§501-c-9 Post-Retirement Medical Plan & Trust

A single employer plan sponsored by
Truckee Meadows Water Authority

AGENDA
§501-c-9 Post-Retirement Medical Plan & Trust
Tuesday, April 16, 2019 at 1:00 p.m.
Truckee Meadows Water Authority
Independence Room
1355 Capital Boulevard, Reno, NV 89502

1. Roll call*
2. Public comment — limited to no more than three minutes per speaker*
3. Approval of the agenda **(For Possible Action)**
4. Approval of the January 18, 2019 minutes **(For Possible Action)**
5. Review and approval of Post-Retirement Medical Plan & Trust calculations for TMWA Retiree Scott Knecht—Jessica Atkinson **(For Possible Action)**
6. Review and consideration for approval of request for reimbursement of premiums for Ameritas Dental Coverage. —Jessica Atkinson **(For Possible Action)**
7. Review and consideration for approval of request for reimbursement of premiums for United Health Care/AARP—Jessica Atkinson **(For Possible Action)**
8. Review and consideration for approval of request for reimbursement of premiums for Medicare premium paid for by retiree through Social Security —Jessica Atkinson **(For Possible Action)**
9. Review and consideration for approval of request for reimbursement of premiums for United Health Care and Rx coverage paid for by retiree —Jessica Atkinson **(For Possible Action)**
10. Review and consideration for approval of request for reimbursement of premiums for Physicians Mutual paid for by retiree—Jessica Atkinson **(For Possible Action)**
11. Review and consideration for approval of request for reimbursement of premiums for Blue Cross Blue Shield paid for by retiree —Jessica Atkinson **(For Possible Action)**
12. Review and consideration for approval of request for reimbursement of premiums for Medicare Part B paid for by retiree through Social Security—Jessica Atkinson **(For Possible Action)**
13. Review of actuarial analysis–Michele Sullivan*****
14. Review of Retirement Benefits Investment Fund (RBIF) performance—Michele Sullivan
15. Update of interpretation of Trust document regarding a beneficiary spouse eligibility for continuation of benefit. – Jessica Atkinson
16. Trustee comments and requests for future agenda items*

17. Public comment — limited to no more than three minutes per speaker*

18. Adjournment **(For Possible Action)**

NOTES:
1. The announcement of this meeting has been posted at the following locations: Truckee Meadows Water Authority (1355 Capital Blvd., Reno), Reno City Hall (1 E. First St., Reno), Sparks City Hall (431 Prater Way, Sparks), Sparks Justice Court (1675 E. Prater Way, Sparks), Washoe County Courthouse (75 Court St., Reno), Washoe County Central Library (301 South Center St., Reno), Washoe County Administration (1001 East Ninth St., Reno), and at http://www.tmwa.com.
2. In accordance with NRS 241.020, this agenda closes three working days prior to the meeting. We are pleased to make reasonable accommodations for persons who are disabled and wish to attend meetings. If you require special arrangements for the meeting, please call 834-8002 before the meeting date.
3. The Board may elect to combine agenda items, consider agenda items out of order, remove agenda items, or delay discussion on agenda items. Arrive at the meeting at the posted time to hear item(s) of interest.
4. Asterisks (*) denote non-action items.
5. Public comment is limited to three minutes and is allowed during the public comment periods. The public may sign-up to speak during the public comment period or on a specific agenda item by completing a "Request to Speak" card and submitting it to the clerk. In addition to the public comment periods, the Chairman has the discretion to allow public comment on any agenda item, including any item on which action is to be taken.

Post-Retirement Medical Plan & Trust
A single employer plan sponsored by
Truckee Meadows Water Authority

TRUCKEE MEADOWS WATER AUTHORITY
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DRAFT JANUARY 18, 2019 MINUTES

The meeting of the TMWA Post-Retirement Medical Plan and Trust (Trust) Trustees was held on Friday, January 18, 2019 in the Truckee Meadows Water Authority Independence Room, 1355 Capital Blvd., Reno, Nevada.

Michele Sullivan, Chairman, called the meeting to order at 10:59 A.M.

1. ROLL CALL AND DETERMINATION OF PRESENCE OF A QUORUM.

A quorum was present.

