§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, October 19, 2021 at 1:00 p.m.
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 July 20, 2021 minutes **(For Possible Action)**
5. Review and approval of Post-Retirement Medical Plan & Trust calculation for TMWA Retiree John Woods — Rosalinda Rodriguez **(For Possible Action)**
6. Review and approval of Post-Retirement Medical Plan & Trust calculation for TMWA Retiree Bradley Chase — Rosalinda Rodriguez **(For Possible Action)**
7. Review and approval of Post-Retirement Medical Plan & Trust calculation for TMWA Retiree Todd Milich— 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 Retirement Benefits Investment Fund (RBIF) performance review—Michele Sullivan*
10. Discussion and possible Trustee direction regarding meetings being held only in person or a hybrid option (virtual and in person), and date and times for 2022—Rosalinda Rodriguez **(For Possible Action)**
11. Update regarding status of trust document subcommittee and revision*
12. Trustee comments and requests for future agenda items*
13. Public comment — limited to no more than three minutes per speaker*
14. 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
Quality. Delivered.

DRAFT July 20, 2021 MINUTES

The meeting of the TMWA Post-Retirement Medical Plan and Trust (Trust) Trustees was held on Tuesday, July 20, 2021.

Michele Sullivan, Chairman, called the meeting to order at 1:00 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
Juan Esparza

Members Present
Jessica Atkinson
Rosalinda Rodriguez
Gus Rossi

Members Absent:
Mike Venturino

2. PUBLIC COMMENT

There was no public comment

3. APPROVAL OF THE AGENDA

Ms. Sullivan advised that Agenda item 10 should be removed as there is no new information at this time for this topic.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the agenda with the noted revision that Agenda item 10 should be removed from the Agenda.

4. APPROVAL OF THE APRIL 20, 2021 MINUTES

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the April 20, 2021 minutes (formal documentation of meeting cancelation due to not having a quorum).

5. REVIEW AND APPROVAL OF POST-RETIREMENT MEDICAL PLAN & TRUST CALCULATIONS FOR TMWA RETIREE JON KIESSLING

Ms. Rodriguez presented the benefits calculation for Jon Kiessling. Mr. Kiessling will retire on 10/11/2021, with a benefit effective date of November 1, 2021. Ms. Rodriguez met with the retiree and confirmed the information on the benefit calculation form. Mr. Kiessling has elected not to continue on TMWA health coverages at this time. He will submit for reimbursement at a later time. He is accepting the benefit as is. He is eligible for Life Insurance.

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

6. REVIEW AND APPROVAL OF POST-RETIREMENT MEDICAL PLAN & TRUST CALCULATIONS FOR TMWA RETIREE PATRICK KUYKENDALL

Ms. Rodriguez presented the benefits calculation for Patrick Kuykendall. Mr. Kuykendall will retire on 11/01/2021 and is requesting trust benefits beginning on 12/01/2021. Ms. Rodriguez met with the retiree and confirmed the information on the benefit calculation form. Mr. Kuykendall has elected to continue on TMWA coverage as Retiree and Spouse for medical, dental, and vision coverages. Mr. Kuykendall has elected to have any remaining premium balance paid from his 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 Patrick Kuykendall.

7. REVIEW AND APPROVAL OF POST-RETIREMENT MEDICAL PLAN & TRUST CALCULATIONS FOR TMWA RETIREE DANA MCKINNEY

Ms. Rodriguez presented the benefits calculation for Dana McKinney. Mr. McKinney will retire on 09/30/2021 and is requesting trust benefits beginning on 10/01/2021. Ms. Rodriguez met with the retiree and confirmed the information on the benefit calculation form. Mr. McKinney has elected to continue on TMWA coverage as Retiree and Spouse for medical, dental, and vision coverages. Mr. McKinney has elected to have any remaining premium balance paid from his 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 Dana McKinney.

8. REVIEW AND CONSIDERATION FOR APPORVAL OF REQUEST(S) FOR REIMBURSEMENT OF PREMIUMS

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

Upon motion made and seconded, and carried by unanimous consent by the trustee's present, the reimbursement request for Medicare, RX coverage, paid through Social Security, were approved

Ms. Rodriguez presented a reimbursement request received for United Healthcare supplemental coverage paid for directly by the retiree.

