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THE TRUSTEES OF

DELMARVA UNITED FOOD & COMMERCIAL WORKERS HEALTH & WELFARE FUND

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November 5, 2010

Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Office of Oversight
Attn: James Mayhew
Room 737-F-04
200 Independence Avenue SW
Washington, DC 20201

Re: Delmarva UFCW Health and Welfare Fund
Application for Waiver of Restricted Annual Limit Requirements

This letter is regarding the Delmarva UFCW Health and Welfare Fund ("the Plan"). Because of the Plan's status as a limited benefits plan, the Plan wishes to apply for the waiver of the restricted annual limit requirements of Section 2711 of the Public Health Service Act and the interim final regulations at 26 CFR § 54.9815-2719T, 29 CFR § 2590.715-2719, and 45 CFR § 147.126.

In addition to the description of the Plan and a discussion of the projected impact of the restricted annual limit requirements on the Plan provided below, please find enclosed an attestation signed by the Administrator of the Plan certifying (1) that the Plan was in force prior to September 23, 2010 and (2) that 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.

I. Summary

The Plan is a "limited benefit" or "mini med" plan with extremely low annual dollar limitations that are well below the restricted annual limits set out in the interim final regulations. The Plan provides benefits primarily to workers in the poultry processing industry, an industry whose workers generally cannot afford health insurance coverage at all. The Plan's participants do not currently pay premiums, and the Plan is fully funded by employer contributions pursuant to the terms of applicable collective bargaining agreements. In recent years, hypothetically applying the restricted annual limit requirements of the Patient Protection and Affordable Care Act to the Plan would have meant an increase in Plan costs attributable to the payment of claims of between (b)(4)% and (b)(4)%. These significant increases could not be offset either by

implementation of premiums affordable to these low-paid workers or by increased contributions acceptable to employers participating in this collectively bargained plan. The increased costs, compounded by the inability to offset the increased costs, would lead to the likely insolvency of the Plan and the ultimate termination of all benefits to the workers who presently participate in the Plan.

II. Terms of the Plan

The Plan includes two schedules of benefits, both of which include terms for which a waiver is sought. The schedules of benefits are attached to this waiver application.

Plan 2 includes annual maximums for vision care, dental care, hospitalization, prescription drug coverage, and laboratory services, including the following:

Vision Care Benefits: Maximum payment during any 24 month period:

For glasses: $ for examination
$(b)(4) for frames Up to
$ for lenses Up to

For contacts: $100 for contacts including exam Up to[1]

Dental Care Benefits: Part I and Part II of Basic Plan with $ (b)(4) per calendar year maximum.[2]

Major Medical Benefits:

After basic hospital/surgical and anesthesia benefits are applied, the fund will pay (b)(4)% of the remaining unpaid balances up to an annual maximum of $ (b)(4) for usual and reasonable customary charges for in-patient hospital confinement, surgery, and anesthesia charges only. Additionally, some outpatient surgical procedures are covered by the Major Medical Program if the procedure is normally performed in an inpatient setting but is shifted to an outpatient surgical center in an effort to reduce the total cost or if the procedure requires general anesthesia. **You should contact the Fund office prior to scheduling an Outpatient surgical procedure to predetermine the levels of coverage available to you.**[3]

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[1] This Plan provision provides for essential health benefits only to the extent that it provides for pediatric vision care under Section 1302(b)(1) of the Patient Protection and Affordable Care Act.

[2] This Plan provision provides for essential health benefits only to the extent that it provides for a pediatric oral care benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.

[3] This Plan provision provides for essential health benefits only to the extent that it provides for an ambulatory patient services benefit or a hospitalization benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.

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Consolidated Out-Patient Services:

Combination of out-patient doctor's services, prescription drugs, and out-patient diagnostic x-rays and lab charges (b)(4)% of the first $ (b)(4) of charges with a maximum payment of $ (b)(4) per calendar year.[4]

Plan 3 includes annual maximums for vision care, dental care, hospitalization, laboratory services, and prescription drug coverage, including the following:

Vision Care Benefits: Provided by "Advantica EyeCare". See Table 1.d for additional information, details and/or restrictions.[5]

Advantica EyeCare Optical Services Table 1.d

COVERAGE	IN-NETWORK BENEFITS	OUT-OF-NETWORK REIMBURSEMENT BENEFITS
COMPREHENSIVE EYE EXAMINATION	(b)(4)	
EYEGLASS LENSES		
EYEGLASS FRAMES		
CONTACT LENSES (in lieu of Eyeglasses) Conventional/Disposable		
CONTACT LENSES (in lieu of Eyeglasses) Medically Necessary		
CONTACT LENS FITTING FEE		
LASER VISION CORRECTION (LASIK)		
BENEFIT FREQUENCY		
EXAMINATION		
EYEGLASS LENSES (standard plastic)		
EYEGLASS FRAMES		
CONTACT LENSES (in lieu of frames)		

[4] This Plan provision provides for essential health benefits only to the extent that it provides for ambulatory patient services, prescription drug benefits or laboratory services under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.

[5] This Plan provision provides for essential health benefits only to the extent that it provides for a pediatric vision care benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.