Voting Members Present:	Voting Members Absent
Michele Sullivan	Steve Enos
Juan Esparza	
James Weingart	

Members Present	Members Absent:
Rosalinda Rodriguez	Gus Rossi
Jessica Atkinson	
Adam Weber	
Michael Venturino	

2. PUBLIC COMMENT

Ms. Atkinson advised that on December 13, 2018, the Truckee Meadows Water Authority Board of Directors officially signed and adopted a resolution which closes the trust for any new hires going forward and the Trust will only apply to those whose hire date was prior to the December 13, 2018.

Ms. Atkinson also advised that a beneficiary of the PRMT trust passed away in December, this individual was receiving reimbursements from the trust. In the plan document under surviving spouse death benefits language it mentions that the surviving beneficiary is eligible to continue on the plan for 3 years following the death of the participant, that spouse would then be treated as the participant for the 1st year, this reads to apply for those who are on the TMWA medical plan. Ms. Atkinson advised that there is other language that states that all terms applicable to the participant in the year of his/her death shall apply to the surviving spouse for the 1st year following the participants death and then proceeds to discuss the final 2 years which they can stay on the

plan under COBRA rates. Ms. Atkinson advised she is not sure how to interpret this information and is waiting to hear back from the trust attorney Gus Rossi, who is not at todays meeting. This could come back in future meetings once there is clarification.

3. APPROVAL OF THE AGENDA

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the agenda.

4. APPROVAL OF THE OCTOBER 16, 2018 MINUTES

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the October 16, 2018 minutes.

5. DISCUSSION AND REQUEST TO APPOINT TMWA 501-C-9 POST RETIREMENT MEDICAL PLAN AND TRUST TRUSTEE CHAIRPERSON AND VICE CHAIRPERSON FOR TWO-YEAR TERM BEGINNING JANUARY 1, 2019 THROUGH DECEMBER 31, 2020

Ms. Atkinson advised that every two years the trustees are selected and appointed to the trust. The plan document states that two trustees appointed at the direction of IBEW, and two of them be appointed at the direction of management by the General Manager and confirmed by the TMWA board of directors. The trustees that were appointed to represent the MPAT group are Juan Esparza and Michele Sullivan. The trustees that were appointed to represent the IBEW group are James Weingart and Steve Enos.

Ms. Atkinson then recommended that the Board of Trustees discuss and decide which Trustees would serve as Chairperson and Vice Chairperson for a two-year term beginning January 1, 2019 through December 31, 2020.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the appointment of Michele Sullivan as Chairperson.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the appointment of Steve Enos for Vice-person.

6. DISCUSSION AND ACTION OF SIGNING 501-C-9 POST RETIREMENT MEDICAL PLAN AND TRUST BOARD OF TRUSTEES ANNUAL PLEDGE OF PERSONAL COMMITMENT/DISCLOSURE FORM

Ms. Atkinson advised this is an annual disclosure form the trustees are required to review and complete each year.

No other action required.

7. REVIEW AND APPROVAL OF POST-RETIREMENT MEDICAL TRUST BENEFIT CALCULATION FOR TMWA RETIREE MIKE BRYANT

Ms. Atkinson presented the benefits calculation for Mike Bryant. Mr. Bryant will retire on 04/03/2019 and is requesting trust benefits beginning on 05/01/2019. Ms. Atkinson met with the retiree and confirmed the information on the benefit calculation form. He has elected to continue on TMWA coverage as Retiree for medical (W/O Medicare), Retiree and Spouse for dental, and vision coverage. Mr. Bryant has elected to have any remaining premium balance paid from his retirement Health Savings (RHS) or PERS check.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the benefits calculation for Mike Bryant.

8. REVIEW AND APPROVAL OF POST-RETIREMENT MEDICAL TRUST BENEFIT CALCULATION FOR TMWA RETIREE SHERYL HOULIHAN

Ms. Atkinson presented the benefits calculation for Sheryl Houlihan. Ms. Houlihan will retire on 05/30/2019 and is requesting trust benefits beginning on 06/01/2019. Ms. Atkinson met with the retiree and confirmed the information on the benefit calculation form. He has elected to continue TMWA coverage as Retiree only for medical (W/O Medicare), dental and vision coverage. Ms. Houlihan has elected to have any remaining premium balance paid from his retirement Health Savings (RHS) or PERS check.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the benefits calculation for Sheryl Houlihan.

