JAMAICA CENTRAL LABOUR ORGANISATION

1812 R STREET, N.W.
P.O. BOX 53272
TEMPLE HEIGHTS P.O.
WASHINGTON, D.C. 20009

TELEPHONE : 202-667-6190
FAX NO. : 202-387-0450
E-mail: employers@jaclo.org

IN REPLY PLEASE REFER TO:

FILE NO. CLO: 806

October 14, 2010

REPRESENTING THE GOVERNMENT OF:
BARBADOS DOMINICA
JAMAICA ST. LUCIA
ST. VINCENT TRINIDAD & TOBAGO

Mr. James Mayhew
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Office of Oversight
Room 737-F-04
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Mr. Mayhew,

Re: Request for waiver of the Annual Limits Requirements of PHS Act section 2711

I am writing to seek a waiver from the restricted annual limits set forth in the Interim Final Regulations. In respect of the Caribbean Workers' Voluntary Employees' Beneficiary Association Health and Welfare Plan (CWVEBA), I am requesting that you:

- Allow the CWVEBA to replace the $750,000 annual limit with an annual limit of (b)(4) retroactively to October 1, 2010, the beginning of the current plan year.

(b)(4) was the lifetime maximum limit under the plan, and we are aware that effective October 1, 2010 there is no longer a lifetime benefits limit.

Application Requirements:

Terms of the CWVEBA Plan for which a Waiver is sought:

1. The Caribbean Workers' Voluntary Employees' Beneficiary Association Health and Welfare Plan (CWVEBA) was adopted on December 31, 1992 under the name H-2A and H-2B Voluntary Employees' Beneficiary Association Health and Welfare Plan. Following an amendment, the name was changed to CWVEBA on October 1, 2004. The CWVEBA complies with requirements of ERISA, the Department of Labor and the IRS. The required reporting documents are filed annually with the respective agencies.

   The purpose of the plan is to provide life, accidental death and dismemberment benefits, accident and sickness benefits, surgical expenses benefits, medical expense benefits, and

drug benefits for its members (Migrant workers from the participating Caribbean countries), during their seasonal assignment in the USA.

The CWVEBA Plan Year is from October 1st - September 30th.

The Number of Individuals covered by the CW VEBA:

2. The plan covers approximately (b)(4) members (all seasonal migrant workers) each year. The population is approximately (b)(4) as at the date of this request, October 14, 2010

The Annual Limit (s) and rates applicable to the CWVEBA:

3. The plan has no annual limits or rates applicable to the payment of benefits; however, the lifetime limit was capped at (b)(4).

Reason compliance with the Interim Final Regulations would result in significant decrease in access to benefits:

4. Compliance with the interim final regulations, applying the annual limit of $750,000 for the current plan year, would adversely affect the members of the CWVEBA. Due to the limiting funding of the CWVEBA, the plan would not be able to offer coverage to its members and this would result in a significant decrease in access to healthcare benefits while they are on contract in the United States. If the CWVEBA is not given a waiver from the annual limit of $750,000 for the current plan year, the CWVEBA would have to either suspend or terminate coverage to members for the following reasons:

    a. The plan is funded by the limited contributions paid into the Trust by its members;

    b. The only source of funds is from contributions which the members are required to contribute under the terms of the plan;

    c. Compliance with the annual limits would require a significant increase in member contributions to enable the plan to remain functional; and

    d. It would not be feasible to substantially increase member contributions since all of its members are migrant workers who have limited resources.

Attestation by the Plan Administrator:

5. As the administrator for the CWVEBA health plan, I hereby certify that:

I. The Caribbean Workers' Voluntary Employees' Beneficiary Association Health and Welfare Plan (CWVEBA) was adopted on December 31, 1992 and was in force prior to September 23, 2010; and that

II. The application of the restricted annual limits would be prohibitive to the CWVEBA and would result in the significant decrease in access to benefits for its members. The coverage currently offered under the health plan would either be suspended or terminated and the workers would have to work without non-job related insurance coverage during the period transitioning to 2014.

Thank you for your kind consideration in processing this application for the waiver from the annual limits set for the current plan year. Your favourable consideration will enable the members of the CWVEBA to have continued access to the healthcare benefits provided under the plan.

Yours truly,

Barbara DaCosta
Plan Administrator - CWVEBA

Enc.

cc: Ms. Jane Andrews

JAMAICA CENTRAL LABOUR ORGANISATION

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FAX NO. : 202-387-0450
E-mail: employers@jaclo.org

IN REPLY PLEASE REFER TO:

FILE NO. CLO: 806

October 19, 2010

REPRESENTING THE GOVERNMENT OF:
BARBADOS DOMINICA
JAMAICA ST. LUCIA
ST. VINCENT TRINIDAD & TOBAGO

Ms Erika M. Kottenmeier
Division of Enforcement
Office of Oversight
HHS/OCHIIO
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Ms Kottenmeier,

Re: Application for Waiver of Annual Limits for CWVEBA

Please refer to your email dated October 18, 2010, requesting that we provide the increase premiums that CWVEBA members would likely pay if a waiver is not granted.

As indicated in our Application for Waiver dated October 14, 2010, the cost of maintaining the health plan, without a waiver of the annual limits are prohibitive and would require the suspension or termination of the CWVEBA plan. On that basis, the JCLO explored the possibilities of using a Third Party Administrator (TPA), and a Reinsurer which would act in coordination as the insurer. However, this would also require a significant increase in member contributions.

The proposed insurance would:

- Increase member contributions by (b)(4), and place the insurance cost at a level that would be too expensive for participants given their limited resources; and

- Significantly reduce benefits. Even with the substantial increase in cost, the proposed insurance would eliminate some existing benefits; namely, disability, life, accidental death and dismemberment benefit all currently covered under CWVEBA.