Dental Care Benefits: Provided by "DeltaDental PPO", with $ (b)(4) per calendar year maximum.[6]

Inpatient Medical Consultation(s):

(b)(4) consultation per admission
Maximum of (b)(4) admissions per year
Maximum payment of $ (b)(4) per year
This coverage is excluded from major medical benefits

Major Medical Benefits:

After basic hospital/surgical and anesthesia benefits are applied, the fund will pay (b)(4)% of the remaining unpaid balances up to an annual maximum of $ (b)(4) for usual reasonable and customary charges for in-patient hospital confinement, surgery, and anesthesia charges only.* Additionally, substance abuse treatment and some outpatient surgical procedures are covered by the Major Medical Program. Outpatient surgical procedures are covered only if the procedure is normally performed in an inpatient setting but is shifted to an outpatient surgical center in an effort to reduce the total cost or if the procedure requires general anesthesia. **You should contact the Fund office prior to scheduling an Outpatient surgical procedure to predetermine the levels of coverage available to you.**[7]

Assisting Surgeons Charges:

(b)(4)% of applicable surgical schedule with an annual maximum of $ (b)(4)
This coverage is excluded from major medical benefits

Consolidated Out-Patient Services:

Combination of out-patient doctor's services, and outpatient diagnostic x-rays and lab charges (b)(4)% of the first $ (b)(4) of charges with a maximum payment of $ (b)(4) per calendar year.[8]

Prescription Drug Benefit Card Program

Prescription drug coverage is provided by EnvisionRx with a maximum payment of $ (b)(4) per calendar year. (You will receive a separate card from EnvisionRx). Mail-Order prescription services are provided by OrchardRx.

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[6] This Plan provision provides for essential health benefits only to the extent that it provides for a pediatric vision care benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.
[7] This Plan provision provides for essential health benefits only to the extent that it provides for an ambulatory patient services benefit or a hospitalization benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.
[8] This Plan provision provides for essential health benefits only to the extent that it provides for an ambulatory patient services benefit or a laboratory services benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.

III. Number of Individuals Covered by the Plan

(b)(4) individuals are covered by Delmarva UFCW Health and Welfare Fund.

IV. Annual Limits Under the Plan

As described above under Section I, Plan 2 provides for the following annual dollar limits:

- (b)(4) for eye examination, (b)(4) for frames, and (b)(4) for lenses per 24 month period; (b)(4) for eye exam and contact lenses per 24 month period;[9]
- (b)(4) for dental care;[10]
- (b)(4) for Major Medical Benefits;[11]
- (b)(4) for Consolidated Out-Patient Services, including prescription drug benefits and laboratory services as well as services that are not essential health benefits.[12]

As described above under Section I, Plan 3 provides for the following annual dollar limits:

- (b)(4) for eye examination, (b)(4) for frames, and (b)(4) for lenses per (b)(4) month period; (b)(4) for eye exam and contact lenses per (b)(4) month period;[13]
- (b)(4) for dental care benefits;[14]
- (b)(4) for Major Medical Benefits;[15]
- (b)(4) for Inpatient Medical Consultation;[16]
- (b)(4) for Assisting Surgeons Charges;[17]
- (b)(4) for Consolidated Out-Patient Services, including laboratory services as well as services that are not essential health benefits;[18]

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[9] This Plan provision provides for essential health benefits only to the extent that it provides for a pediatric vision care benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.
[10] This Plan provision provides for essential health benefits only to the extent that it provides for a pediatric oral care benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.
[11] This Plan provision provides for essential health benefits only to the extent that it provides for a hospitalization benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.
[12] This Plan provision provides for essential health benefits only to the extent that it provides for prescription drug benefits and laboratory services under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.
[13] This Plan provision provides for essential health benefits only to the extent that it provides for a pediatric, vision care benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.
[14] This Plan provision provides for essential health benefits only to the extent that it provides for a pediatric oral care benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.
[15] This Plan provision provides for essential health benefits only to the extent that it provides for a hospitalization benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.
[16] This Plan provision provides for essential health benefits only to the extent that it provides for a hospitalization benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.
[17] This Plan provision provides for essential health benefits only to the extent that it provides for a hospitalization benefit under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.
[18] This Plan provision provides for essential health benefits only to the extent that it provides for and laboratory services under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations.

- (b)(4) for prescription drug coverage.

V. Impact of Restricted Annual Limit Requirements

This Plan is a collectively bargained health plan funded by contributions from contributing employers. Individuals covered by the Plan do not pay premiums. The anticipated increase in costs to the Plan following implementation of the restricted annual limits could not be absorbed by the current assets of the Plan as funded by employer contributions at the current level. The increase in funding necessary to make up the shortfall far exceeds any feasible sources of funding. For example, in order for participant premiums to be introduced, they would have to be set low enough to be affordable, taking into account participant income as set by the collective bargaining agreement. Similarly, any increase in the rate of employer contributions could risk the loss of employers from the collectively bargained plan, resulting in even lower funding. Because there is no sufficient means of additional funding, the application of the restricted annual limits will result in the termination of the Plan and a cessation of benefits to participants currently covered by the Plan

As of September 1, 2010, the Plan had (b)(4) eligible participants. During the period of January 1, 2009 through December 31, 2009 (the most recent full year for which relevant data is available), the Plan received claims for benefits with total charges of (b)(4). After processing these claims, the Plan paid (b)(4) in benefits pursuant to the terms of the Plan. For this period, the Plan had denials of benefits in the amount of (b)(4) attributable to claims in excess of Plan maximums to which the annual and lifetime limit requirements are now applicable. As such, for the period of January 1, 2009 through December 31, 2009, the Plan would have faced increased payouts of up to (b)(4)% if it were not for the Plan terms providing for maximum dollar limitations. Such an increase in costs would be catastrophic to the Plan and would rapidly deplete the funds that the Plan has available to pay benefits.