9. REVIEW AND APPROVAL OF POST-RETIREMENT MEDICAL TRUST BENEFIT CALCULATION FOR TMWA RETIREE JAMES PEZONELLA

Ms. Atkinson presented the benefits calculation for James Pezonella. Mr. Pezonella will retire on 07/28/2019 and is requesting trust benefits beginning on 08/01/2019. Ms. Atkinson met with the retiree and confirmed the information on the benefit calculation form. He has elected to continue on TMWA coverage as Retiree and Spouse for medical (W/O Medicare), dental and vision coverage. Mr. Pezonella has elected to have any remaining premium balance paid from his retirement Health Savings (RHS) or PERS check.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the benefits calculation for James Pezonella.

10. REVIEW AND CONSIDERATION FOR APPROVAL FOR REIMBURSEMENT OF PREMIUMS FOR UNITED HEALTH CARE PAID BY THE RETIREE

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the reimbursement request for premiums for United Health care.

11. REVIEW AND CONSIDERATION FOR APPROVAL FOR REIMBURSEMENT OF PREMIUMS FOR UNITED HEALTHCARE, AND SYMPHONIX VALUE RX PLAN PAID FOR BY RETIREE

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the reimbursement request for premiums for United Health care and Symphonix Value RX Plan.

12. REVIEW AND CONSIDERATION FOR APPROVAL FOR REIMBURSEMENT OF PHYSICIANS MUTUAL AND CIGNA HEALTH.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the reimbursement request for Physicians Mutual and Cigna Health.

13. PRESENTATION OF BUDGET FOR CALENDAR YEAR 2019

Ms. Sullivan presented the budget for calendar year 2019. Ms. Sullivan referenced Attachment A and advised that there is expected employer contributions of $138,578, and plan member contributions of $97,800. There is an estimate of $228,000 for investment income with investment expenses of $2500. The plan will pay out $402,400 for benefits, and $25,400 for administrative expenses which includes fees for tax filing and audits.

Trustee Weingart asked how the net appreciation was calculated. Chairperson Sullivan advised that they use historical data to come up with the number.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the budget for calendar year 2019.

14. REVIEW OF RETIREMENT BENEFITS INVESTMENT FUND (RBIF) PERFORMANCE REVIEW

Ms. Sullivan reviewed the report dated as of June 30, 2018. There is no updated report since June of 2018. Schedule of their performance, the plan has been doing really well up to that point. A 6% rate of return is project for the next quarter, which is a conservative number, but we have met in the past.

Ms. Sullivan reviewed the RBIF and highlighted that the Fiscal Year to date 4.0%, and 3.9%, it's not as good as it has been previously but still doing well considering the markets performance. Ms. Sullivan also advised that since inception the plan has seen 6.6% which is what the estimate of 6.0% is based on which is used in the Actuarial analysis.

This is for informational purposes only, no action required.

15. TRUSTEE COMMENTS AND REQUEST FOR FUTURE AGENDA ITEMS*

RBIF review

Actuarial analysis

16. PUBLIC COMMENT

There was no public comment.

17. ADJOURNMENT

With no further business to discuss, Chairman Sullivan adjourned the meeting at 11:28 a.m.

Minutes were approved by the Trustees in session on _____.

Respectfully Submitted,

_____
Rosalinda Rodriguez, Recording Secretary

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STAFF REPORT

TO: Board of Trustees of the Post-Retirement Medical Plan & Trust
THRU: Rosalinda Rodriguez, TMWA Human Resources Coordinator
DATE: April 16, 2019
SUBJECT: **Review and approval of Post-Retirement Medical Trust benefit calculations for TMWA Retiree Scott Knecht**

Recommendation

TMWA staff recommends the Post-Retirement Medical Plan and Trust (PRMPT) approve the retirement health insurance benefit calculation for the following TMWA retiree:

CY2019: Scott Knecht

Summary

Trustees move to approve the benefit calculation, as presented.