Of importance is the fact that the contributions proposed are based on the period when enrollment is at its maximum. However, during off-peak periods when membership is lower, rates will be considerably higher. As a result, the rates quoted are subject to change, and will undoubtedly be more unfavourable for the participants at that time.

The following chart shows the lowest possible monthly contribution required to cover plan benefits.

*** N.B. Coverage is for medical and drugs only.**

	2009 Total October Premium	2010 Total October Premium (renewal without $750,000 annual limit)	2010 Total October Premium (renewal with $750,000 annual limit)
EE	(b)(4) [redacted]		
EE + Child (if applicable or other appropriate tier)			
EE + Spouse (if applicable or other appropriate tier)			
Family (if applicable or other appropriate tier)			

As requested, I am forwarding herewith a copy of the Summary Plan Description for the CWVEBA.

Thank you for your consideration in this matter.

Yours truly,

Barbara DaCosta
Plan Administrator - CWVEBA

Enc.

cc: Ms. Jane Andrews

From: Grace Brown [GBrown@jaclo.org]
Sent: Wednesday, October 27, 2010 2:02 PM
To: Botwinick, Alexandra (HHS/OCIIO)
Cc: Kottenmeier, Erika (HHS/OCIIO); Janice Andrews
Subject: RE: Waiver of the Annual Limits Requirements of PHS Act Section 2711
October 27, 2010

Mr. Steve Larsen
Director, Office of Oversight
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
Washington, DC

Attn: Ms. Alexandra Botwinick

Dear Sirs:

I am writing to acknowledge and thank you for your letter granting approval for the waiver of the Annual Limits Requirements of PHS Act Section 2711 with respect to the CWVEBA Health and Welfare Plan.

The JCLO is grateful that you have afforded us the opportunity to continue the administration of the health plan for the current plan year beginning on October 1, 2010, for the benefit of its participants, H2-A and H2-B temporary workers.

Sincerely,

Grace Brown
Insurance Officer
Jamaica Central Labour Organisation
1812 R Street, N.W.
Washington, DC 20009
Telephone : (202) 667-6190
Fax : (202) 387-0450
E-mail : employers@jaclo.org

cc: Ms. Jane Andrews
cc: Ms. Erica Kottenmeier

From: Botwinick, Alexandra (HHS/OCIIO) [mailto:Alexandra.Botwinick@hhs.gov]
Sent: Tuesday, October 26, 2010 3:19 PM
To: Grace Brown
Subject: FW: Waiver of the Annual Limits Requirements of PHS Act Section 2711
Importance: High

The letter is attached

Alexandra Botwinick

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

From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Tuesday, October 26, 2010 3:18 PM
To: 'gbrown@jaclo.org'
Subject: Waiver of the Annual Limits Requirements of PHS Act Section 2711
Importance: High

Good Afternoon,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section for CWVEBA "Jamaica Plan". HHS has reviewed your application and made its determination. Please see the attached letter.

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

SUMMARY PLAN DESCRIPTION

for

THE CARIBBEAN WORKERS' VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION HEALTH AND WELFARE PLAN

(Formerly known as
The H-2A andH-2B Voluntary Employees' Beneficiary
Association Health and Welfare Plan)

January 1, 2006

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I. INTRODUCTION

The Caribbean Workers' Voluntary Employees' Beneficiary Association (the Association) is an organization established to benefit workers who currently are sponsored by participating Caribbean countries to work in the United States of America (the United States) under the Visa Programs described below. On December 31, 1992, the Association put into effect the H-2A and H-2B Voluntary Employees' Beneficiary Association Health and Welfare Plan, which has been renamed as the Caribbean Workers' Voluntary Employees' Beneficiary Association Health and Welfare Plan (the Plan). The Association is the Plan Sponsor. The Employer Identification Number that was assigned to the Plan Sponsor is 52-1801184. You can contact the Plan Sponsor by calling (202) 667-6190 or by writing:

Caribbean Workers' Voluntary Employees' Beneficiary Association
1812 R Street, N.W.
P.O. Box 53272
Temple Heights P.O.
Washington, D.C. 20009

As a member of the Association, you are automatically a participant in the Plan. The Plan is an employee welfare benefit plan which provides life benefits; benefits in the event of accidental death, dismemberment or accident and sickness; and benefits for hospital, surgical, medical and drug and medicine expenses. The Plan Number that has been assigned to the Plan is 501.

Members' contributions to the Plan are held in a trust fund. The trust fund was created by the Grantors, who are the Permanent Secretary-Ministry of Labour, Jamaica, who is a member of the Regional Labour Board, and another member of the Regional Labour Board. The Trustees of the trust fund have been elected by the members. The elected Trustees are the Permanent Secretary-Ministry of Labour, Jamaica and another member of the Regional Labour Board. The individuals who hold these positions will continue to be the Trustees unless the members of the Association elect others as Trustees, or until they cease to be members of the Regional Labour Board. You can contact the Trustees by calling (202) 667-6190 or by writing:

Trustees, Caribbean Workers' Voluntary Employees' Beneficiary Association Trust
1812 R Street, N.W.
P.O. Box 53272
Temple Heights P.O.

Washington, D.C. 20009

The Trustees appoint the Plan Administrator. The Plan Administrator serves at the pleasure of the Trustees. The Plan is administered by contract with the Jamaica Central Labour Organisation (JACLO). As the Plan Administrator, JACLO has the responsibility for making the rules under which the Plan is run, and for seeing that the Plan is administered in a way that is fair to all members. You can contact the Plan Administrator by calling (202) 667-6190 or by writing:

Jamaica Central Labour Organisation
1812 R Street, N.W.
P.O. Box 53272
Temple Heights P.O.
Washington, D.C. 20009

The members may elect a Membership Committee. Any Membership Committee must consist of five Members who are elected by all of the Members. If a Membership Committee is properly elected, it will oversee the activities of the Trustees and the Plan Administrator.