Upon motion made and seconded, and carried by unanimous consent by the trustee's present, the reimbursement request for United Healthcare paid for directly by the retiree, were approved

Ms. Rodriguez presented a reimbursement request received for United Health Care premiums, and RX premiums paid for directly by the Retiree.

Upon motion made and seconded, and carried by unanimous consent by the trustee's present, the reimbursement request for United Health care premiums and RX premiums paid for directly by the Retiree were approved

Ms. Rodriguez presented a reimbursement request received for Medicare paid through Social Security and, Medicare supplement paid premiums paid for directly by the retiree.

Upon motion made and seconded, and carried by unanimous consent by the trustee's present, the reimbursement request for Medicare premiums paid through Social Security and Medicare supplement premiums paid for directly by the retiree were approved

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

Upon motion made and seconded, and carried by unanimous consent by the trustee's present, the reimbursement request for Medicare Part B paid for through Social Security were approved

9. UPDATE REGARDING STATUS OF TRUST DOCUMENT REVISIONS

During the April 20, 2021 trust meeting, Ms. Atkinson advised that staff had received an inquiry from an employee considering retirement options asking about premium payment options. Based on this retiree's age, his preference was to defer enrolling in NV PERS to avoid an age penalty. The premium payment policy approved by trustees allows only for premiums to be paid via NV PERS or a Retiree's RHS account. Neither of which will apply to this retiree if indeed enrollment in NV PERS is delayed.

In researching this issue further, staff became aware of language in the Nevada Revised Statutes (NRS) 287.023 as well as in the health plan documents that require a retiree to be enrolled in PERS to continue on TMWA's insurance plan.

Sections 4.1.2, 4.1.3, 4.1.4(a), and 4.1.4(b), of the VEBA document conflict with both the NRS and TMWA's health plan eligibility requirements.

4.1.2 – Specific Post Retirement Benefits for Health Plan Coverage for MPAT Employees. "A participant who was an MPAT Employee at his or her Retirement Date may elect coverage under the Health Plans that are made available to TMWA's active employees who are entitled to receive health and life benefits."

4.1.3 –"All IBEW 1245 Employees hired on or after January 1, 1998, and "IBEW Transfer Employee's Receiving Sierra Plan Benefits" hired before January 1, 1998, are entitled to receive Post-Retirement Benefits for coverage under the Health Plans made available to Benefited Employees of TMWA or other Health Plans as described in Section 2.5."

4.1.4 (a) – "A Participant who was an IBEW Transfer Employee, was hired by Sierra before January 1, 1998 and is at least age 55 and under age 65 on his or her retirement date, is entitled to receive Post-Retirement benefits only for coverage under a Health Plan that is offered by TMWA to its benefited employees until the Plan Year in which the Participant attains age 65."

4.1.4 (b) – "A Participant who was an IBEW Transfer Employee, was hired by Sierra before January 1, 1998 and is age 65 or over on his retirement date, is eligible to receive Post-Retirement benefits for coverage under Health Plans offered by TMWA to its benefited employees..."

Ms. Atkinson had during that meeting recommended further review and revision of the VEBA document to ensure that there is no conflicting language. Ms. Atkinson also recommended trustees discuss implications of the NRS and health plan language on the intent of the benefits to be provided to retirees and determine if other changes may be necessary.

Trustee's discussed Ms. Atkinson's recommendation and agreed that this should be reviewed and that the VEBA document should be revised to ensure there is no conflicting language with regards to the entire document, so no further revisions are needed. It was determined that a subcommittee would meet, this committee would consist of Human resources staff and Trustee's Juan Esparza and Steve Enos as they may have insight to the document's original intent. Once a draft is ready for review it will be brought before trustees for review and approval to then be presented for approval before the TMWA Board of Trustees.

As of the April meeting, trustee members Steve Enos, and Juan Esparza, along with HR Manager, Jessica Atkinson and HR Coordinator Rosalinda Rodriguez, met to review the current VEBA plan and discuss the original intent of the plan. An agenda item will be added for the next Trustee Meeting and the outcome of the subcommittee meeting will be presented.