Background

Based on the PRMPT plan document, TMWA Human Resources has completed the benefit calculation for the declared retiree. Please refer to the attached benefit calculation worksheet for specific details.

TMWA Human Resources has met to discuss this calculation with the retiree and provided a copy of the PRMPT Plan Document and applicable PRMPT Policies. The retiree is aware that this calculation is based on current plan year (CY19) premium costs. These costs are subject to change (increase or decrease) in accordance with annual open enrollment periods.

Retiree has been made aware that in order to qualify for the Post-Retirement Medical Benefits, after attaining age 65, the retiree and their qualified dependents must enroll in and pay the cost of Medicare A and Medicare Part "B" or Medicare Part "C."

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From 12/4/17
To 1/2/19

RETRIEE INFORMATION:

Name: [redacted]

Employee #: _____

Address: [redacted]

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
12/4/17	MONTHLY PREMIUM	AMEIZITAS		$ 50 -85
1/2/18	MONTHLY " (DENTAL)	"		$ 50 -85
2/2/18	" "	"		$ 50 -85
3/2/18	" "	"		$ 50 -85
4/3/18	" "	"		$ 50 -85
5/2/18	" "	"		$ 50 -85
6/4/18	" "	"		50 85

Medicare Eligible? ✓ YES ____ NO

Total $~~0.00~~ -

SEE NEXT PAGE

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] Date: 2/20/19

PRMPT Approval*: _____ Date: _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval**: _____ Date: _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From 12/4/17
To 1/2/19

RETRIEE INFORMATION:

Name: [redacted]

Employee #: _____

Address: [redacted]

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
7/3/18	MONTHLY PREMIUM	AMERITAS		$ 50-85
8/2/18	"	"		$ 50-85
9/4/18	"	"		$ 50-85
10/2/18	"	"		$ 49-42
11/7/18	"	"		$ 49-42
12/4/18	"	"		$ 49-42
1/2/19	"	"		49 42

Medicare Eligible? _____YES _____NO

Total ~~$0.00~~ 706-18

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] Date: 2/20/19

PRMPT Approval*: _____ Date: _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval**: _____ Date: _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From July 18
To Dec 18

RETRIEE INFORMATION:

Name: [redacted] Employee #: _____

Address: [redacted] Phone # [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
7/18 12/18	MONTHLY PREM	UNITED HEALTH CARE INS CO	120.79/MO	$ 724.74
				$ -
				$ -
				$ -
				$ -
				$ -
			$0.00	

Medicare Eligible? ____YES ____NO **Total** $ 724.74

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] **Date:** 4/17/2019

PRMPT Approval*: _____ **Date:** _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval:** _____ **Date:** _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From 10-19
To 12-19

RETRIEE INFORMATION:

Name: [redacted]

Address: [redacted]

Employee #: _____

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
10-1-19	Medicare Premium	U.S. Government	135.50	135.50
11-1-19	" "	" "	"	135.50
12-1-19	" "	" "	"	135.50
			$0.00	

Medicare Eligible? X YES ____NO

Total $ 406.50 -

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] **Date:** 1-29-19

PRMPT Approval*: _____ **Date:** _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval:** _____ **Date:** _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Return completed form to: PRMPT c/o TMWA Human Resources, PO Box 30013, Reno, NV 89520

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

In order for an eligible recipient to receive reimbursement of medical insurance premiums from the Post Retirement Medical Plan & Trust, the eligible participant must submit at least one of the following as proof of payment for the medical insurance premiums:

- A copy of the invoice from the insurance company and copy of the receipt of payment;
- A copy of the invoice from the insurance company and copy of the front and back of the cancelled check made out to the insurance company;
- A copy of a pay stub if the pay stub clearly shows a deduction for medical insurance on a post-tax basis;
- A statement from the eligible recipient's employer listing dates and amounts of premiums deducted from wages on a post-tax bas
- A copy of a bank statement showing deductions for medical insurance if the statement clearly indicates payment to a company that provides only medical insurance;
- A copy of a bank statement showing deductions to an insurance company along with a statement from the insurance company listing dates and amounts of premiums; or
- Other documentation which the Trust, or its designees, determines is sufficient to prove payment for medical insurance.