This plan description will inform you of the main provisions of the Plan and tell you when you may expect benefits. If you have any questions after you read this plan description, the Plan Administrator should be contacted.

II. JOINING THE PLAN

A. Who Can Be a Member

You are a member of the Association and the Plan if you are recruited from participating Caribbean countries to work in the United States under a "Visa Program" while under the supervision of (but not in the employ of) the Jamaica Central Labour Organization. Upon your written request, the Plan will issue you a written statement regarding your membership (including whether any employer you identify is approved along with the employer's address).

B. Visa Program

A "Visa Program" is one that allows individuals from participating countries to work lawfully in the United States. Visa Program includes H2-A and H2-B visas, but excludes United States citizenship and "green-card" status (i.e., the status of having been lawfully accorded the privilege of residing in the United States as an immigrant in accordance with its immigration laws). The Trustees determine which categories of other visas under the laws of the United States qualify as Visa Programs and which countries may participate in the Program.

C. How To Become a Member and Continue as a Member

If you are eligible for membership, you become a member of the Association when you arrive in the United States. Shortly before or shortly after your arrival, you will be given a contribution authorization form. In order to continue your membership in the Association after being given this form, you must agree to make contributions to the Plan by signing the form. By signing this form, you authorize your employer to deduct the required contribution amount from your wages. Your employer will then pay the contribution to the Plan for you.

D. When Membership Ends

Your membership in the Association ends automatically when you:

(1) refuse or fail to sign a contribution authorization form;

(2) are no longer employed by an approved employer under a Visa Program;

(3) leave the United States;

(4) give the Plan Administrator written notice of your decision to end your membership; or

(5) stop making contributions.

In general, when your membership ends, so does your eligibility to receive benefits. Sections V, VII, VIII, IX, X and XI of this description contain information on extension of coverage beyond the end of your membership if you are "totally disabled". "Totally disabled" means having a condition which makes you unable to perform any and every duty of your job. Section XIV describes your rights to elect to continue coverage after your membership ends, if you remain in the United States.

III. REQUIRED CONTRIBUTIONS

As indicated in Section II, you will be given a contribution authorization form. In order to continue your membership in the Association, you must agree to make contributions to the Plan by signing the contribution authorization form. By signing this form, you allow your employer to deduct the required contribution amount from your wages. Your employer will then pay the contribution to the Plan for you. Your contribution and the contributions of the other members are necessary to provide the benefits under the Plan.

The amount of the necessary contribution may be adjusted by the Plan Administrator with the consent of any Membership Committee. As of the date of this plan description, the required contribution is $20.00 weekly.

You must make contributions beginning with the week during which you sign a contribution authorization form. Contributions must continue to be made until you are no longer a member. You must contribute the entire $20.00 for any week during which you are a member for any one or more days.

You will not receive any refunds of your contributions to the Plan when your membership ends.

Subject to the approval of any Membership Committee, the Plan Administrator determines the amount of contributions necessary to maintain the Plan on a sound financial basis. All contributions by members are paid into the trust fund. Contributions by members are used to provide benefits to the members and their beneficiaries, and to pay the Plan's administrative expenses. Benefits may be paid directly from the trust fund, or the Trustees may authorize insurance coverage.

The accounting year of the Plan (the Plan Year) begins on October 1 and ends on September 30. Plan records are kept on that basis.

IV. BENEFITS GENERALLY

A. Benefit May Not Exceed Expenses

You are not entitled to hospital benefits, surgical expense benefits, medical expense benefits or drug and medicine expense benefits in an amount that exceeds your actual hospital, surgical, medical and/or drug and medicine expenses.

B. Benefits May Not Exceed Reasonable and Customary Charges

Hospital benefits, surgical expense benefits, medical expense benefits and drug and medicine expense benefits are limited to reasonable and customary charges and fees. "Reasonable and customary" is defined in the Plan and you should check with the Plan Administrator for the specific definition. The amount of a charge or fee is reasonable and customary if it is equal to or less than the amount charged by others in the same area for the same service. If your expenses for treatment, services or supplies are greater than reasonable and customary charges, benefits will not be paid for all of your expenses.

C. Benefits May Not Be Paid For Expenses That Are Not Medically Necessary

Hospital benefits, surgical expense benefits, medical expense benefits and drug and medicine expense benefits are limited to charges and fees that are medically necessary. "Medically necessary expenses" is defined in the Plan and you should check with the Plan Administrator for the specific definition. A charge or fee is medically necessary if a physician determines that the charges or fees are required for the proper treatment of injury or sickness.

Certain expenses are never considered medically necessary. Dental work or treatment is not medically necessary unless it results from an injury to your natural teeth that happens while you are off the job. Similarly, the expenses for the fitting of glasses or hearing aids are not medically necessary.

D. Exclusions

Certain types of surgical or medical care, services, supplies or treatment (referred to as "Treatments") are excluded. If you have one of these Treatments, you will receive no benefits from the Plan. These excluded Treatments include:

- Confinement in an institution where the confinement is provided free of charge
- Treatment provided free of charge
- Treatment by a physician who is employed by any local, state or federal government agency

- Treatment that is determined by the Plan Administrator in its absolute discretion as (1) experimental in nature, or (2) employed for purposes other than to diagnose and treat nonoccupational sickness or nonoccupational injury. Examples are preventative medical examinations, mammography, pap smear, colonoscopy, contraceptive management, oral contraceptives, contraceptive devices, abortion, Depo-Provera, fertility/infertility treatment, sexual dysfunction, all dental and eye exams, eye glasses, contact lenses, cosmetic procedures or drugs, weight-loss drugs or treatment, organ transplants, knee and hip replacements.