This was for informational purposes only, no action required.

10. REVIEW OF ACTUARIAL ANALYSIS

This item was removed with trustee approval as this was presented in the April 2021 meeting.

11. REVIEW OF FINANCIAL AUDIT

Principal Accountant Sophie Cardinal reviewed the most recent Audited financials for the PRMT trust plan. This relates to the audit of financial statements for the calendar year 2020. Eide Bailley is the external auditor who performed this audit. The report was issued at the end of June 2021. We received a clean audit opinion meaning that our statements are fairly presented and conform to accepted general accounting principles. Ms. Cardinal reviewed the most notable highlight of the Plan's report was that Net position totaled $14.0 million, which was a $1.6 million increase from the prior year.

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

Ms. Sullivan reviewed the last RBIF report dated March 31, 2021 excess of 20% return on investments. Since inception in 2008 the total RBIF fund is at 7.7%, the Market return is at 7.6%. This is doing well; we have used 6% assumption rate as historically that is what has been earned.

13. TRUSTEE COMMENTS AND REQUEST FOR FUTURE AGENDA ITEMS*

RBIF

Reimbursement Request

Trust document revision update if available

14. PUBLIC COMMENT

There was no public comment.

15. ADJOURNMENT

With no further business to discuss, Chairman Sullivan adjourned the meeting at 1:19 PM.

Minutes were approved by the Trustees in session on _____.

Respectfully Submitted,

_____

Rosalinda Rodriguez, Recording Secretary

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

DATE RANGE From 7-1-21
To 9-1-21

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
7-1	Medicare Premium	Medicare	297.00	$ 297 -
8-1	"	"	"	$ 297 -
9-1	"	"	"	$ 297 -
				$ -
				$ -
				$ -

Medicare Eligible? X YES ____ NO **Total** $ 0.00 891.00

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:** 4-11-21

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.

Social Security Administration
Important Information

Date: November 25, 2020

[redacted]

[redacted]

We review Social Security benefits each year to make sure they keep up with the cost of living. Your Social Security benefits will increase by 1.3% in 2021 because of a rise in the cost of living.

The law requires some people to pay higher premiums for their Medicare Part B (Medical Insurance) and Part D (Prescription Drug Plan) because of their income. These increases in the premiums are called the Income-Related Monthly Adjustment Amounts (IRMAA). Based on your income, you are required to pay IRMAA. We use information from the Internal Revenue Service (IRS) to decide if you will need to pay IRMAA. The information in this letter is for one year only.

How Much You Will Get

This letter explains your benefit amount, your Medicare premiums, your IRMAA, and what you can do if you disagree or your situation has changed. The information below shows your monthly benefit amount before and after deductions:

- Your new 2021 monthly benefit amount before deductions is: - [redacted]
- Your 2021 monthly deduction for the Medicare Part B premium is: - $297.00
  - — $148.50 for the standard Medicare premium, plus
  - — $148.50 for the Medicare Part B IRMAA based on your 2019 income tax return
- Your 2021 deduction for Medicare Part D IRMAA based on your 2019 income tax return is: - $31.80
- Your deduction for voluntary tax withholding is: - $242.70
- Your benefit amount after deductions that will be deposited into your bank account or sent in your check on January 13, 2021 is: - [redacted]

The Treasury Department requires Federal benefit payments to be made electronically. If you still receive a paper check, please visit the Department of the Treasury's Go

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See Next Page

0301YVAPA051022 CCM.M12.YVAPA.R20112000000000003610635601634294 8.894335618 25

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

RETRIEE INFORMATION:

DATE RANGE From _____
To _____

Name: [redacted]

Employee #: 50057

Address: [redacted]

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total Eligible for Reimbursement
1/13/2021	Medicare withholding	Social Security Administration	$220.20	$220.20
2/10/2021	Medicare withholding	Social Security Administration	$220.20	$220.20
3/10/2021	Medicare withholding	Social Security Administration	$220.20	$220.20
4/14/2021	Medicare withholding	Social Security Administration	$220.20	$220.20
5/12/2021	Medicare withholding	Social Security Administration	$220.20	$80.77
			$1,101.00	
			Total	$961.57

Medicare Eligible? X 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: [redacted] **Date:** 25 Aug 2021

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

0301YVAPK139797 CCM.M15.YVAPK.R20112000000000036106356019378532.8943421405O

Social Security Administration
Important Information

Date: November 25, 2020

[redacted]

[redacted]

We review Social Security benefits each year to make sure they keep up with the cost of living. Your Social Security benefits will increase by 1.3% in 2021 because of a rise in the cost of living.