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From 7-19
To 9-19

RETRIEE INFORMATION:

Name: [redacted]

Address: [redacted]

Employee #: _____

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
7-1-19	Medicare premium	U.S. Government	135.50	135.50
8-1-19	" "	" "	135.50	135.50
9-1-19	" "	" "	135.50	135.50
			$0.00	

Medicare Eligible? X YES ____NO

Total $ 406.50 -

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] **Date:** 1-29-19

PRMPT Approval*: _____ **Date:** _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval:** _____ **Date:** _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Return completed form to: PRMPT c/o TMWA Human Resources, PO Box 30013, Reno, NV 89520

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

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- A copy of the invoice from the insurance company and copy of the receipt of payment;
- A copy of the invoice from the insurance company and copy of the front and back of the cancelled check made out to the insurance company;
- A copy of a pay stub if the pay stub clearly shows a deduction for medical insurance on a post-tax basis;
- A statement from the eligible recipient's employer listing dates and amounts of premiums deducted from wages on a post-tax bas
- A copy of a bank statement showing deductions for medical insurance if the statement clearly indicates payment to a company that provides only medical insurance;
- A copy of a bank statement showing deductions to an insurance company along with a statement from the insurance company listing dates and amounts of premiums; or
- Other documentation which the Trust, or its designees, determines is sufficient to prove payment for medical insurance.

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From 4-19
To 6-19

RETRIEE INFORMATION:

Name: [redacted]

Address: [redacted]

Employee #: _____

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
4-1-19	Medicare premium	U.S. Government	135.50	135.50
5-1-19	" "	" "	"	135.50
6-1-19	" "	" "	"	135.50
			$0.00	

Medicare Eligible? X YES ____NO

Total $ 406.50 -

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] **Date:** 1-29-19

PRMPT Approval*: _____ **Date:** _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval:** _____ **Date:** _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Return completed form to: PRMPT c/o TMWA Human Resources, PO Box 30013, Reno, NV 89520

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

In order for an eligible recipient to receive reimbursement of medical insurance premiums from the Post Retirement Medical Plan & Trust, the eligible participant must submit at least one of the following as proof of payment for the medical insurance premiums:

- A copy of the invoice from the insurance company and copy of the receipt of payment;
- A copy of the invoice from the insurance company and copy of the front and back of the cancelled check made out to the insurance company;
- A copy of a pay stub if the pay stub clearly shows a deduction for medical insurance on a post-tax basis;
- A statement from the eligible recipient's employer listing dates and amounts of premiums deducted from wages on a post-tax bas
- A copy of a bank statement showing deductions for medical insurance if the statement clearly indicates payment to a company that provides only medical insurance;
- A copy of a bank statement showing deductions to an insurance company along with a statement from the insurance company listing dates and amounts of premiums; or
- Other documentation which the Trust, or its designees, determines is sufficient to prove payment for medical insurance.

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From 1-19
To 3-19

RETRIEE INFORMATION:

Name: [redacted]

Address: [redacted]

Employee #: _____

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
1-1-19	Medicare premium	US Government	135.50	135.50
2-1-19	" "	" "	"	135.50
3-1-19	" "	" "	"	135.50
			$0.00	

Medicare Eligible? ✓ YES ____ NO

Total $406.50 -

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] **Date:** 1-29-19

PRMPT Approval* [redacted] **Date:** _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval:** _____ **Date:** _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Return completed form to: PRMPT c/o TMWA Human Resources, PO Box 30013, Reno, NV 89520

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

In order for an eligible recipient to receive reimbursement of medical insurance premiums from the Post Retirement Medical Plan & Trust, the eligible participant must submit at least one of the following as proof of payment for the medical insurance premiums:

- A copy of the invoice from the insurance company and copy of the receipt of payment;
- A copy of the invoice from the insurance company and copy of the front and back of the cancelled check made out to the insurance company;
- A copy of a pay stub if the pay stub clearly shows a deduction for medical insurance on a post-tax basis;
- A statement from the eligible recipient's employer listing dates and amounts of premiums deducted from wages on a post-tax bas
- A copy of a bank statement showing deductions for medical insurance if the statement clearly indicates payment to a company that provides only medical insurance;
- A copy of a bank statement showing deductions to an insurance company along with a statement from the insurance company listing dates and amounts of premiums; or
- Other documentation which the Trust, or its designees, determines is sufficient to prove payment for medical insurance.