- Treatment for self-inflicted injuries or illnesses

- Chiropractic Treatments

- Any Pre-Existing Condition, as described below

- Physiotherapy sessions in excess of the maximum of ten sessions

No benefits of any type will be paid under the Plan for any injury or sickness that is self inflicted or any death that is as a result of suicide. No benefits of any type will be paid under the Plan for any sickness or illness that is occupational. "Occupational" means any injury, illness, or sickness that either did arise out of and in the course of any employment for wage or profit or with respect to which you are entitled to benefits under any workers' compensation law or similar legislation.

E. Pre-Existing Conditions

A Pre-Existing Condition is any condition (regardless of its cause) for which medical advice, diagnosis, care, or treatment was recommended or received within six months prior to your becoming a Member. No benefits will be paid for a Pre-Existing Condition until twelve months after you become a Member. Medical advice, diagnosis, care, or treatment that was recommended or received with respect to the Pre-Existing Condition during the twelve-month period will not be covered.

The twelve-month period described above will be shortened by the period of any "Creditable Coverage" that you had prior to becoming a Member. Creditable Coverage is coverage under any group health plan, health insurance coverage, Medicaid, Medicare, or other health plan described in the Plan document. However, Creditable Coverage will generally be disregarded for any periods preceding a 63-day period in which you had no Creditable Coverage. So,

a 63-day break in Creditable Coverage can result in a longer period during which Pre-Existing Conditions are excluded.

F. Geographic Limitations

No benefits may be paid for any injury or sickness that occurs outside the United States.

G. Benefits Limited to Trust Fund

This Plan is funded by member contributions, which are paid into the trust fund. As indicated, all Plan benefits are paid from the trust fund. Benefits under this Plan are therefore limited to the amount of money available in the trust fund.

H. Lifetime Maximum Benefit

No more than $100,000 in Plan benefits will be paid to any one Member. This limit applies on a lifetime basis. The limit does NOT apply on a year by year basis and does NOT apply to each injury or accident. The limit applies to total benefits paid, no matter when or why benefits are paid.

The limit applies to all types of Plan benefits in the aggregate. It does not apply on a benefit by benefit basis. For example, if a Member receives $50,000 in hospital and surgical expense benefits, $25,000 in medical expense benefits, and $25,000 of drug and medicine expense benefits, no additional benefits of any kind will be paid to that Member.

I. Deductible

You are responsible for paying all expenses otherwise covered under the Medical Expense Benefit or Drug and Medical Supply Benefit up to a cash deductible of $100.00. The responsibility for this deductible must be satisfied separately and independently for each calendar year or part thereof while employed in the United States.

J. Third-Party Recovery

If you recover any judgment, insurance, settlements or other funds (a "Recovery") from a third party for any illness, injury, or death covered by this Plan, then the Recovery will become the property of the Plan to the extent it has and/or will pay benefits attributable to the illness, injury, or death. The following provisions govern the Plan's right of recovery:

- The right extends to third parties and to the covered person's insurer and any other insurer that covers injuries sustained by the covered person;
- The plan may utilize all possible remedies, both legal and equitable, including subrogation, restitution, constructive trust, and equitable lien, to

recover funds;

- The plan may offset future benefits to the extent required to provide for full recovery;
- Recovery may be made from any funds paid and from any and all sources, including judgment, settlement, and insurance;
- The plan will have the right of first recovery, and recovery may be sought from any full or partial recovery, notwithstanding the fact that the covered person has not been made whole; and
- Attorney's fees and all other litigation expenses are the sole responsibility of the covered person.

V. LIFE BENEFITS

A. Eligibility for Benefits

If you die while you are a member of this Plan, the Plan will pay life benefits to your named beneficiary or beneficiaries. Life benefits also may be paid if you die within one year after your coverage ended because you have become totally disabled and, while you continued to be disabled, your death results from the condition that made you totally disabled (see Section C. below).

B. Amount of Benefits

After proof of your death has been given to the Plan Administrator, life benefits in the amount of $7,500 shall be paid to your named beneficiary or beneficiaries. If no named beneficiary is living at the time of your death, the $7,500 shall be paid: to your husband or wife or, if none, to your children or, if none, to your parents or, if none, to your estate.

C. Extension of Coverage

If your membership ends because you become totally disabled, part of your life benefits coverage may be extended for one year. This extended coverage will continue only for so long as you remain totally disabled from the condition which caused the termination of your coverage under the Plan. During this time, you may have to submit to physical examinations to prove that you remain totally disabled. These examinations will be paid for by the Plan. If you die as a result of the injury or sickness which caused you to be totally disabled and your death occurs within one year after the termination of coverage, the life benefits described in B. above will be paid as indicated.

VI. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

A. Eligibility for Benefits

Accidental death and dismemberment benefits may be paid if an accident causes you to lose your life, one or both hands or feet, sight of one or both eyes, or a thumb, finger or toe. These benefits will be paid only if the loss occurs within thirteen (13) weeks after the accident and bodily injury occur. Benefits are also paid for partial loss of a thumb, finger or toe.

B. Schedule of Benefits

After proof of your death due to accidental bodily injuries has been given to the Plan Administrator, a benefit of $7,500 shall be paid to your named beneficiary or beneficiaries. If no named beneficiary is living at the time of your death, the amount shall be paid: to your husband or wife or, if none, to your children or, if none, to your parents or, if none, to your estate.

The amounts payable under this Section, for accidental bodily injuries that do not result in your death, will be determined as follows:

Amount of Benefit That May be Paid	Bodily Injury or Injuries Suffered
$7,500	The total loss of: both hands; both feet; one hand and one foot; one foot and sight of one eye; or sight of both eyes
$3,750	The total loss of one hand, one foot, or sight of one eye
$1,500	The total loss of a thumb or an index finger
$750	The total loss of any other finger or a toe
$750	The partial loss of a thumb or an index finger
$375	The partial loss of any other finger or a toe

Please note that the total loss of a hand or foot means severance at or above the wrist or ankle.

C. Limitations and Exclusions

The maximum amount that can be paid under this coverage is $7,500.

