

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

*A single employer plan sponsored by  
Truckee Meadows Water Authority*

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### **AGENDA**

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

**Tuesday, July 21, 2020 at 1:00 p.m.**

**Meeting Via Teleconference Only**

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MEMBERS OF THE PUBLIC MAY ATTEND TELPHONICALLY BY CALLING THE NUMBER LISTED BELOW.

NO PHYSICAL LOCATION IS BEING PROVIDED FOR THIS MEETING

**(be sure to keep your phones on mute, and do not place the call on hold)**

**Phone: (775) 325-5404**

**Meeting ID: 806 130 891#**

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 April 21, 2020 minutes **(For Possible Action)**
5. Approval of the May 19, 2020 minutes **(For Possible Action)**
6. Review and approval of Post-Retirement Medical Plan & Trust calculations for TMWA Retiree Dave Bundt— Rosalinda Rodriguez **(For Possible Action)**
7. Review and approval of Post-Retirement Medical Plan & Trust calculations for TMWA Retiree Jack Byrom— Rosalinda Rodriguez **(For Possible Action)**
8. Review and consideration for approval of request(s) for reimbursement of premiums. — Rosalinda Rodriguez **(For Possible Action)**
9. Review of Actuarial Analysis – Sophie Cardinal\*
10. Review of Retirement Benefits Investment Fund (RBIF) performance review—Michele Sullivan\*
11. Trustee comments and requests for future agenda items\*
12. Public comment — limited to no more than three minutes per speaker\*
13. Adjournment **(For Possible Action)**

#### NOTES:

1. This meeting is being conducted pursuant to the Governor's Declaration of Emergency Directive 006 ("Directive 006") [http://gov.nv.gov/uploadedFiles/govnewnv.gov/Content/News/Emergency\\_Orders/2020/DeclarationofEmergencyDirective006reOML3-21-20.pdf](http://gov.nv.gov/uploadedFiles/govnewnv.gov/Content/News/Emergency_Orders/2020/DeclarationofEmergencyDirective006reOML3-21-20.pdf)
2. The announcement of this meeting has been electronically posted in compliance with NRS 241.020(3) and Directive 006 at <http://www.tmwa.com>, and NRS 232.2175 at <https://notice.nv.gov/>.
3. Pursuant to Directive 006, the requirement contained in NRS 241.020(3)(c) that physical locations be available for the public to receive supporting material for public meetings has been suspended. Staff reports and supporting material for the meeting are available on the TMWA website at <http://www.tmwa.com/meeting/> or you can contact Rosalinda Rodriguez at (775) 834-8294. Supporting material is made available to the general public in accordance with NRS 241.020(6).
4. 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.
5. Asterisks (\*) denote non-action items.

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6. Pursuant to Directive 006, public comment, whether on action items or general public comment, may be provided without being physically present at the meeting by submitting written comments online on TMWA's Public Comment Form ([tmwa.com/PublicComment](http://tmwa.com/PublicComment)) or by email sent to [boardclerk@tmwa.com](mailto:boardclerk@tmwa.com) prior to the Board opening the public comment period during the meeting. In addition, public comments may be provided by leaving a voicemail at (775)834-0255 prior to 4:00 p.m. on July 20th. Voicemail messages received will either be broadcast on the telephone call during the meeting or transcribed for entry into the record. Public comment is limited to three minutes and is allowed during the public comment periods. The Board may elect to receive public comment only during the two public comment periods rather than each action item.



## ***Post-Retirement Medical Plan & Trust***

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### **DRAFT April 21, 2020 MINUTES**

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The meeting of the TMWA Post-Retirement Medical Plan and Trust (Trust) Trustees was held on Tuesday, April 21, 2020 via Teleconference.

Michele Sullivan, Chairman, called the meeting to order at 1:02 P.M.

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

A quorum was present.

Voting Members Present:

Michele Sullivan  
Juan Esparza  
James Weingart  
Steve Enos

Voting Members Absent

Members Present

Jessica Atkinson  
Rosalinda Rodriguez  
Gus Rossi  
Mike Venturino

Members Absent:

2. PUBLIC COMMENT

There was no public comment

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 JANUARY 21, 2020 MINUTES

**Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the January 21, 2020 minutes.**

5. REVIEW AND CONSIDERATION FOR APPROVAL OF REQUEST FOR REIMBURSEMENT OF PREMIUMS

Ms. Rodriguez presented a reimbursement request received for Medicare Part B premiums paid for through Social Security.

**Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the reimbursement request for premiums for Medicare premiums paid for through Social Security.**

Ms. Rodriguez presented a reimbursement request received for Medicare Part B, premiums paid for through Social Security.

**Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the reimbursement request for premiums for Medicare Part B, premiums paid for through Social Security.**

Ms. Rodriguez presented a reimbursement request received for Blue Cross Blue Shield, Metlife dental and VSP vision, premiums paid for 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 Blue Cross Blue Shield, Metlife dental, and VSP vision premiums paid for by the retiree.**

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

Ms. Sullivan reviewed the most recent RBIF performance report which ended December 31, 2019. The market return at the one-year mark at the end of 2019 was 22.5%. Ms. Sullivan advised that based on the Markets recent performance there would be a noticeable difference once the March return is received. There is no concern at this time with regards to the funding as historically the inception to date has remained within a 6% market return.