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From JAN. 2019
To MAR. 2019

RETRIEE INFORMATION:

Name: [redacted] Employee #: 50078

Address: [redacted] Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
Jan – Mar. 2019	Monthly Premium $138.48 x 3 mos.	United HealthCare Supplemental	$138.48 x 3 mos.	$ 415.44
				$ -
				$ -
Jan – Mar. 2019	Monthly Premium $26.70 x 3 mos.	United HealthCare Prescription Drug Coverage	$26.70 x 3 mos.	$ 80.10
				$ -
				$ -
			$0.00	

Medicare Eligible? ✓ YES ____ NO [redacted] **Total** $ 495.54

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] **Date:** 3/13/19

PRMPT Approval*: _____ **Date:** _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval:** _____ **Date:** _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Return completed form to: PRMPT c/o TMWA Human Resources, PO Box 30013, Reno, NV 89520

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

In order for an eligible recipient to receive reimbursement of medical insurance premiums from the Post Retirement Medical Plan & Trust, the eligible participant must submit at least one of the following as proof of payment for the medical insurance premiums:

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- A copy of the invoice from the insurance company and copy of the front and back of the cancelled check made out to the insurance company;
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- A statement from the eligible recipient's employer listing dates and amounts of premiums deducted from wages on a post-tax bas
- A copy of a bank statement showing deductions for medical insurance if the statement clearly indicates payment to a company that provides only medical insurance;
- A copy of a bank statement showing deductions to an insurance company along with a statement from the insurance company listing dates and amounts of premiums; or
- Other documentation which the Trust, or its designees, determines is sufficient to prove payment for medical insurance.

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From 11/3/2017
To 12/4/2017

RETRIEE INFORMATION:

Name: [redacted]

Employee #: 50035

Address: [redacted]

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
11/3/2017	Montly Medicare Supplement	Physicians Mutual Phusicians	$218.28	$218.28
12/4/2017	Montly Medicare Supplement	Physicians Mutual Phusicians	$218.28	$218.28
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
			$436.56	

Medicare Eligible? X YES ____NO

Total $ 436.56

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] **Date:** 11/30/18

PRMPT Approval*: _____ **Date:** _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval:** _____ **Date:** _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Return completed form to: PRMPT c/o TMWA Human Resources, PO Box 30013, Reno, NV 89520

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

In order for an eligible recipient to receive reimbursement of medical insurance premiums from the Post Retirement Medical Plan & Trust, the eligible participant must submit at least one of the following as proof of payment for the medical insurance premiums:

- A copy of the invoice from the insurance company and copy of the receipt of payment;
- A copy of the invoice from the insurance company and copy of the front and back of the cancelled check made out to the insurance company;
- A copy of a pay stub if the pay stub clearly shows a deduction for medical insurance on a post-tax basis;
- A statement from the eligible recipient's employer listing dates and amounts of premiums deducted from wages on a post-tax bas
- A copy of a bank statement showing deductions for medical insurance if the statement clearly indicates payment to a company that provides only medical insurance;
- A copy of a bank statement showing deductions to an insurance company along with a statement from the insurance company listing dates and amounts of premiums; or
- Other documentation which the Trust, or its designees, determines is sufficient to prove payment for medical insurance.