If you have more than one loss as the result of one accident, only one benefit may be paid. The one benefit paid will be for the loss for which the highest amount may be paid.

No benefit may be paid under this coverage for loss resulting from war or act of war, military service or police duty. No benefit will be paid under this coverage for loss if the loss occurs as you commit or try to commit a felony.

VII. ACCIDENT AND SICKNESS BENEFITS

A. Eligibility for Benefits

You may receive Plan benefits if you have a condition which makes you unable to perform any and every duty of your job. You will not receive benefits if the condition which makes you unable to work arises from your employment. Benefits will not be paid if you are receiving workers' compensation. Benefits are payable only if you must visit or receive visits from a physician every fourteen (14) days because you are totally disabled. You may have to submit to physical examinations to prove that you remain totally disabled. The cost of any physical examinations will be paid by the Plan.

B. Benefits and Limitations

After proof is given to the Plan Administrator, $20.00 per day may be paid to you. These payments may be made for as many as thirteen (13) weeks for each period of disability. If you are totally disabled due to sickness, however, benefits will not be paid before you have been sick for six (6) days. If you are disabled for two or more periods of time, these periods of time generally will be treated as a single period of disability. Two or more periods of disability will not be treated as a single period if they are separated by a return to full-time employment for two weeks or they are due to unrelated causes.

C. Extension of Coverage

It is possible that you will return to your home Caribbean country while you are eligible to receive accident and sickness benefits as described in A. above. In this case, you will receive benefits of $10.00 per day for the remainder of the thirteen (13) week period.

VIII. HOSPITAL BENEFITS

A. Eligibility for Benefits

You may receive benefits if you are in a hospital or infirmary because of a sickness or injury which did not arise from and during employment. These benefits cover charges for room and board and for service charges. Benefits will be paid only for a period of confinement or for services which are recommended and approved by a physician.

B. Benefits and Limitations

After proof is given to the Plan Administrator, benefits may be paid for reasonable and customary charges for room and board while you stay in a hospital or infirmary.

Benefits may also be paid for reasonable and customary charges (other than for room and board) as hospital service benefits while you stay in a hospital or infirmary. Hospital service benefits include charges made by a physician or registered anesthetist for anesthetics and administering anesthetics.

These benefits will only be paid for expenses that are medically necessary and result from an injury or sickness that occurs within the United States.

C. Exclusions

No benefits are payable under this coverage for: professional, surgical and medical care; non-medical personal services; or private duty nursing (other than skilled home nursing care recommended by a physician following hospital or infirmary confinement).

D. Extension of Coverage

This coverage may be temporarily extended if your membership ends because you become totally disabled due to a condition which did not arise from and during employment. Benefits may be extended for up to thirteen (13) weeks after your employment ends, if you remain totally disabled. The benefits described in B. above will be paid, if you incur covered expenses within this thirteen (13) week period and the expenses result from the injury or sickness which caused you to be totally disabled.

IX. SURGICAL EXPENSE BENEFITS

A. Eligibility for Benefits

Benefits may be paid for surgical expenses if you have a surgical operation. These benefits will be paid only if the surgical operation(s) is necessary because of a sickness or injury which did not arise from and during employment.

B. Amount of Benefits

After proof has been given to the Plan Administrator, surgical expense benefits may be paid to you in an amount equal to your actual reasonable, customary and medically necessary expenses for surgical fees. Benefits may be paid only for expenses that result from an injury or sickness that occurs within the United States.

C. Limitations and Exclusions

Benefits may be paid only for surgical procedures performed by a surgeon or physician licensed to render medical services or perform surgery in accordance with local law.

If more than one surgical procedure is performed through the same incision, benefits will not be paid in an amount greater than the cost of the more expensive procedure.

D. Extension of Coverage

This coverage may be temporarily extended if your membership ends because you become totally disabled due to a condition which did not arise from and during employment. Benefits may be extended for up to thirteen (13) weeks after your employment ends, if you remain totally disabled. The benefits described in B. above will be paid, if you incur covered expenses within this thirteen (13) week period and the expenses result from the injury or sickness which caused you to be totally disabled.

X. MEDICAL EXPENSE BENEFITS

A. Eligibility for Benefits

Benefits may be paid for medical expenses if you visit or receive visits from a physician for medical treatment of a sickness or injury which did not arise from and during employment.

B. Amount of Benefits

After proof is given to the Plan Administrator, your reasonable and customary actual expenses for medical fees charged to you by a physician may be paid as medical expense benefits. These benefits will be paid only if your expenses were medically necessary and result from an injury or sickness that occurs within the United States.

C. Exclusions

If you visit or receive a visit from a physician, no benefits will be paid for the covered medical expenses below the cash deductible payable by you. No benefits will be paid for immunizations, allergy testing or desensitizing, unless you had to be immunized, tested or desensitized due to accidental bodily injury or unless required by public health officials.

D. Extension of Coverage

This coverage may be temporarily extended if your membership ends because you become totally disabled due to a condition which did not arise from and during employment. Benefits may be extended for up to thirteen (13) weeks after your employment ends, if you remain totally disabled. The benefits described in B. above will be paid, if you incur covered expenses within this thirteen (13) week period and the expenses result from the injury or sickness which caused you to be totally disabled.

XI. DRUG AND MEDICAL SUPPLY EXPENSE BENEFITS

A. Eligibility for Benefits

Benefits may be paid if you have expenses for drugs or medical supplies prescribed by a physician as a result of an injury or sickness which did not arise from and during employment. In order for this benefit to be paid to you, you may have to ask the provider of the drugs or medical supplies to make information, such as copies of your prescription, available to the Plan Administrator.

B. Amount of Benefits

After proof is given to the Plan Administrator, the reasonable and customary actual expenses for drugs or medical supplies prescribed by a physician may be paid as drug and medical supply expense benefits. These benefits will be paid only if your drug and medical supply expenses were medically necessary and result from an injury or sickness that occurs within the United States.

