlaw.com
Subject: Addition to Application for Wavier of PHS Act 2711- SPD for Civil Service Bar Association Security Benefit Fund

Attachments: CSBA Your Plan at a Glance.pdf

Dear Ms. Habit:

The law firm of Holm & O'Hara LLP represents the Civil Service Bar Association Security Benefit Fund. The Fund filed an application by email dated November 10, 2010 with HHS for a Waiver of the Annual Limits Requirement of PHS Act 2711. It has come to our attention that a file for the Fund's Summary Plan Description was not attached with the emailed application. Since then, our office has located a copy of the Fund's SPD, which is attached. Thank you for your courtesy and cooperation in this matter.

Very truly yours,

Timothy S. Klimpl
Holm & O'Hara LLP
3 West 35th Street- 9th Floor
New York, New York 10001
Tel (212)682-2280, Fax (212)682-2153
t.klimpl@hohlaw.com
www.hohlaw.com

From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Monday, December 06, 2010 8:58 AM
To: 'v.ohara@hohlaw.com'
Subject: Waiver of the Annual Limits Requirements of PHS Act Section 2711

Importance: High

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

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section 2711 for **Civil Service Bar Association Security Benefit Fund.** 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 address with a copy to OCIIOOversight@hhs.gov.

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

Sincerely,

Alexandra Botwinick

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

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.