Further, it is not uncommon for the Plan to receive claims greatly in excess of the Plan's dollar limit maximums. For the period of January 1, 2010 through September 30, 2010, for example, the Plan paid (b)(4) in total claims in accordance with the Plan's provisions. Were it not for the dollar limit maximums in place during this period, the Plan would have been exposed to additional claims in the amount of (b)(4). This could have resulted in the Plan's costs associated with paying claims increasing by (b)(4)% just during the period of January 1, 2010 through September 30, 2010.

It is also important to note that due to the low dollar amount of the Plan's limitations at issue, it is highly possible that very few individual members could expose the Plan to extremely large claim amounts. For example, as referenced above, during January 1, 2010 through September 30, 2010 the Plan denied (b)(4) in claims that were excess of Plan maximums. Of this amount, (b)(4) (more than (b)(4)% of claims denied as in excess of Plan maximums) was attributable to just (b)(4) participants out of the (b)(4) covered by the Plan, or (b)(4)% of participants. This clearly demonstrates that without annual dollar limits in place, the Plan could be overwhelmed by massive claims from just a few participants. This in turn would lead to the Plan's insolvency and ultimately lead to the termination of the Plan for all beneficiaries.

Due to the relatively small size of the Plan, annual dollar limits are necessary for the continued vitality of the Plan. Without the granting of a waiver of the restricted annual dollar limits, the Plan will be exposed to additional claims that it simply can not afford to pay. It is precisely the dollar limits that are in place at this time that allow for the Plan's solvency and allow for coverage to be provided to its (b)(4) participants.

The Plan respectfully requests a waiver of the restricted annual limit requirements with respect to the provisions listed above to the extent that they provide for essential health benefits under Section 1302(b)(1) of the Patient Protection and Affordable Care Act and applicable regulations. The Plan provides health benefits to a population that would not otherwise be able to afford health insurance coverage, at no cost to participants in the plan. Because of the nature of the Plan as a collectively bargained plan in which contributing employers participate voluntarily, there is a limited amount by which employer contributions may be increased without alienating employers and causing them to withdraw from the Plan entirely, leaving those employees without benefits and putting the remaining participants' benefits in jeopardy. This collectively bargained limited benefit health plan faces underfunding and ultimately termination under the restricted annual limit requirements as imposed by the interim final regulations.

Should you need additional information please contact me at 800.692.1313.

Cordially,

Robert Morris
Administrator

AFFIDAVIT OF ADMINISTRATOR

I, Robert Morris, am over the age of 18 years and am competent to testify to the following matters.

1. I am the Administrator for Delmarva UFCW Health and Welfare Fund, which is located at 305 West Dupont Highway, PO Box 1768, Millsboro, Delaware 19966.

2. The Delmarva UFCW Health and Welfare Fund is a limited benefit plan providing health benefits to workers in the poultry processing industry. As this is a seasonal industry, non-union workers in the poultry processing industry typically do not have access to health insurance coverage.

3. The Delmarva UFCW Health and Welfare Fund was in force prior to September 23, 2010.

4. The application of restricted annual limits to the Delmarva UFCW Health and Welfare Fund would result the cessation of benefits to current participants.

5. The historic costs discussed in the Delmarva UFCW Health and Welfare Fund's Application for Waiver of Restricted Annual Limit Requirements are true and correct, and are based on accurate records of the Delmarva UFCW Health and Welfare Fund.

6. I have read this statement, I fully understand its contents and I state under penalty of perjury that it is true and correct to the best of my knowledge and belief.

11/4/10
Date

Robert Morris

I hereby certify that on this 4 day of November, 2010, before the undersigned, a Notary Public of the State of Maryland, personally appeared Robert Morris, who gave oath in due form of law that he has personal knowledge of and is competent to testify with regard to the facts recited in the within affidavit, and that the facts and matters recited herein are true and correct to the best of his knowledge, information, and belief.

My Commission Expires:

Deborah Lynn Hickman
Notary Public

DEBORAH LYNN HICKMAN
NOTARY PUBLIC
STATE OF DELAWARE
My Commission Expires on July 22, 2014

DELMARVA UFCW HEALTH AND WELFARE FUND

PLAN 2 SUMMARY

SERVING UNION MEMBERS AND THEIR FAMILIES SINCE 1957

PLAN 2

Eligibility: You are eligible for Plan 2 benefits as set forth in the schedule of benefits on the first day of the month following (b)(4) months of continuous employment with a participating employer in the Plan,

Benefits for eligible participants only:

Death Benefit: (b)(4) regular life

Disability Benefits: (b)(4) per day or (b)(4) per week
From 1st day accident or 4th day illness Maximum of 13 weeks (91 days)

Benefits for eligible participants and dependents:

Vision Care Benefits: Maximum payment during any 24 month period:

for glasses: (b)(4) for examination
for frames Up to
for lenses Up to

for contacts: (b)(4) for contacts including exam Up to

Dental Care Benefits: Part I and Part II of Basic Plan with (b)(4) per calendar year maximum. *for additional information a full Dental Schedule is available upon request from the Health and Welfare office.