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From Feb. 2018
To Dec. 2018

RETRIEE INFORMATION:

Name: [redacted] Employee #: 50077

Address: [redacted] Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
	Medical	Blue Cross Blueshield-Basic	$218.00 x 11 mos.	$ 2,398.00
	Dental	MetLife	$ 45.48 x 11 mos.	$ 500.28
	Vision	VSP	$ 14.47 x 11 mos.	$ 159.17
				$ -
				$ -
				$ -
			$0.00	

Medicare Eligible? ____YES X NO **Total** $ 3,057.45

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] **Date:** March 11, 2019

PRMPT Approval*: _____ **Date:** _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval:** _____ **Date:** _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Return completed form to: PRMPT c/o TMWA Human Resources, PO Box 30013, Reno, NV 89520

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

In order for an eligible recipient to receive reimbursement of medical insurance premiums from the Post Retirement Medical Plan & Trust, the eligible participant must submit at least one of the following as proof of payment for the medical insurance premiums:

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- A copy of the invoice from the insurance company and copy of the front and back of the cancelled check made out to the insurance company;
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- A copy of a bank statement showing deductions for medical insurance if the statement clearly indicates payment to a company that provides only medical insurance;
- A copy of a bank statement showing deductions to an insurance company along with a statement from the insurance company listing dates and amounts of premiums; or
- Other documentation which the Trust, or its designees, determines is sufficient to prove payment for medical insurance.

Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

DATE RANGE From Jan. 1, 2019
To March 31, 2019

RETRIEE INFORMATION:

Name: [redacted]

Employee #: cn50068

Address: [redacted]

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
Jan - March	Monthly Premium	Medicare "Part B"	$135.50 per month	$ 406.50
				$ -
				$ -
				$ -
				$ -
				$ -

Medicare Eligible? X YES ____NO

Total $ 406.50

Attach copies of Proof of Insurance and Payment of Premium. See back of form for examples of acceptable documentation.

I certify that the above information is correct. I understand that I will not be reimbursed for medical insurance premiums for any period during which I was not eligible for participation or failed to maintain coverage. I further understand that if I receive reimbursement for premiums for which I was not eligible or did not meet eligibility criteria, the Trust may recover these payments from my future benefit award(s) and I will be liable for all related taxes. I also authorize the Trust, and its designees to contact the insurance company I have listed above to verify coverage and premium amounts paid. I certify that all expenses for which reimbursement or payment is claimed were incurred by myself, my spouse, my eligible dependents, or a spouse beneficiary (after the participant's death only) while eligible to receive benefits under the trust. I also certify as follows: 1.) The premium expenses have not been reimbursed or will not be reimbursed by any other plan, 2.) The premium expenses were not paid by an employer of a participant or an employer of a participant's spouse on a "pre-tax" basis, including, without limitation, a policy or plan offered by an employer under a Code Section 125 plan (commonly referred to as a "Cafeteria Plan"). I understand that I am fully responsible for the sufficiency, accuracy, and veracity of all information relating to this reimbursement request.

Retiree Signature: [redacted] Date: 4/2/19

PRMPT Approval*: _____ Date: _____

* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

Accounting Approval**: _____ Date: _____

** Indicates the trust accountant has ensured any amounts reimbursed are within the participants available trust balance.

Retirement Benefits Investment Fund

December 31, 2018

Performance

Asset Class	Market Value	Target Allocation	Actual Allocation	FYTD Return	One Year	3 Years	5 Years	10 Years	Since Inception (2008)
U.S. Stocks- S&P 500 Index	$ 227,797,076	50.5%	50.8%	-6.8%	-4.4%	9.2%	8.5%	13.1%	8.0%
Market Return				**-6.9%**	**-4.4%**	**9.3%**	**8.5%**	**13.1%**	**7.9%**
Int'l Stocks- MSCI World x US Index	$ 92,583,493	21.5%	20.7%	-11.6%	-13.8%	3.0%	0.7%	6.2%	1.4%
Market Return				**-11.6%**	**-14.0%**	**2.8%**	**0.5%**	**6.3%**	**1.3%**
U.S. Bonds- U.S. Bond Index	$ 123,776,079	28.0%	27.6%	194.0%	0.9%	1.4%	2.2%	2.9%	3.1%
Market Return				**2.0%**	**0.9%**	**1.4%**	**2.0%**	**2.1%**	**2.9%**
	$ 3,940,052	0.0%	0.9%						
Total RBIF Fund	**$ 448,096,700**	**100.0%**	**100.0%**	**-5.3%**	**-4.8%**	**5.8%**	**5.1%**	**8.7%**	**5.5%**
Market Return				**-5.4%**	**-5.0%**	**5.6%**	**5.0%**	**8.8%**	**5.6%**