C. Exclusion

Benefits for covered expenses under this Section will not include the amount of the cash deductible payable by you.

D. Extension of Coverage

This coverage may be temporarily extended if your membership ends because you become totally disabled due to a condition which did not arise from and during employment. Benefits may be extended for up to thirteen (13) weeks after your employment ends if you remain totally disabled. The benefits described in B. above will be paid if you incur covered expenses within this thirteen (13) week period and the expenses result from the injury or sickness which caused you to be totally disabled.

XII. ELECTIONS AND CLAIMS PROCEDURE

A. Making and Changing Elections

Any elections or choices you may make under the Plan, or any changes in your elections (for example, choosing or changing your beneficiary), must be made in writing on the forms provided by the Plan Administrator.

B. Claims Procedure

The Trustees may appoint a Claims Administrator to serve at their pleasure. If appointed, a Claims Administrator will handle benefit payments. If no Claims Administrator is appointed, the Plan Administrator will handle benefit payments. As of the date of this plan description, the Plan Administrator will handle benefit payments.

To claim any benefit under the Plan, you or your beneficiary must submit written proof of your claim to the Plan Administrator. If the Plan Administrator does not provide a claim form within fifteen (15) days of your request for a form, you should send written proof of the event that makes you eligible for benefits. You should fully explain the occurrence, character and extent of the event that makes you eligible for benefits.

There are time limits for submitting claims. You should send your claim for benefits within ninety (90) days of the date the expenses were incurred.

C. Payment of Benefits

Benefits will be paid from the Plan as you establish written proof of claim for the benefits. Benefits may be paid by the Plan Administrator directly to the hospital, infirmary, physician or other person or persons to whom you owe money. At its option, the Plan Administrator may pay benefits to you.

For the protection of your interests and those of your beneficiary or beneficiaries, your benefits under the Plan generally cannot be assigned to anyone else, nor are your benefits subject to attachment. This means that you cannot name someone to receive your benefits instead of you, and your creditors have no right to claim your benefits in payment of your debts.

D. *Review of Denied Claims*

If you (or in the event of your death, your beneficiary) believe that benefits which are due are not paid, a written claim for the benefits should be sent to the Plan Administrator. You may appoint a representative, at your own cost, to act on your behalf. The Plan Administrator will decide whether to grant or deny the claim. The Plan will follow the provisions of section 2560.503-1 of the Department of Labor regulations in reviewing the claim under this Paragraph D and considering any appeals under the following Paragraph E.

If the claim is denied, the claimant will receive a written notice stating why the claim was denied. The notice will be provided to the claimant according to the following timeline:

(1) Life and Accidental Death and Dismemberment Benefits

Generally, notice will be provided within 90 days after filing your claim. The Plan Administrator may take up to an additional 90 days to make a decision if the situation warrants an extension and written notice is provided to you.

(2) Accident and Sickness Benefits

Generally, notice will be provided within 45 days after filing your claim. The Plan Administrator may take up to an additional 30 or 60 days to make a decision if the situation warrants an extension and written notice is provided to you.

(3) Hospital, Surgical, Medical, and Drug and Medical Supply Expense Benefits

The timing of notice depends on whether your claim is an *Urgent Claim* (one where lack of immediate treatment could imperil life or health or result in severe pain) or a *Non-Urgent Claim* (one that is not an Urgent Claim).

For an Urgent Claim, notice will be provided within 72 hours after the Plan Administrator receives your claim, provided that you provide all the information necessary to make a decision. If all the information is not provided, then the Plan will notify you of this fact within 24 hours after it receives your claim. You will then have 48 hours to provide the information, and a decision will be made within 48 hours of the Plan's receipt of this information (but in no event later than 48 hours after the deadline for you to provide the additional information).

For a Non-Urgent Claim, notice will be provided within 30 days after the Plan Administrator receives your claim. The Plan Administrator may take up to an additional 15 days to make a decision if the situation warrants an extension and written notice is provided to you. If the extension is caused by your failure to

provide information, then the Plan Administrator will notify you and give you at least 45 days to provide the information.

In all cases where your claim is denied, the notice will describe the specific reason or reasons for the denial, refer to the specific Plan provisions on which the denial is based, describe any additional material or information necessary for you to appeal the denial (along with explanation of why such material or information is necessary), and describe the Plan's review procedures and the time limits applicable to such procedures, including the expedited procedures for reviewing an Urgent Claim and a statement of your right to bring a civil action under section 502(a) of ERISA following a denial on review. Additional disclosures will be made if the denial does not relate to Life Benefits or Accidental Death or Dismemberment Benefits. In those cases, you will be notified if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial. You will also be provided either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be provided either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

E. Appeal of Denied Claims

You will be given an opportunity to appeal your denied claim. You or your representative will be permitted to review Plan documents that relate to your claim, and to submit written comments to the Plan Administrator. Your claim will then be reviewed by the Plan Administrator at a hearing. You or your representative may be present at the hearing. For Life Benefits, Accidental Death and Dismemberment Benefits, and Accident and Sickness Benefits, this request must be made in writing within 60 days after you receive notice that your claim has been denied. For all other benefits (Hospital Benefits; Surgical Expense Benefits; Medical Expense Benefits; Drug and Medical Supply Expense Benefits), the deadline is 180 days after you receive this notice. In addition, for these other benefits the appeal will be conducted by a party that did not make the initial denial and no deference will be given to the initial denial. The review will (when necessary) take into account the medical judgment of a health care professional, who will be identified whether or not the professional's judgment was relied upon in making the determination on review.

If your appeal is denied, you will receive a written notice stating why your claim was denied. The notice will be provided to you according to the following timeline:

(1) Life and Accidental Death and Dismemberment Benefits

Generally, notice will be provided within 60 days after filing your appeal. The Plan Administrator may take up to an additional 60 days to make a decision if the situation warrants an extension and written notice is provided to you.