Examples: (b)(4) for teeth cleaning
for upper or lower denture

Hospital Expense Benefits: Maximum Benefit Payable

Daily Room and Board
other than Intensive Care (b)(4) per day
Intensive Care per day
Up to (b)(4) Days combined maximum benefit for intensive care and/or non-intensive care per covered illness or accident
Hospital Services &
Supplies up to (b)(4) per illness

Surgical Expense Benefits:

Surgical payments by schedule up to (b)(4) per operation
Anesthesia payments
of 30% of surgical payment up to per operation
2nd procedure through same incision is (b)(4)% of the schedule for that procedure

Doctor's Services in Hospital

1st day of confinement (b)(4)
2nd through (b)(4) days

Major Medical Benefits:

After basic hospital/surgical and anesthesia benefits are applied, the fund will pay (b)(4)% of the remaining unpaid balances up to an annual maximum of (b)(4) for usual reasonable and customary charges for in-patient hospital confinement, surgery, and anesthesia charges only, Additionally, some outpatient surgical procedures are covered by the Major Medical Program if the procedure is normally performed in an inpatient setting but is shifted to an outpatient surgical center in an effort to reduce the total cost or if the procedure requires general anesthesia. **You should contact the Fund office prior to scheduling an Outpatient surgical procedure to predetermine the levels of coverage available to you.**

Sudden & Serious Emergency Room Benefit:

up to (b)(4) per incident

Consolidated Out-Patient Services:

Combination of out-patient doctor's services, prescription drugs, and out-patient diagnostic x-rays and lab charges (b)(4)% of the first (b)(4) of charges with a maximum payment of (b)(4) per calendar year.

Prescription Drug Benefit Reimbursement

Covered prescriptions are reimbursed up to the limits as listed under the "Consolidated Out-Patient Services" section above. **Receipts must be presented to the Fund office in order to be reimbursed for covered expenses.**

VISION CARE BENEFITS

For You and Your Eligible Dependents

Payment will be made for expenses incurred while your coverage is in effect for an eye examination by a Optometrist or Ophthalmologist and for eyeglasses or frames or contract lenses up to the amount in the Schedule of Benefits.

Payment will be made for no more than one examination, one pair of lenses, and one pair of frames or one set of contract lenses during any 24 month period.

No benefit will be paid for charges for sunglasses, or services not listed in the Schedule of Benefits, or for replacement of eye glasses unless a significant uncorrected defect exists.

DENTAL BENEFITS

For You and Your Eligible Dependents

PLAN 2

When dental services listed in the Dental Schedule are performed after the effective date of your dental coverage payments will be made for the dentist's charges up to the amounts shown in the Dental Schedule. No payments will be made for expenses incurred for charges for services received after your coverage is terminated, or after your employment is terminated. Dental expense benefits will be limited to a maximum per calendar year amount for each participant and dependent covered under the Plan as provided in the Schedule of Benefits.

Maximum payment for any type of dentures during a five year period will not exceed the maximum allowance for a complete set of dentures as provided in the Dental Schedule.

COVERED DENTAL SERVICES

Part I Cleanings, fillings and extractions.

Part II Inlays, root canals, bridges, caps and dentures,

A full Dental Schedule is available upon request from the Health and Welfare office.

DENTAL EXCLUSIONS

1. Part II Inlays, root canals, bridges, caps, etc, on baby teeth.
2. Orthodontics
3. Periodontics

Additional Information

Anyone having any questions about their eligibility dates and coverage's should contact the Delmarva United Food and Commercial Workers Health and Welfare Fund Office, PO Box 1768, 305 W. DuPont Hwy, Millsboro, DE 19966 or call 302.934.7737 or 1.800.692.1313

Important Telephone Numbers

Delmarva UFCW Health and Welfare Fund - (302) 934-7737 / (800) 692-1313

OneNet PPO - (800) 962-0643

DELMARVA UFCW HEALTH AND WELFARE FUND

PLAN 3 SUMMARY

SERVING UNION MEMBERS AND THEIR FAMILIES SINCE 1957

PLAN 3

Eligibility: You are eligible for Plan 3 benefits as set forth in the schedule of benefits on the first day of the month following two years of continuous employment with a participating employer in the Plan.

Benefits for eligible participants only:

Death Benefit: $ (b)(4) regular life

Disability Benefits: (b)(4) per day or (b)(4) per week
From 1st day accident or 4th day illness
Maximum of 13 weeks (91 days)

Benefits for eligible participants and dependents:

Vision Care Benefits: Provided by "Advantica EyeCare". *See Table 1.d for additional information, details and/or restrictions.