**This is for informational purposes only, no action required.**

7. TRUSTEE COMMENTS AND REQUEST FOR FUTURE AGENDA ITEMS\*

RBIF review

Actuarial analysis

Audit Review

8. PUBLIC COMMENT

There was no public comment.

9. ADJOURNMENT

With no further business to discuss, Chairman Sullivan adjourned the meeting at 1:14 P.M.

Minutes were approved by the Trustees in session on \_\_\_\_\_.

Respectfully Submitted,

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Rosalinda Rodriguez, Recording Secretary

## ***Post-Retirement Medical Plan & Trust***

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### **DRAFT May 19, 2020 MINUTES**

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The meeting of the TMWA Post-Retirement Medical Plan and Trust (Trust) Trustees was held on Tuesday, May 19, 2020 via Teleconference.

Michele Sullivan, Chairman, called the meeting to order at 1:01 P.M.

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

A quorum was present.

Voting Members Present:

Michele Sullivan  
Juan Esparza  
James Weingart  
Steve Enos

Voting Members Absent

Members Present

Rosalinda Rodriguez

Members Absent:

Jessica Atkinson  
Gus Rossi  
Mike Venturino

2. PUBLIC COMMENT

There was no public comment

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. REVIEW AND CONSIDERATION FOR APPROVAL OF REQUEST FOR REIMBURSEMENT OF PREMIUMS

Ms. Rodriguez presented a reimbursement request received for United Health care, and RX premiums 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 RX premiums paid for by retiree.**

5. TRUSTEE COMMENTS AND REQUEST FOR FUTURE AGENDA ITEMS\*

6. PUBLIC COMMENT

There was no public comment.

7. ADJOURNMENT

With no further business to discuss, Chairman Sullivan adjourned the meeting at 1:05 P.M.

Minutes were approved by the Trustees in session on \_\_\_\_\_.

Respectfully Submitted,

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Rosalinda Rodriguez, Recording Secretary

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

**RETRIEE INFORMATION:**
DATE RANGE From 4-20To 6-20

Name: \_\_\_\_\_

Employee #: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**Expenses**

| Date Paid | Description<br>(example: Monthly Premium) | Name of Provider<br>(example: Anthem Blue Cross) | Cost   | Total                 |
|-----------|---|--|--------|-----------------------|
| 4-5-20    | Monthly Premium                           | Medicare   | 144.60 | \$ 144.60-            |
| 5-5-20    | " "                                       | " "  | "      | \$ 144.60-            |
| 6-5-20    | " "                                       | " "  | "      | \$ 144.60 -           |
|           |   |  |        | \$ -                  |
|           |   |  |        | \$ -                  |
|           |   |  |        | \$ -                  |
|           |   |  |        | \$ -                  |
| Total     |   |  |        | \$ 0.00 <u>433.80</u> |

Medicare Eligible? ☒ YES ☐ NO

**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: \_\_\_\_\_

Date: 2-3-20

PRMPT Approval\*: \_\_\_\_\_

Date: \_\_\_\_\_

Accounting Approval\*\*\*: \_\_\_\_\_

Date: \_\_\_\_\_

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

\*\* 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 basis;
- 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.



**BENEFICIARY'S NAME:** [REDACTED]

Your Social Security benefits will increase by 1.6% in 2020 because of a rise in the cost of living. You can use this letter as proof of your benefit amount if you need to apply for food, rent, or energy assistance. You can also use it to apply for bank loans or for other business. Keep this letter with your important financial records.

**How Much Will I Get And When?**

- Your monthly amount (before deductions) is [REDACTED]
- The amount we deduct for Medicare Medical Insurance is [REDACTED] \$144.60  
(If you did not have Medicare as of November 22, 2019, or if someone else pays your premium, we show \$0.00.)
- The amount we deduct for your Medicare Prescription Drug Plan is [REDACTED] \$0.00  
(We will notify you if the amount changes in 2020. If you did not elect withholding as of November 1, 2019, we show \$0.00.)
- The amount we deduct for voluntary Federal tax withholding is [REDACTED]  
(If you did not elect voluntary tax withholding as of November 22, 2019, we show \$0.00.)
- After we take any other deductions, you will receive [REDACTED]  
on or about January 8, 2020.

If you disagree with any of these amounts, you must write to us within 60 days from the date you receive this letter. Or visit [www.ssa.gov/non-medical/appeal](http://www.ssa.gov/non-medical/appeal) to appeal online. We would be happy to review the amounts.

If you receive a paper check and want to switch to an electronic payment, please visit the Department of the Treasury's Go Direct website at [www.godirect.org](http://www.godirect.org) online.

**What If I Have Questions?**

- Visit our website at [www.socialsecurity.gov](http://www.socialsecurity.gov)
- Call us toll-free at 1-800-772-1213 (TTY 1-800-325-0778)
- Contact your nearest Social Security office

1170 HARVARD WAY  
RENO NV 89502

**Other Help For Seniors**

Call the Eldercare Locator service of the U.S. Administration on Aging at 1-800-677-1116 or visit [www.eldercare.acl.gov](http://www.eldercare.acl.gov) to learn about a wide variety of services that may be helpful to you.