(2) Accident and Sickness Benefits

Generally, notice will be provided within 45 days after filing your appeal. The Plan Administrator may take up to an additional 45 days to make a decision if the situation warrants an extension and written notice is provided to you.

(3) Hospital, Surgical, Medical, and Drug and Medical Supply Expense Benefits

For an Urgent Claim, notice will be provided within 72 hours after the Plan Administrator receives your appeal.

For a Non-Urgent Claim, notice will be provided within 60 days after the Plan Administrator receives your claim.

If your appeal is denied, the Plan Administrator will give you a written notice including: (a) the specific reason or reasons for the denial; (c) reference to the specific Plan provisions on which the benefit determination is based; (c) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all relevant documents; and (d) and a statement of your right to bring an action under section 502(a) of the ERISA.

Additional disclosures will be made if the denial does not relate to Life Benefits or Accidental Death or Dismemberment Benefits. In those cases, you will be notified if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the denial. You will also be provided either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request. If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be provided either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

You and the Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

XIII. PLAN AMENDMENT AND TERMINATION

It is the intention of the Plan Sponsor to continue the Plan indefinitely, but, at some time in the future, it may be necessary or desirable to amend (change) or even to terminate (end) the Plan. The Plan may be amended at any time in writing by the Trustees. The Trustees also have the right to terminate the Plan, in whole or in part.

The amendment and/or termination of the Plan may not result in any part of the trust fund being used for purposes other than providing benefits and paying administrative expenses.

If the Plan is terminated, any money remaining in the trust fund after payment of benefits and expenses will be used to provide life, accident, sickness or other benefits to members.

XIV. CONTINUATION COVERAGE

A. Eligibility

Your membership in the Association and in the Plan ends when you terminate your employment. At that time you will be given the opportunity to elect continuation coverage under the Plan. If you were dismissed for gross misconduct, however, you do not have the right to elect continuation coverage. If you elect continuation coverage, you will not be a member, but you will have coverage that is the same as the coverage provided to members. Because the Plan only covers injury and sickness that occur in the United States, your continued coverage will only cover injury and sickness that occur in the United States.

B. Election and Payment of Premiums

In order to have continuation coverage, you must make your election within sixty (60) days after your coverage ends or within sixty (60) days after you receive notice that you can elect to continue your coverage. To receive the continued coverage you must pay premiums. Your premium will be 102% of the contribution that other members are paying to the Plan. If you were disabled within the meaning of the Social Security Act at the time your coverage ended, after eighteen (18) months you will pay 150% of the contribution other members are paying to the Plan. Your first premium payment will be due no later than forty-five (45) days after you elect continuation coverage. If your premiums are not timely paid, your continuation coverage will end.

C. When Continuation Coverage Begins and Ends

Continuation coverage begins on the date on which your employment ends. Continuation coverage ends on the earliest of the following dates:

(1) eighteen (18) months after the date on which your employment ended (twenty-nine (29) months if you were disabled within the meaning of the Social Security Act at the time your coverage ended);

(2) the date on which your employer ceases to provide any group health plan to any employee;

(3) the date you fail to pay any premium when due;

(4) the date on which you are covered under another group health plan which does not contain exclusions or limitations with respect to any preexisting condition; or

(5) the date you become entitled to Medicare benefits.

XV. YOUR RIGHTS UNDER THE PLAN

The following information about your rights under the Plan is required to be included in this description by federal law and regulations.

As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

A. Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.

Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

B. Continue Group Health Plan Coverage

Continue health care coverage for yourself if there is a loss of coverage under the plan as a result of a qualifying event. You will have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a

preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

C. Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants. No one, including your employer or any other person, may end your employment or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

D. Other Rights

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Because the Plan does not provide medical benefits to dependents, the Plan cannot be subject to any qualified medical child support orders (QMCSOs).

Title II of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") imposes numerous requirements on health plans concerning the use and disclosure of individual health information. This information, known as protected health information, includes virtually all individually identifiable health information held by the Plan - whether received in writing, in an electronic medium, or as an oral communication. Your privacy rights under Title II of HIPAA will be protected to the extent required in accordance with the terms found in the Plan.

E. Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

F. Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefit Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefit Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefit Security Administration.

G. Agent for Service of Legal Process

The JACLO Chief Liaison Officer, currently Barbara DaCosta, is the agent for service of legal process and may be served at 1812 R Street, N.W., P.O. Box 53272, Temple Heights P.O., Washington, D.C. 20009. Legal process may also be served upon the Trustees.

XVI. PLAN PROVISIONS WILL CONTROL

This is a summary plan description of the Plan; it is not the Plan or a substitute for the Plan. The Plan itself is a much longer, much more detailed document which is written in legal terms. This description explains how the Plan works in a format we hope you find easy to follow and handy to use. Because this is only a description of the Plan, however, misunderstandings can occur. In the case of any conflict between any statement in this description and the actual terms of the Plan, the terms of the Plan take precedence. If you have any questions about the Plan after reading this plan description, please contact the Plan Administrator for help.

The Plan Administrator has the duty and the authority to make factual finding and to interpret the provisions of the Plan in the event of ambiguity or inconsistency.

To: Participants
From: Plan Administrator
Date: March 16, 2010

SUMMARY ANNUAL REPORT FOR CARIBBEAN WORKERS' VOLUNTARY EMPLOYEES' BENEFICIARY ASSOCIATION HEALTH AND WELFARE PLAN

This is a summary of the annual report of the Caribbean Workers' Voluntary Employees' Beneficiary Association Health and Welfare Plan, EIN No. 52-1801184 for the period from October 1, 2008 to September 30, 2009. The annual report has been filed with the Internal Revenue Service as required under the Employee Retirement Income Security Act of 1974 (ERISA).