Dental Care Benefits: Provided by "DeltaDental PPO", with $ (b)(4) per calendar year maximum. *See additional information on Tables 1a-1b

Hospital Expense Benefits: Maximum Benefit Payable

Daily Room and Board
other than Intensive Care $ (b)(4) per day
Intensive Care $ (b)(4) per day
Up to (b)(4) Days combined maximum benefit for intensive care and/or non-intensive care per covered illness or accident,
Hospital Services & Supplies up to $ (b)(4) per illness

Surgical Expense Benefits:

Surgical payments by schedule up to $ (b)(4) per operation
Anesthesia payments of (b)(4)% of surgical payment up to $ (b)(4) per operation
2nd procedure through same incision is (b)(4)% of the schedule for that procedure

Doctor Services in Hospital:

1st day of confinement $ (b)(4)
2nd through 31st day $ (b)(4)

Major Medical Benefits:

After basic hospital/surgical and anesthesia benefits are applied, the fund will pay (b)(4)% of the remaining unpaid balances up to an annual maximum of $ (b)(4) for usual reasonable and customary charges for in-patient hospital confinement, surgery, and anesthesia charges only* Additionally, some outpatient surgical procedures are covered by the Major Medical Program If the procedure is normally performed in an inpatient setting but is shifted to an outpatient surgical center in an effort to reduce the total cost or if the procedure requires general anesthesia. **You should contact the Fund office prior to scheduling an Outpatient surgical procedure to predetermine the levels of coverage available to you.**

Inpatient Medical Consultation(s):

(b)(4) consultation per admission
Maximum of (b)(4) admissions per year
Maximum payment of (b)(4) per year
This coverage is excluded from major medical benefits

Assisting Surgeons Charges:

(b)(4)% of applicable surgical schedule with an annual maximum of $ (b)(4)
This coverage is excluded from major medical benefits

Sudden & Serious Emergency Room Benefit:

Up to $ (b)(4) per incident.

Consolidated Out-Patient Services:

Combination of outpatient doctors services and, outpatient diagnostic x-rays and lab charges (b)(4)% of the first $ (b)(4) of charges with a maximum payment of $ (b)(4) per calendar year.

Prescription Drug Benefit Card Program

Prescription drug coverage is provided by EnvisionRx with a maximum payment of $ (b)(4) per calendar year. (You will receive a separate card from EnvisionRx). Mail-Order prescription services are provided by OrchardRx. *See Table 1.c for additional information.

VISION CARE BENEFITS

For You and Your Eligible Dependents

Payment will be made for expenses incurred while your coverage is in effect for an eye examination by a Optometrist or Ophthalmologist and for eyeglasses or frames or contract lenses up to the amount in the Schedule of Benefits.

Payment will be made for no more than one examination, one pair of lenses, and one pair of frames or one set of contract lenses during any 24 month period.

No benefit will be paid for charges for sunglasses, or services not listed in the Schedule of Benefits, or for replacement of eye glasses unless a significant uncorrected defect exists.

DENTAL BENEFITS

For You and Your Eligible Dependents

PLAN 3

ELIGIBILITY

Eligible for coverage are employees, spouses, and dependent children to age 19, unless a full-time student, in which case eligibility is extended to age 23.

LIMITATIONS AND EXCLUSIONS

There are certain limitations and exclusions which apply to your dental plan. For example, dentistry that is performed for appearance only, preventive plaque control programs, periodontal splinting, and services provided or devices started prior to the effective date of the program are not covered. Orthodontics is not a covered benefit.

PREDETERMINATION

If the cost of care to be provided to any one patient is expected to exceed $ (b)(4), Delta Dental recommends that you ask your dentist to submit the claim form in advance of treatment. Delta Dental will review the claim and return a predetermination voucher to both you and the dentist indicating the services that are covered, how much of the proposed treatment will be paid by Delta Dental and how much is your responsibility. This understanding can make it easier to plan an appropriate course of treatment. Predetermination also can be helpful for any service for which you would like an advance breakdown of the coverages and the charges.

ONLINE SERVICES

Visit Delta Dental's web site, **www.MidAtlanticDeltaDental.com**, to locate participating dentists and to check your eligibility and benefits. Delta Dental's online dentist directory helps you find the dentists most convenient to you or to find out if your current dentist is a participating dentist with Delta Dental.

CUSTOMER SERVICE

If you or your dentist have questions about claim status or filing procedures, please contact Delta Dental's Customer Service Department at: (800) 932-0783

Additional Information

Anyone having any questions about their eligibility dates and coverage's should contact the Delmarva United Food and Commercial Workers Health and Welfare Fund Office, PO Box 1768, 305 W. DuPont Hwy Millsboro, DE 19966 or call 302.934.7737 or 1.800.692.1313

Important Telephone Numbers

Delmarva UFCW Health and Welfare Fund - (302) 934-7737 / (800) 692-1313
OneNet PPO - (800) 962-0643
EnvisionRx - (800) 361-4542
OrchardRx (Mail-Order) - (866) 909-5170
DeltaDental PPO - (800) 932-0783
Advantica EyeCare - (866) 425-2323

DeltaDental PPO Plan 3 Benefit Table 1.a

The following illustrates the coverage and copayments available when dentists are selected according with Delta Dental's specialty levels.		Delta Dental PPO Dentist		Delta Dental Premier® Dentist		Non-Participating Dentist	
Service	Examples of Procedures	Delta Dental	Patient	Delta Dental	Patient	Delta Dental	Patient
Diagnostic	exam & x-rays	(b)(4)					
Preventive	fluoride treatments to age 19, teeth cleaning, sealants to age 14						
Basic Restorative	fillings						
Major Restorative	crowns						
Oral Surgery	extractions						
Endodontics	root canal therapy						
Periodontics	treatment of gum disorders						
Prosthodontics	dentures, bridgework						
*DELTA DENTAL'S ALLOWED AMOUNT: Based on a fee schedule and PPO Dentists agree to this amount. Premier Dentists agree to this amount. Non-Participating Dentists may bill more than the Allowed Amount.							