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

DATE RANGE From April 1, 2020  
To June 30, 2020

## RETRIEE INFORMATION:

Name:

Employee #: cn50068

Address:

Phone #:

## Expenses

| Date Paid    | Description<br>(example: Monthly Premium) | Name of Provider<br>(example: Anthem Blue Cross) | Cost                              | Total      |
|--------------|---|--|-----------------------------------|------------|
| April - June | Monthly Premium                           | Medicare "Part B"                                | \$144.60 per month X three months | \$433.80 - |
|              |   |  |                                   | \$0.00 -   |
|              |   |  |                                   | \$0.00 -   |
|              |   |  |                                   | \$0.00 -   |
|              |   |  |                                   | \$0.00 -   |
|              |   |  |                                   | \$0.00 -   |
|              |   |  |                                   | \$0.00 -   |
|              |   |  |                                   | 0.00       |
| Total        |   |  |                                   | \$433.80 - |

Medicare Eligible? ☒ YES ☐ NO

**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:

Date: 7/7/20

PRMPT Approval\*:

Date:

Accounting Approval\*\*:

Date:

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

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



# Social Security Administration

Date: July 07, 2020

You asked us for information from your record. The information that you requested is shown below. If you want anyone else to have this information, you may send them this letter.

## Information About Current Social Security Benefits

Beginning December 2019, the full monthly Social Security benefit before any deductions is

We deduct \$144.60 for medical insurance premiums each month. *Medicare "Part B"*

The regular monthly Social Security payment is \$  
(We must round down to the whole dollar.)

Social Security benefits for a given month are paid the following month. (For example, Social Security benefits for March are paid in April.)

Your Social Security benefits are paid on or about the fourth Wednesday of each month.

## Information About Past Social Security Benefits

From December 2018 to November 2019, the full monthly Social Security benefit before any deductions was \$

We deducted \$135.50 for medical insurance premiums each month.

The regular monthly Social Security payment was \$

(We must round down to the whole dollar.)

**Suspect Social Security Fraud?**

Please visit <http://oig.ssa.gov/r> or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

**If You Have Questions**

We invite you to visit our web site at [www.socialsecurity.gov](http://www.socialsecurity.gov) on the Internet to find general information about Social Security. If you have any specific questions, you may call us toll-free at 1-800-772-1213, or call your local office at 800-772-1213. We can answer most questions over the phone. If you are deaf or hard of hearing, you may call our TTY number, 1-800-325-0778. You can also write or visit any Social Security office. The office that serves your area is located at:

SOCIAL SECURITY  
1170 HARVARD WAY  
RENO, NV 89502

If you do call or visit an office, please have this letter with you. It will help us answer your questions. Also, if you plan to visit an office, you may call ahead to make an appointment. This will help us serve you more quickly when you arrive at the office.

*Social Security Administration*



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

DATE RANGE From April 2020  
To June 2020

## RETIREE INFORMATION:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Employee #: 50078

Phone #: \_\_\_\_\_

## Expenses

| Date Paid | Description<br>(example: Monthly Premium) | Name of Provider<br>(example: Anthem Blue Cross) | Cost         | Total     |
|-----------|---|--|--------------|-----------|
| Apr/May   | \$159.13 x 2                              | United Healthcare                                | \$159.13 x 2 | \$ 318.26 |
| June      | \$166.35                                  | (Supplemental)                                   | \$166.35     | \$ 166.35 |
|           |   |  |              | \$ -      |
| Apr, May  | \$24.20 x 3                               | United Healthcare                                | \$24.20 x 3  | \$ 72.60  |
| June      |   | Prescription Drug                                |              | \$ -      |
|           |   | Coverage   |              | \$ -      |
|           |   |  | \$0.00       |           |
| Total     |   |  |              | \$ 557.21 |

Medicare Eligible?

☒ YES ☐ NO

**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: \_\_\_\_\_

Date: 6/29/20

PRMPT Approval\*: \_\_\_\_\_

Date: \_\_\_\_\_

Accounting Approval\*\*: \_\_\_\_\_

Date: \_\_\_\_\_

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

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

## Withdrawals and other subtractions - continued

### Other subtractions - continued

| Date                            | Description  | Amount    |
|---------------------------------|--|-----------|
| 03/18/20                        | Today Tomorrow Together Campaign Bill Payment  |           |
| 03/24/20                        | MACY'S Bill Payment  |           |
| 03/30/20                        | STATE FARM BANK Bill Payment   |           |
| 04/03/20                        | NV ENERGY Bill Payment   |           |
| 04/03/20                        | AT&T Bill Payment  |           |
| 04/03/20                        | Online scheduled payment to LOC 1299 Confirmation# 1991238231  |           |
| 04/03/20                        | TRUCKEE MEADOWS WATER AUTHORITY Bill Payment   |           |
| 04/06/20                        | Little Flower Sc DES:FACTS ID:000000103230994 [REDACTED] CO<br>ID:9470751402 WEB                     |           |
| 04/06/20                        | UnitedHealthcare DES:PREMIUM ID:3430418891 [REDACTED] D CO ID:1836282001<br>PPD                      | -159.13 ✓ |
| 04/06/20                        | BANK OF AMERICA DES:LINE PYMT ID:068189002581299 INDN:[REDACTED] 10000017771<br>CO ID:1333687665 TEL |           |
| 04/06/20                        | UnitedHCMedicare DES:MedInsPymt ID:000000906726787 INDN:[REDACTED] D CO<br>ID:9000447048 PPD         | -24.20 ↗  |
| <b>Total other subtractions</b> |  |           |