BASIC FINANCIAL STATEMENT

The value of plan assets, after subtracting liabilities of the plan, was $4,085,957 as of September 30, 2009, compared to $3,404,440 as of October 1, 2008. During the plan year, the plan experienced an increase in its net assets of $681,518. During the plan year, the plan had total income of $2,098,893 including member contributions of $2,054,824 and earnings from investments of $44,069. Plan expenses were $1,417,375. These expenses included $166,909 in administrative expenses, $1,236,794 in benefits paid to participants and beneficiaries, and $13,672 in other expenses.

YOUR RIGHTS TO ADDITIONAL INFORMATION

You have the right to receive a copy of the full annual report or any part thereof, on request. The items listed below are included in that report:

1. An accountant's report;
2. Assets held for investment; and
3. Fiduciary information.

To obtain a copy of the full annual report, or any part thereof, write or call the office of the Jamaica Central Labour Organisation (formerly West Indies Central Labour Organisation) which is the Plan Administrator, at 1812 R Street, N.W., Temple Heights P.O., Box 53272, Washington, D.C. 20009, ((202)) 667-6190). The charge to cover copying cost will be $1.00 for the full annual report, or $0.10 per page for any part thereof.

You also have the right to receive from the Plan Administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the Plan Administrator, these two statements and accompanying notes, will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan, 1812 R Street, N.W., Temple Heights P.O., Box 53272, Washington, D.C. 20009, in the offices of your employer ten days after making a written request to the Plan Administrator, and at the U.S. Department of Labor in Washington, D.C. or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department of Labor should be addressed to Public Disclosure Room, N4677, Pension and Welfare Benefit Programs, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

From: Kottenmeier, Erika (HHS/OCIIO)
Sent: Monday, October 18, 2010 6:45 PM
To: 'gbrown@jaclo.org'
Cc: Botwinick, Alexandra (HHS/OCIIO)
Subject: CWVEBA Annual Limits Waiver Application

Follow Up Flag: Follow up
Flag Status: Blue
Dear Ms. Brown,

Thank you for your application to the Waiver of the Annual Limits Requirements of the PHS Act Section 2711 on behalf of the CWVEBA. In order to finish evaluating your application, we require the following information:

- Please provide the increase premiums that employees would likely pay if a waiver is not granted. Ideally, we would appreciate a chart populated with the following information:

	2009 Total October Premium	2010 Total October Premium (renewal without $750,000 annual limit)	2010 Total October Premium (renewal with $750,000 annual limit)
EE			
EE + Child (if applicable or other appropriate tier)			
EE + Spouse (if applicable or other appropriate tier)			
Family (if applicable or other appropriate tier)			

Additionally, if you have a summary of plan benefits you provide to your members describing how benefits are disbursed, it would be more useful to our evaluation of your application than the IRS documents provided. If not, the description provided in the application, along with the additional information requested above may suffice. However, the more information you can provide us about your plan to help us understand how it works, the better we can assess whether the CWVEBA should be granted a waiver from the annual limits requirement.

Thank you for providing this additional information. We look forward to your response soon.

Kind Regards,

Erika M. Kottenmeier
Division of Enforcement
Office of Oversight
HHS/OCIIO
(301) 492-4170
erika.kottenmeier@hhs.gov

From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Tuesday, October 26, 2010 3:19 PM
To: 'gbrown@jaclo.org'
Subject: FW: Waiver of the Annual Limits Requirements of PHS Act Section 2711

Importance: High

Attachments: Updated 10-1 approval letter .pdf
The letter is attached

Alexandra Botwinick

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

From: Botwinick, Alexandra (HHS/OCIIO)
Sent: Tuesday, October 26, 2010 3:18 PM
To: 'gbrown@jaclo.org'
Subject: Waiver of the Annual Limits Requirements of PHS Act Section 2711
Importance: High

Good Afternoon,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section for CWVEBA "Jamaica Plan". HHS has reviewed your application and made its determination. Please see the attached letter.

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

Pages 43 through 113 redacted for the following reasons:
- -
Exemption(b)(6)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201

Date: September 24, 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 October 1, 2010. 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.

A waiver approval granted under this process applies only for the plan or policy year beginning between September 23, 2010 and September 23, 2011. 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 after reviewing the information provided in connection with the waiver process set forth in this memorandum and other relevant information.

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

Sincerely,

Steve Larsen
Director, Office of Oversight
Office of Consumer Information and Insurance Oversight

From: Grace Brown [GBrown@jaclo.org]
Sent: Thursday, October 14, 2010 2:08 PM
To: HHS HealthInsurance (HHS)
Cc: Andrews, Jane (HHS/OCIIO)
Subject: Waiver

Attachments: SKMBT_C25010101412410.pdf

Dear Mr. Mayhew,

I am forwarding herewith the application for waiver of the annual limits in respect to the Caribbean Workers' Voluntary Employees' Beneficiary health and Welfare Plan (CWVEBA). The supporting documents, Form 5500 for the plan year 2007, 2008 and 2009 will be forwarded under separate cover.

Thank you for your kind consideration in this matter.

Grace Brown
Insurance Officer
Jamaica Central Labour Organisation
1812 R Street, N.W.
Washington, DC 20009
Telephone : (202) 667-6190
Fax : (202) 387-0450
E-mail : employers@jaclo.org

From: Marcia Williams
Sent: Thursday, October 14, 2010 1:39 PM
To: Grace Brown
Subject: FW: Message from KMBT_C250

Marcia Williams
Secretary
Jamaica Central Labour Organisation
1812 R Street, N.W.
Washington, D.C. 20009
Telephone : (202) 667-6190
Fax : (202) 387-0450
E-mail : employers@jaclo.org

From: administrator@jaclo.org [mailto:administrator@jaclo.org]
Sent: Thursday, October 14, 2010 1:41 PM
To: Marcia Williams
Subject: Message from KMBT_C250