The law requires some people to pay higher premiums for their Medicare Part B (Medical Insurance) and Part D (Prescription Drug Plan) because of their income. These increases in the premiums are called the Income-Related Monthly Adjustment Amounts (IRMAA). Based on your income, you are required to pay IRMAA. We use information from the Internal Revenue Service (IRS) to decide if you will need to pay IRMAA. The information in this letter is for one year only.

How Much You Will Get

This letter explains your benefit amount, your Medicare premiums, your IRMAA, and what you can do if you disagree or your situation has changed. The information below shows your monthly benefit amount before and after deductions:

- Your new 2021 monthly benefit amount before deductions is: - [redacted]
- Your 2021 monthly deduction for the Medicare Part B premium is: - $207.90
  - — $148.50 for the standard Medicare premium, plus
  - — $59.40 for the Medicare Part B IRMAA based on your 2018 income tax return
- Your 2021 deduction for Medicare Part D IRMAA based on your 2018 income tax return is: - $12.30
- Your benefit amount after deductions that will be deposited into your bank account or sent in your check on January 13, 2021 is: - [redacted]

The Treasury Department requires Federal benefit payments to be made electronically. If you still receive a paper check, please visit the Department of the Treasury's Go Direct website at ***www.godirect.org*** or call their Electronic Payment Solution Center at **1-800-333-1795**. If outside the United States, please call **1-214-254-3113**.

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Individual Services

Benefit Details

Social Security (Retirement)

Medicare

Get a Benefit Verification Letter

Need proof that you receive Social Security benefits? Here's your official letter.

Navigation

Overview

Benefit & Payment Details

Earnings Record

Replacement Documents

My Profile

Payment Details

Payment History | Overpayments

Your **monthly payment amount can change** depending on the types of benefits you receive, as well as any adjustments in your premiums or deductions.

Showing 1 to 12 of 23 entries Page 1 of 2

Date	Payment Type	Amount
07/14/2021	Social Security (Retirement)	[redacted]
06/09/2021	Social Security (Retirement)	
05/12/2021	Social Security (Retirement)	
04/14/2021	Social Security (Retirement)	
03/10/2021	Social Security (Retirement)	
02/10/2021	Social Security (Retirement)	
01/13/2021	Social Security (Retirement)	
12/09/2020	Social Security (Retirement)	

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

DATE RANGE From 1/1/2021
To 8/31/2021

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
1/1-5/31	MONTHLY PREM	UNITED HEALTHCARE	141.75/MO	$ 708.75
6/1-8/31	"	"	147.00/MO	$ 441.00
				$ -
				$ -
				$ -
				$ -
			$0.00	

Medicare Eligible? X YES ____NO **Total** $ 1149.75

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:** 8/18/2021

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.

AARP Supplemental and Personal Health
from UnitedHealthcare

PO BOX 30607
Salt Lake City, UT 84130-0607

Toll-Free # 1-800-523-5800

August 9, 2021

[redacted]

[redacted]

Dear Mr Kenneth Briscoe,

I'm writing to you about your AARP® Supplemental or Personal Health Insurance Plan, from UnitedHealthcare.

At UnitedHealthcare, we try to provide the best possible experience to our insured members.

Why did you receive this letter?
UnitedHealthcare recently received a request regarding the status of this account.

Our records show that this account is set up for the Electronic Funds Transfer (EFT) Service.

The chart below summarizes coverage and payments for active coverage on the account.