DeltaDental PPO Plan 3 Services Table 1.b

PAYMENT FOR SERVICES

The following illustrates payment responsibilities depending on your choice of dentist:

Dentist Status	Allowance	Payment Responsibilities
Delta Dental PPO Participating	Dentists are paid the Delta Dental PPO Allowed Amount.	Delta Dental's benefit is a percentage of the Delta Dental PPO Maximum Plan Allowance, which may require a copayment. Deductibles may also apply. If you visit a dentist who participates in only the Delta Dental Premier program, your copayment may be higher because it includes the difference between Delta Dental's allowances for the Delta Dental Premier and PPO programs.
Delta Dental Premier Participating	Dentists are paid the Delta Dental PPO Allowed Amount.	
Non-Participating	Claims for services provided by non-participating dentists will be processed using the Delta Dental PPO Allowed Amount.	You are responsible for paying the non-participating dentist's actual fee. Delta Dental sends its applicable benefit payment to you. Your out-of-pocket cost may include applicable copayments or deductibles, as well as any difference between Delta Dental's payment and the dentist's actual charge.

EnvisionRx Pharmacy Services Table 1.c

	30-Day Retail			90-Day Orchard Mail Order		
	Generic	Brand	Combined	Generic	Brand	Combined
Fund Paid*	(b)(4)					
Member Paid						
*ALL PAYMENTS ARE LIMITED TO YOUR PRESCRIPTION PLAN MAXIMUM BENEFIT						

***Note: All mail-order prescriptions will be handled by OrchardRx**

Advantica EyeCare Optical Services Table 1.d

COVERAGE	IN-NETWORK BENEFITS	OUT-OF-NETWORK REIMBURSEMENT BENEFITS*
COMPREHENSIVE EYE EXAMINATION	(b)(4)	
EYEGLASS LENSES (standard plastic)		
EYEGLASS FRAMES		
CONTACT LENSES (in lieu of Eyeglasses) ** Conventional / Disposable		
CONTACT LENSES (in lieu of Eyeglasses) ** Medically necessary ***		
CONTACT LENS FITTING FEE		
LASER VISION CORRECTION (LASIK)		
BENEFIT FREQUENCY		
EXAMINATION		
EYEGLASS LENSES (standard plastic)		
EYEGLASS FRAMES		
CONTACT LENSES (in lieu of Eyeglasses)		
SELECT DISCOUNT PLAN	Included as part of the SP150 Plan.	
	In-network benefits only.	
	No additional monthly premium cost.	
	After initial insurance funded benefits have been utilized, continous savings provided	
	beyond the plan coverage on additional eyewear purchases is available through	
	discount (may not be combined with any other discounts or promotional offers).	
	MAIL ORDER (replacement) Contact Lenses from For Eyes-Direct	

**** Submit Member Out-Of-Network Reimbursement Form and copy of paid receipt to Advantica EyeCare.***

***** This benefit is paid only once during the Group's Benefit Period and must be fully utilized at the time of purchase.***

****** Limited to Aphakia, Keratoconus or Severe Anisometropia and REQUIRES PRE-AUTHORIZATION BY ADVANTICA.***

Plan is qualified under IRS Section 125.

From: Scelzo, Kathleen (HHS/OCIIO)
Sent: Tuesday, November 23, 2010 11:31 AM
To: 'bob@delmarva.org'
Cc: Habit, Sandra (HHS/OCIIO)
Subject: Delnarva UFCW Annual Limit Waiver

Importance: High

Attachments: Delmarva UFCW Plan 3 Waiver Application Questions.doc; Delmarva UFCW Plan 2 Waiver Application Questions.doc

Robert Morris,

I left a message for you this morning alerting you about an e-mail you would receive from me concerning Delmarva UFCW application for Annual Limits Requirements of the PHS Act Section 2711 for Plans: Level 2, and 3. Attached above are the documents that need to be completed in order to finalize the application process.

Many thanks for your assistance with these documents.

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO)
Department of Health and Human Services
7501 Wisconsin Avenue
Bethesda, MD
301-492-4121

file:////co-adshare/...marva%20United%20Food%20&%20Commercial%20Workers/Request%20for%20additional%20info%2011.23.10.htm[11/10/2011 1:49:16 PM]

November 23, 2010

Dear Applicant:

RE: Delmarva United Food and Commercial Workers (Plan 3)

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 about Delmarva United Food and Commercial Workers (Plan 3):

1. Effective date of next renewal.

2. Provide the number of individuals covered by the plan to include dependents.

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

	Premium (Current)	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)				

4. Indicate if the plan is fully-insured plan or a self-insured plan.

5. Indicate if there are any deductibles for the plan and the amount.

6. Indicate if this plan has Grandfather Status.

Please provide this information by 5:00 pm Tuesday November 30, 2010. We look forward to receiving your completed application. Thank you.