## Checks

| Date     | Check # | Amount |
|----------|---------|--------|
| 03/19/20 | 6420    |        |
| 03/20/20 | 6421    |        |
| 03/17/20 | 6424*   |        |
| 03/20/20 | 6425    |        |

| Date                     | Check # | Amount |
|--------------------------|---------|--------|
| 03/11/20                 | 6426    |        |
| 03/10/20                 | 6427    |        |
| 04/07/20                 | 6429*   |        |
| <b>Total checks</b>      |         |        |
| <b>Total # of checks</b> |         |        |

\* There is a gap in sequential check numbers

## Withdrawals and other subtractions - continued

### Other subtractions - continued

| Date                            | Description  | Amount     |
|---------------------------------|--|------------|
| 05/05/20                        | Little Flower Sc DES:FACTS ID:000000104597473 [REDACTED] CO              | [REDACTED] |
| 05/05/20                        | UnitedHealthcare DES:PREMIUM ID:3430418891 [REDACTED] D CO ID:1836282001 | -159.13 ✓  |
| 05/05/20                        | UnitedHCMedicare DES:MedInsPymt ID:000000913310692 [REDACTED] D CO       | -24.20 ✓   |
| 05/06/20                        | AT&T Bill Payment  | [REDACTED] |
| 05/06/20                        | TRUCKEE MEADOWS WATER AUTHORITY Bill Payment                             | [REDACTED] |
| <b>Total other subtractions</b> |  | [REDACTED] |

## Checks

| Date                     | Check # | Amount     |
|--------------------------|---------|------------|
| 04/29/20                 | 6428    | [REDACTED] |
| <b>Total checks</b>      |         | [REDACTED] |
| <b>Total # of checks</b> |         | [REDACTED] |

## Withdrawals and other subtractions - continued

### Other subtractions - continued

| Date     | Description  | Amount    |
|----------|--|-----------|
| 05/14/20 | CARDMEMBER SERVICE Bill Payment  |           |
| 05/14/20 | Cory's Lawn Service Bill Payment   |           |
| 05/15/20 | CITI CARDS Bill Payment  |           |
| 05/15/20 | EDWARD JONES DES:INVESTMENT ID:26843 XXXXXXXX I [REDACTED] CO<br>ID:3430345811 PPD             |           |
| 05/20/20 | Catholic Services Appeal Bill Payment  |           |
| 05/20/20 | Today Tomorrow Together Campaign Bill Payment  |           |
| 05/29/20 | STATE FARM BANK Bill Payment   |           |
| 06/02/20 | AT&T LOCAL AND LONG DISTANCE Bill Payment  |           |
| 06/03/20 | NV ENERGY Bill Payment   |           |
| 06/05/20 | Online scheduled payment to LOC 1299 Confirmation# 4435550582                                  |           |
| 06/05/20 | TRUCKEE MEADOWS WATER AUTHORITY Bill Payment   |           |
| 06/05/20 | UnitedHealthcare DES:PREMIUM ID:3430418891 [REDACTED] D CO ID:1836282001<br>PPD                | -166.35 ✓ |
| 06/05/20 | UnitedHCMedicare DES:MedInsPymt ID:000000918616771 [REDACTED] D CO<br>ID:9000447048 PPD        | -24.20 ✓  |
| 06/08/20 | BANK OF AMERICA DES:LINE PYMT ID:068189002581299 [REDACTED] 0000017771<br>CO ID:1333687665 TEL |           |

### Total other subtractions

## Checks

| Date         | Check # | Amount | Date              | Check # | Amount |
|--------------|---------|--------|-------------------|---------|--------|
| 05/13/20     | 6430    |        | 05/26/20          | 6433    |        |
| 05/12/20     | 6431    |        | 05/27/20          | 6434    |        |
| 05/15/20     | 6432    |        | 06/08/20          | 6436*   |        |
| Total checks |         |        | Total # of checks |         |        |
|              |         |        | 6                 |         |        |

\* There is a gap in sequential check numbers



## Post Retirement Medical Plan &amp; Trust - Medical Premium Expense Reimbursement Request

## RETRIEE INFORMATION:

Name:

Employee #: 50144

Address:

Phone #:

DATE RANGE From 01/01/2020  
To 06/30/2020

## Expenses

| Date Paid  | Description<br>(example: Monthly Premium) | Name of Provider<br>(example: Anthem Blue Cross) | Cost                    | Total                    |
|--|---|--|-------------------------|--------------------------|
| 12/13/2019   | January Premium                           | United Health Care                               | \$356.47 / 2 = \$178.23 | \$ 178.23                |
| 01/14/2020   | February Premium                          | United Health Care                               | \$356.47 / 2 = \$178.23 | \$ 178.23                |
| 02/12/2020   | March Premium                             | United Health Care                               | \$356.47 / 2 = \$178.23 | \$ 178.23                |
| 03/13/2020   | April Premium                             | United Health Care                               | \$375.97 / 2 = \$187.99 | \$ 187.99                |
| 04/13/2020   | May Premium                               | United Health Care                               | \$375.97 / 2 = \$187.99 | \$ 187.99                |
| 05/13/2020   | June Premium                              | United Health Care                               | \$382.77 / 2 = \$191.39 | \$ 191.39                |
|  |   |  |                         |                          |
| Medicare Eligible? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |                         | <b>Total</b> \$ 1,102.06 |

**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:

Date: 06/27/2020

PRMPT Approval\*:

Date:

\* Indicates the reimbursement request &amp; 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 basis;
- 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.