Sincerely,

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO)
Department of Health and Human Services
301-492-4121

November 23, 2010

Dear Applicant:

RE: Delmarva United Food and Commercial Workers (Plan 2)

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 about Delmarva United Food and Commercial Workers (Plan 2):

1. Effective date of next renewal.

2. Provide the number of individuals covered by the plan to include dependents.

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

	Premium (Current)	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)				

4. Indicate if the plan is fully-insured plan or a self-insured plan.

5. Indicate if there are any deductibles for the plan and the amount.

6. Indicate if this plan has Grandfather Status.

Please provide this information by 5:00 pm Tuesday November 30, 2010. We look forward to receiving your completed application. Thank you.

Sincerely,

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO)
Department of Health and Human Services
301-492-4121

From: Scelzo, Kathleen (HHS/OCIIO)
Sent: Wednesday, December 01, 2010 7:54 AM
To: Habit, Sandra (HHS/OCIIO)
Subject: FW: Delmarva UFCW Health

Attachments: 20101130143546724.pdf

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO) Department of Health and Human Services
7501 Wisconsin Avenue
Bethesda, MD
301-492-4121

-----Original Message-----
From: Bob Morris [mailto:bob@delmarvaufcw.org]
Sent: Tuesday, November 30, 2010 2:53 PM
To: Scelzo, Kathleen (HHS/OCIIO)
Subject: FW: Delmarva UFCW Health

Ms. Scelzo,

I have attached our response to your information request for your review.
Should you need any additional information or have any questions please let me know.

Thanks

Bob
800.692.1313

Cordially yours,

Robert Morris

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to whom it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies.

-----Original Message-----
From: sharp@delmarvaufcw.org [mailto:sharp@delmarvaufcw.org]
Sent: Tuesday, November 30, 2010 2:36 PM
To: Bob; Buddy
Subject:

This E-mail was sent from "RNPE5A4C2" (8070).

Scan Date: 11.30.2010 14:35:46 (-0500)
Queries to: sharp@delmarvaufcw.org

THE TRUSTEES OF
DELMARVA UNITED FOOD & COMMERCIAL WORKERS
HEALTH & WELFARE FUND

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Employer Trustees
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TELEPHONE 302-934-7737

November 30, 2010

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services

Re: Delmarva United Food and Commercial Workers Health and Welfare Plan (Plan 2)

Dear Ms. Scelzo:

Thank you for your correspondence of November 23, 2010 regarding the application of the Delmarva United Food and Commercial Workers Health and Welfare Plan (Plan 2) (hereinafter the "Plan") for a waiver of the annual limits requirements.

With respect to each of the numbered items:

1. Renewal. The Plan is a self-insured health plan and, as such, does not have an insurance policy to renew. The next Plan Year begins January 1, 2011.

2. Covered Lives. There were (b)(4) individuals, including dependents, enrolled in Plan 2 in Plan Year 2010.

3. Premiums (Contribution Rates). Each participating employer contributes (b)(4)% of gross wages per employee pursuant to the applicable collective bargaining agreement. The contribution rate is (b)(4)% of gross wages regardless of the employee's eligibility for coverage and regardless of whether any member of the employee's family is enrolled or eligible for coverage. The average annual contribution per employee for Plan Year 2009 was $ (b)(4) . In order to cover the increased cost if the $750,000 annual limit is applied, that amount would have to be $ (b)(4) , or a (b)(4) % increase.

The Plan calculates the cost of coverage pursuant to the COBRA rules, and charges that cost. Below is an estimate of the increased Plan cost that would be charged if the $750,000 annual limit was applied and the percentage increase.

Per Participant Premium (2010 to date)	Per Participant Premium (if $750,000 annual limit was applied)	Percentage increase if the $750,000 annual limit was applied
(b)(4)		

4. Self-Insured Plan. The Plan is self-insured, and claims are paid from the joint trust that is funded by employer contributions.

5. Deductibles. The Plan has (b)(4) deductibles.

6. Grandfathered Status. Because the Plan was in existence on the date of enactment of the Patient Protection and Affordable Care Act and has not decreased or eliminated benefits since the enactment of the Patient Protection and Affordable Care Act, the Plan is a grandfathered health plan.

If you have any further questions or concerns, please do not hesitate to call.

Very truly yours,

Robert Morris

THE TRUSTEES OF

DELMARVA UNITED FOOD & COMMERCIAL WORKERS HEALTH & WELFARE FUND

Union Trustees
ERIC W. MASTEN, *Chairman*
CARVEL M. MAYS, JR.
P.O. Box 1768
MILLSBORO, DELAWARE 19966

Employer Trustees
ALAN ZLOTORZYNSKI
TRACY MORRIS

TELEPHONE 302-934-7737

November 30, 2010

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services

Re: Delmarva United Food and Commercial Workers Health and Welfare Plan (Plan 3)

Dear Ms. Scelzo:

Thank you for your correspondence of November 23, 2010 regarding the application of the Delmarva United Food and Commercial Workers Health and Welfare Plan (Plan 3) (hereinafter the "Plan") for a waiver of the annual limits requirements.

With respect to each of the numbered items:

1. Renewal. The Plan is a self-insured health plan and, as such, does not have an insurance policy to renew. The next Plan Year begins January 1, 2011.