# Premium Payments

Plan name(s): AARP MEDICARE SUPPLEMENT PLAN

From: January 1, 2020  
To: June 27, 2020

Combined premium. My premium is one-half this amount.

| Premium Due Date | Premium Amount | Payment Status |
|------------------|----------------|----------------|
| 06/01/2020       | \$382.77       | PAID           |
| 05/01/2020       | \$375.97       | PAID           |
| 04/01/2020       | \$375.97       | PAID           |
| 03/01/2020       | \$356.47       | PAID           |
| 02/01/2020       | \$356.47       | PAID           |
| 01/01/2020       | \$356.47       | PAID           |
| Total Premium    | \$2204.12      |                |

RETRIEE INFORMATION:

Name:

**Address:**

| Date Paid  | Description<br>(example: Monthly Premium) | Name of Provider<br>(example: Anthem Blue Cross) | Cost                          | Total                         |
|--|---|--|-------------------------------|-------------------------------|
| 1/1/2020<br>to<br>6/30/2020  | monthly<br>premiums                       | AARP UnitedHealth<br>Medicare Supplement<br>Plan | \$390 per month, 5 months     | \$ 1,950.00                   |
|  |   |  | \$375.57 per month<br>January | \$ -375.57                    |
|  |   | See Attachment I                                 | See Attachment I              | \$ -                          |
|  |   |  |                               | \$ -                          |
|  |   |  |                               | \$ -                          |
|  |   |  |                               | \$ -                          |
|  |   |  |                               | \$ -                          |
| Medicare Eligible? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |                               | <b>Total</b> \$ 0.00 2,325.57 |

**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: \_\_\_\_\_

Date: 7/2/2020

PRMPT Approval\*:

Date: \_\_\_\_\_

**Accounting Approval\*\*:**

Date: \_\_\_\_\_

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

\*\* 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

## RETRIEE INFORMATION:

DATE RANGE From 1/1/2020  
To 6/30/2020

Name: [REDACTED]

Address: [REDACTED]

Phone #: [REDACTED]

## Expenses

| Date Paid  | Description<br>(example: Monthly Premium) | Name of Provider<br>(example: Anthem Blue Cross)                 | Cost           | Total                             |
|--|---|--|----------------|-----------------------------------|
| 1/1 to 6/1/2020  | Monthly premiums                          | AARP Medicare Rx Walgreens Plan [REDACTED]<br>(See Attachment 1) | \$34 per month | \$ 204 -00                        |
|  |   |  |                | \$ -                              |
|  |   |  |                | \$ -                              |
| 1/1 to 6/1/2020  | Monthly Premiums                          | For [REDACTED] Attachment 2                                      | \$34 per month | \$ 204 -00                        |
|  |   |  |                | \$ -                              |
|  |   |  |                | \$ -                              |
| Medicare Eligible? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO |   |  |                | Total \$ 0.00 <del>\$ 08-00</del> |

**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: 7/2/2020

PRMPT Approval\*: \_\_\_\_\_

Date: \_\_\_\_\_

Accounting Approval\*\*: \_\_\_\_\_

Date: \_\_\_\_\_

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

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





July 3, 2020

Rosalinda Rodriguez, PHR  
Human Resources Coordinator  
Truckee Meadows Water Authority  
1355 Capital Blvd. Reno, NV 89502

TRUCKEE MEADOWS  
JUL 16 2020  
WATER AUTHORITY



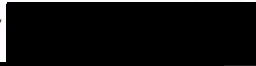
Dear Rosalinda,

Attached are three pages of first Half 2020 Post-Retirement Medical Plan & Trust – Medical Premium Expense Reimbursement Request forms for a total of \$4,468.77. The following attachments are attached:

ATTACHMENT 1 – AARP Medicare Supplement Plan premiums

ATTACHMENT 2 – AARP MedicareRX Walgreens (PDP) premiums

ATTACHMENT 3 – Medicare Part A and B Premiums for



ATTACHMENT 4 – Medicare Payments for



ATTACHMENT 5 – Bank of American premium withdrawal dates (Please note that this total does not include \$867.60 deducted directly from social security payments)

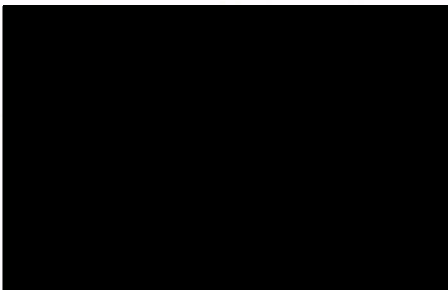


ATTACHMENT 6 –AARP Medicare supplement premium quote from United Health.

ATTACHMENT 7 – AARP MedicareRx Walgreens.premium quote.

Let me know if you need any additional information.

Sincerely



**AARP Medicare Supplement Plan, Attachment 1**

Payment history for [REDACTED]

Plan name(s): AARP MEDICARE SUPPLEMENT PLAN

Member ID: [REDACTED]

From: December 23, 2019

To: June 23, 2020

| Premium Due Date     | Premium Amount    | Payment Status |
|----------------------|-------------------|----------------|
| 6/1/2020             | \$390.00          | PAID           |
| 5/1/2020             | \$390.00          | PAID           |
| 4/1/2020             | \$390.00          | PAID           |
| 3/1/2020             | \$390.00          | PAID           |
| 2/1/2020             | \$390.00          | PAID           |
| 1/1/2020             | \$375.57          | PAID           |
| <b>Total Premium</b> | <b>\$2,325.57</b> |                |



**AARP Medicare RX Walgreens Plan, Attachment 2**

**Payment history for** [REDACTED]

**Plan name(s):** AARP MedicareRx Walgreens (PDP)

**Member ID:** [REDACTED]

**From:** December 23, 2019

**To:** June 23, 2020

| <b>Due Date</b>      | <b>Billed Amount</b> | <b>Paid Date</b> | <b>Amount Paid</b> |
|----------------------|----------------------|------------------|--------------------|
| 6/1/2020             | \$34.00              | 6/1/2020         | \$34.00            |
| 5/1/2020             | \$34.00              | 5/1/2020         | \$34.00            |
| 4/1/2020             | \$34.00              | 4/1/2020         | \$34.00            |
| 3/1/2020             | \$34.00              | 3/1/2020         | \$34.00            |
| 2/1/2020             | \$34.00              | 2/1/2020         | \$34.00            |
| 1/1/2020             | \$34.00              | 1/1/2020         | \$34.00            |
| <b>Total Amounts</b> |                      |                  | <b>\$204.00</b>    |

**Payment history for** [REDACTED]

**Plan name(s):** AARP MedicareRx Walgreens (PDP)

**Member ID:** [REDACTED]

**From:** December 23, 2019

**To:** June 23, 2020

| <b>Due Date</b>      | <b>Billed Amount</b> | <b>Paid Date</b> | <b>Amount Paid</b> |
|----------------------|----------------------|------------------|--------------------|
| 6/1/2020             | \$34.00              | 6/1/2020         | \$34.00            |
| 5/1/2020             | \$34.00              | 5/1/2020         | \$34.00            |
| 4/1/2020             | \$34.00              | 4/1/2020         | \$34.00            |
| 3/1/2020             | \$34.00              | 3/1/2020         | \$34.00            |
| 2/1/2020             | \$34.00              | 2/1/2020         | \$34.00            |
| 1/1/2020             | \$34.00              | 1/1/2020         | \$34.00            |
| <b>Total Amounts</b> |                      |                  | <b>\$204.00</b>    |

**GRAND TOTAL = \$408.00**



# Medicare.gov

Attachment 3

## Payment history

Name: [REDACTED]

Payments submitted and posted in the last 5 days will show in both posted payments and recent payments.

## Recent payments

We have no records of any payment made here through your account (online by credit or debit card) in the past 5 years.

## Posted payments

These payments posted to your account. Payments get applied first to any past owed amounts, then Part B, Part A and lastly Part D IRMAA.

Post date

**06/22/2020**

Payment method

**Medicare Easy Pay**

Applied to Part B

**\$144.60**

Applied to Part A

**\$0.00**

Applied to Part D IRMAA

**\$0.00**

**Total amount posted \$144.60**

Post date

**05/20/2020**

Payment method

**Medicare Easy Pay**

Applied to Part B

**\$144.60**

Applied to Part A

**\$0.00**

Applied to Part D IRMAA

**\$0.00**

**Total amount posted \$144.60**

Post date

**04/20/2020**

Payment method

**Medicare Easy Pay**

*Attachment 3*

Applied to Part B **\$144.60**

Applied to Part A \$0.00

Applied to Part D IRMAA \$0.00

**Total amount posted \$144.60**

Post date

**03/20/2020**

Payment method

**Medicare Easy Pay**

Applied to Part B **\$144.60**

Applied to Part A \$0.00

Applied to Part D IRMAA \$0.00

**Total amount posted \$144.60**

Post date

**02/20/2020**

Payment method

**Medicare Easy Pay**

Applied to Part B **\$144.60**

Applied to Part A \$0.00

Applied to Part D IRMAA \$0.00

**Total amount posted \$144.60**

Post date

**01/21/2020**

Payment method

**Medicare Easy Pay**

Applied to Part B **\$144.60**

Applied to Part A \$0.00

Applied to Part D IRMAA \$0.00

**Total amount posted \$144.60**

Post date

**12/20/2019**

Payment method

**Medicare Easy Pay**

Applied to Part B \$144.60

Applied to Part A \$0.00

Applied to Part D IRMAA \$0.00

**Total amount posted \$144.60**



| <u>MEDICARE.GOV, Payment History, 1/1 to</u><br><u>6/30/2020, ATTACHMENT 4</u> |                   |                 |
|--|-------------------|-----------------|
|  |                   |                 |
|  |                   |                 |
| Post Date  | Amount Paid, \$   | Amount Paid, \$ |
|  |                   |                 |
| 6/22/20  | \$144.60          | \$144.60        |
| 5/20/20  | \$144.60          | \$144.60        |
| 4/20/20  | \$144.60          | \$144.60        |
| 3/20/20  | \$144.60          | \$144.60        |
| 2/20/20  | \$144.60          | \$144.60        |
| 1/21/20  | \$144.60          | \$144.60        |
|  |                   |                 |
| <b>SUB TOTAL</b>   | <b>\$867.60</b>   | <b>\$867.60</b> |
| <b>GRAND TOTAL</b>   | <b>\$1,735.20</b> |                 |