2. Covered Lives. There are (b)(4) individuals, including dependents, enrolled in Plan 3 in Plan Year 2010.

3. Premiums (Contribution Rates). Each participating employer contributes (b)(4)% of gross wages per employee pursuant to the applicable collective bargaining agreement. The contribution rate is (b)(4)% of gross wages regardless of the employee's eligibility for coverage and regardless of whether any member of the employee's family is enrolled or eligible for coverage. The average annual contribution per employee is $(b)(4) In order to cover the increased cost if the $750,000 annual limit is applied, that amount would have to be $(b)(4), or a (b)(4)% increase.

The Plan calculates the cost of coverage pursuant to the COBRA rules, and charges that cost. Below is an estimate of the increased Plan cost that would be charged if the $750,000 annual limit was applied and the percentage increase.

Per Participant Premium (2010 to date)	Per Participant Premium (if $750,000 annual limit was applied)	Percentage increase if the $750,000 annual limit was applied
(b)(4)		

4. Self-Insured Plan. The Plan is self-insured, and claims are paid from the joint trust that is funded by employer contributions.

5. Deductibles. The Plan has (b)(4) deductibles.

6. Grandfathered Status. Because the Plan was in existence on the date of enactment of the Patient Protection and Affordable Care Act and has not decreased or eliminated benefits since the enactment of the Patient Protection and Affordable Care Act, the Plan is a grandfathered health plan.

If you have any further questions or concerns, please do not hesitate to call.

Very truly yours,

Robert Morris

From: Scelzo, Kathleen (HHS/OCIIO)
Sent: Wednesday, December 01, 2010 1:21 PM
To: Habit, Sandra (HHS/OCIIO)
Subject: FW: Delmarva UFCW Health

Attachments: DEWaiverP3response.xls

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO)
Department of Health and Human Services
7501 Wisconsin Avenue
Bethesda, MD
301-492-4121

From: Bob Morris [mailto:bob@delmarvaufcw.org]
Sent: Wednesday, December 01, 2010 11:57 AM
To: Scelzo, Kathleen (HHS/OCIIO)
Subject: Delmarva UFCW Health

The additional information you requested for Plan 3

DELMARVA UFCW Health and Welfare Fund
Plan 3

Plan 3	Premium (Current)	Premium (Renewal)	Premium (if $750,000 annual limit was applied)	% increase if the $750,000 was implemented
		(b)(4)		

	Plan 3 A
Anesthesia	(b)(4)
Diagnostic Testing	
Office Visits X-Ray/Lab	
Major Med	
Medical	
Prescriptions	
Sudden & Serious Surgical	

From: Scelzo, Kathleen (HHS/OCIIO)
Sent: Wednesday, December 01, 2010 1:21 PM
To: Habit, Sandra (HHS/OCIIO)
Subject: FW: Delmarva UFCW Health

Attachments: DEWaiverresponseP2.xls

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO)
Department of Health and Human Services
7501 Wisconsin Avenue
Bethesda, MD
301-492-4121

From: Bob Morris [mailto:bob@delmarvaufcw.org]
Sent: Wednesday, December 01, 2010 12:00 PM
To: Scelzo, Kathleen (HHS/OCIIO)
Subject: Delmarva UFCW Health

The additional information you requested for Plan 2

Plan 2	Premium (Current)		Premium (if $750,000 annual limit was applied)	% increase if the $750,000 was implemented
			(b)(4)	

	Plan 2 An
Anesthesia	(b)(4)
Diagnostic Testing Office Visits X-Ray/Lab	
Major Med	
Medical	
Prescriptions	
Sudden & Serious	
Surgical	

From: Scelzo, Kathleen (HHS/OCIIO)
Sent: Monday, December 27, 2010 12:24 PM
To: Habit, Sandra (HHS/OCIIO)
Subject: FW: Delmarva UFCW Health

Kathleen M. Scelzo, RN, MSN
Rules Compliance Division
Office of Insurance Oversight
Office of Consumer Information and Insurance Oversight (OCIIO)
Department of Health and Human Services
7501 Wisconsin Avenue
Bethesda, MD
301-492-4121

From: Bob Morris [mailto:bob@delmarvaufcw.org]
Sent: Wednesday, December 15, 2010 10:28 AM
To: Scelzo, Kathleen (HHS/OCIIO)
Subject: Delmarva UFCW Health

Ms. Scelzo,

When you get a chance can I get a status update on our application for waiver?

Thanks

Bob

Cordially yours,
Robert Morris

Unauthorized interception of this communication could be a violation of Federal and State Law. This communication and any files transmitted with it are confidential and may contain protected health information. This communication is solely for the use of the person or entity to whom it was addressed. If you are not the intended recipient, any use, distribution, printing or acting in reliance on the contents of this message is strictly prohibited. If you have received this message in error, please notify the sender and destroy any and all copies.

From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Monday, December 20, 2010 11:06 AM
To: Bob@DelmarvaUFCW.org
Cc: Habit, Sandra (HHS/OCIIO)
Subject: Delmarva United Food and Commercial Workers Approval Letter for a Waiver of the Annual Limits Requirements 12-20-2010

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 **Delmarva United Food and Commercial Workers.** HHS has reviewed your application and made its determination. Please see the attached letter.

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

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

Sincerely,

Alexandra Botwinick

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

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.