**ATTACHMENT 5**

**BANK OF AMERICA- [REDACTED] 1st HALF 2020  
MEDICARE and AARP UNITEDHEALTH INSURANCE PAYMENTS**

| <u>Personal accounts</u> |   |                    |
|--------------------------|---|--------------------|
| Date                     | Activity Type   | Amount, \$         |
| 6/22/2020                | CMS MEDICARE DES:PREMIUMS ID:0000 INDN: [REDACTED]<br>CO ID:XXXXX08009 PPD                  | -\$144.60          |
| 6/5/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0918365653<br>[REDACTED]                       | -\$34.00           |
| 6/5/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0918792325<br>[REDACTED]                       | -\$34.00           |
| 6/5/2020                 | 390.00UnitedHealthcare DES:PREMIUM ID:XXXXX37401 [REDACTED]<br>CO ID:XXXXX82001 PPD         | -\$390.00          |
| 5/20/2020                | CMS MEDICARE DES:PREMIUMS ID:0000 [REDACTED]<br>CO ID:XXXXX08009 PPD                        | -\$144.60          |
| 5/5/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0911790572<br>[REDACTED]                       | -\$34.00           |
| 5/5/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0911883791<br>[REDACTED]                       | -\$34.00           |
| 5/5/2020                 | 390.00UnitedHealthcare DES:PREMIUM ID:XXXXX37401 [REDACTED]<br>CO ID:XXXXX82001 PPD         | -\$390.00          |
| 4/20/2020                | 44.60CMS MEDICARE DES:PREMIUMS ID:0000 INDN: [REDACTED]<br>[REDACTED]:XXXXX08009 PPD        | -\$144.60          |
| 4/5/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0905647898<br>[REDACTED]                       | -\$34.00           |
| 4/5/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0906152247<br>[REDACTED]                       | -\$34.00           |
| 4/5/2020                 | 390.00UnitedHealthcare DES:PREMIUM ID:XXXXX37401 [REDACTED]<br>CO ID:XXXXX82001 PPD         | -\$390.00          |
| 3/20/2020                | CMS MEDICARE DES:PREMIUMS ID:0000 INDN: [REDACTED]<br>CO ID:XXXXX08009 PPD                  | -\$144.60          |
| 3/5/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0899952894<br>[REDACTED]                       | -\$34.00           |
| 3/5/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0900085871<br>[REDACTED]                       | -\$34.00           |
| 3/5/2020                 | 390.00UnitedHealthcare DES:PREMIUM ID:XXXXX37401 [REDACTED]<br>CO ID:XXXXX82001 PPD         | -\$390.00          |
| 2/20/2020                | 144.60CMS MEDICARE DES:PREMIUMS ID:0000 INDN: [REDACTED]<br>[REDACTED]:XXXXX08009 PPD       | -\$144.60          |
| 2/5/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0893923318<br>[REDACTED]                       | -\$34.00           |
| 2/5/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0893277878<br>[REDACTED]                       | -\$34.00           |
| 2/5/2020                 | 390.00UnitedHealthcare DES:PREMIUM ID:XXXXX37401 [REDACTED]<br>CO ID:XXXXX82001 PPD         | -\$390.00          |
| 1/20/2020                | 144.60CMS MEDICARE DES:PREMIUMS ID:0000 INDN: [REDACTED]<br>[REDACTED] CO ID:XXXXX08009 PPD | -\$144.60          |
| 1/6/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0884635143<br>[REDACTED]                       | -\$34.00           |
| 1/6/2020                 | 34.00UnitedHCMedicare DES:MedInsPymt ID:XXXXX0885237744<br>[REDACTED]                       | -\$34.00           |
| 1/6/2020                 | 375.57UnitedHealthcare DES:PREMIUM ID:XXXXX37401 INDN: [REDACTED]<br>CO ID:XXXXX82001 PPD   | -\$375.57          |
|                          | <b>TOTAL</b>  | <b>-\$3,601.17</b> |

**NOTE: The above total does not include \$876.60 for Mary's Medicare deductions taken directly from her Social Security Payments**



Attachment 6



## Annual Notice

Phone 1-866-562-0923

TTY 711

Membership  
Number  
Date

September 7, 2019

0111098\*\*000442\*\*\*\*\*AUTO\*\*5-DIGIT 89533



0111098

## IMPORTANT HEALTH INSURANCE RATE INFORMATION

Thank you for allowing UnitedHealthcare Insurance Company to bring you quality health insurance.

### 2020 Plan and Payment Information

The information below states the total monthly payments for all plan holders in the household for the upcoming year. The new rates for your AARP® Medicare Supplement Plans will take effect on January 1, 2020.

| Monthly Household Payment (including your discounts and adjustments <sup>1</sup> ) |          |          |           |          |          |          |
|--|----------|----------|-----------|----------|----------|----------|
| Due Date   | January  | February | March     | April    | May      | June     |
| Amount Due   | \$375.57 | \$390.00 | \$390.00  | \$390.00 | \$390.00 | \$390.00 |
| Due Date   | July     | August   | September | October  | November | December |
| Amount Due   | \$390.00 | \$390.00 | \$390.00  | \$390.00 | \$390.00 | \$390.00 |

<sup>1</sup> The monthly payment amount may have been adjusted for one or more of the following reasons: (1) Changes in the discounts you may be receiving including electronic funds transfer (EFT), enrollment discounts and/or multi-insured discounts where applicable. Please note that not all discounts are available in all states. (2) Contributions made on your behalf by your former employer if the employer is paying any portion of your payment amount, or funds applied from your pension. Any changes in discounts, employer contribution amounts, or pension deductions may result in changes to your overall monthly household payment.

The amounts above will be deducted automatically each month from your bank account by electronic funds transfer. If there has been any change to your banking information, please tell us right away so you won't miss any payments. The amount due is the total household payment including all of your discounts and adjustments.

UnitedHealthcare Insurance Company pays royalty fees to AARP for the use of its intellectual property. These fees are used for the general purposes of AARP. AARP and its affiliates are not insurers. Insured by UnitedHealthcare Insurance Company (UnitedHealthcare Insurance Company of New York for New York certificate holders).

7EBILL2020\_EFT\_FL\_J1CA



Attachment 7

AARP® MedicareRx Walgreens (PDP)  
Annual Notice of Changes for 2020

5

**Summary of Important Costs for 2020**

The table below compares the 2019 costs and 2020 costs for AARP® MedicareRx Walgreens (PDP) in several important areas. **Please note this is only a summary of changes.** A copy of the Evidence of Coverage is located on our website at [www.myAARPMedicare.com](http://www.myAARPMedicare.com). You may also call Customer Service to ask us to mail you an Evidence of Coverage.

| Cost  | 2019 (this year)  | 2020 (next year)  |
|---|---|---|
| <b>Monthly Plan Premium*</b><br>*Your premium may be higher or lower than this amount. (See Section 1.1 for details.) | \$28.10   | \$34.00   |
| <b>Part D prescription drug coverage</b><br>(See Section 1.3 for details.)  | Deductible: \$0 Tier 1 and Tier 2<br><br>\$415 Tier 3, Tier 4 and Tier 5<br><br>Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage Stage: <ul style="list-style-type: none"> <li>• Drug Tier 1: Preferred retail cost-sharing (in-network) \$0 copayment</li> <li>• Drug Tier 2: Preferred retail cost-sharing (in-network) \$5 copayment</li> <li>• Drug Tier 3: Preferred retail cost-sharing (in-network) \$30 copayment</li> <li>• Drug Tier 4: Preferred retail cost-sharing (in-network) 32% of the total cost</li> </ul> | Deductible: \$0 Tier 1 and Tier 2<br><br>\$435 Tier 3, Tier 4 and Tier 5<br><br>Copays/Coinsurance for a one-month (30-day) supply during the Initial Coverage Stage: <ul style="list-style-type: none"> <li>• Drug Tier 1: Preferred retail cost-sharing (in-network) \$0 copayment</li> <li>• Drug Tier 2: Preferred retail cost-sharing (in-network) \$5 copayment</li> <li>• Drug Tier 3: Preferred retail cost-sharing (in-network) \$40 copayment</li> <li>• Drug Tier 4: Preferred retail cost-sharing (in-network) 32% of the total cost</li> </ul> |



# Retirement Benefits Investment Fund

March 31, 2020

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          | \$ 267,392,646        | 50.5%             | 50.5%             | -10.8%        | -7.0%         | 5.1%         | 6.7%         | 10.5%        | 7.6%                   |
| <b>Market Return</b>                |                       |                   |                   | <b>-10.8%</b> | <b>-7.0%</b>  | <b>5.1%</b>  | <b>6.7%</b>  | <b>10.5%</b> | <b>7.6%</b>            |
| Int'l Stocks- MSCI World x US Index | \$ 116,216,498        | 21.5%             | 22.0%             | -17.5%        | -14.3%        | -1.6%        | -0.4%        | 3.0%         | 0.8%                   |
| <b>Market Return</b>                |                       |                   |                   | <b>-18.0%</b> | <b>-14.9%</b> | <b>-2.0%</b> | <b>-0.7%</b> | <b>2.7%</b>  | <b>0.6%</b>            |
| U.S. Bonds- U.S. Bond Index         | \$ 145,828,991        | 28.0%             | 27.5%             | 9.9%          | 13.2%         | 5.8%         | 3.7%         | 3.9%         | 4.0%                   |
| <b>Market Return</b>                |                       |                   |                   | <b>9.9%</b>   | <b>13.2%</b>  | <b>5.8%</b>  | <b>3.6%</b>  | <b>3.8%</b>  | <b>3.8%</b>            |
|                                     | \$ 57,434             | 0.0%              | 0.0%              |               |               |              |              |              |                        |
| <b>Total RBIF Fund</b>              | <b>\$ 529,495,569</b> | <b>100.0%</b>     | <b>100.0%</b>     | <b>-6.3%</b>  | <b>-2.6%</b>  | <b>4.2%</b>  | <b>4.6%</b>  | <b>7.2%</b>  | <b>5.5%</b>            |
| <b>Market Return</b>                |                       |                   |                   | <b>-6.7%</b>  | <b>-3.0%</b>  | <b>4.0%</b>  | <b>4.4%</b>  | <b>7.1%</b>  | <b>5.5%</b>            |