Plan Name	Coverage Period	Monthly Amount Due	Number of Months	Total Amount Received
N	01/01/2021-05/31/2021	$141.75	5	$708.75
	06/01/2021-08/31/2021	$147.00	3	$441.00
				$1,149.75

Please call UnitedHealthcare Customer Service if you have questions or need more information:

- For English-speaking representatives, please call **1-800-523-5800, TTY 711.**
- Representatives are available to help:
  - Weekdays from 7 a.m. to 11 p.m., Eastern Time
  - Saturday from 9 a.m. to 5 p.m., Eastern Time
- Para español: **1-800-822-0246**.
  - De lunes a viernes, de 7 a.m. a 11 p.m., hora del este
  - Los sábados de 9 a.m. a 5 p.m., hora del este

Thank you for being a valued customer.

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

DATE RANGE From July 2021
To Sept. 2021

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
July, Aug.	Monthly Premium	United HealthCare	$187.43 x 3 mos =	$ 562.29
Sept.		(Supplemental)		$ -
				$ -
				$ -
				$ -
				$ -
			$0.00	

Medicare Eligible? X YES ____NO Dollars owed [redacted] = $479.76 **Total** $ 562.29

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:** 9/14/21

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.

Withdrawals and other subtractions - continued

Other subtractions

Date	Description	Amount
06/14/21	CARDMEMBER SERVICE Bill Payment	[redacted]
06/15/21	EDWARD JONES DES:INVESTMENT ID:26843 XXXXXXXXX [redacted] CO ID:3430345811 PPD	
06/16/21	Little Flower Ca DES:DONATION ID: [redacted] CO ID:6470751402 WEB	
06/17/21	CITI CARDS Bill Payment	
06/25/21	Catholic Services Appeal Bill Payment	
06/30/21	STATE FARM BANK Bill Payment	
07/02/21	NV ENERGY Bill Payment	
07/02/21	BANK OF AMERICA CREDIT CARD Bill Payment	
07/02/21	AT&T LOCAL AND LONG DISTANCE Bill Payment	
07/06/21	TRUCKEE MEADOWS WATER AUTHORITY Bill Payment	-187.43 ✓
07/06/21	UnitedHealthcare DES:PREMIUM [redacted] D CO ID:1836282001 PPD	
07/06/21	SYNCHRONY BANK DES:PAYMENT I[redacted] CO ID:1061537262 TEL	[redacted]
07/06/21	Online scheduled payment to LOC 8600 Confirmation# 3156957000	
07/06/21	B's Lawn & Pest Control Svcs Bill Payment	-23.90 ✓
07/06/21	UnitedHCMedicare DES:MedInsPymt [redacted] D CO ID:9000447048 PPD	
07/07/21	BANK OF AMERICA DES:MORTGAGE ID:P27795634[redacted] CO ID:PXXXXXXXXX TEL	[redacted]
Total other subtractions		[redacted]

Checks

Date	Check #	Amount
06/22/21	6498	[redacted]
06/25/21	6499	
06/25/21	6500	
06/23/21	6501	
06/25/21	6502	
06/28/21	6503	
Total checks		
Total # of checks		6

[redacted] | July 9, 2021 to August 9, 2021

Withdrawals and other subtractions

ATM and debit card subtractions

Date	Description			Amount
07/14/21	BKOFAMERICA ATM 07/14 #000009736 WITHDRWL RALEYS MAYBERRY	RENO	NV	[redacted]
07/16/21	BKOFAMERICA ATM 07/16 #000009905 WITHDRWL RALEYS MAYBERRY	RENO	NV	
08/04/21	BKOFAMERICA ATM 08/04 #000002273 WITHDRWL RALEYS MAYBERRY	RENO	NV	
Total ATM and debit card subtractions				

Other subtractions

Date	Description		Amount
07/14/21	CARDMEMBER SERVICE Bill Payment		[redacted]
07/15/21	EDWARD JONES DES:INVESTMENT ID:26843 XXXXXXXXX ID:3430345811 PPD	CO	
07/16/21	CITI CARDS Bill Payment		
07/16/21	Little Flower Ca DES:DONATION ID:	CO ID:6470751402 WEB	
07/20/21	Catholic Services Appeal Bill Payment		
07/30/21	State Farm Bank Bill Payment		
08/03/21	NV ENERGY Bill Payment		
08/03/21	AT&T LOCAL AND LONG DISTANCE Bill Payment		
08/04/21	Online scheduled payment to LOC 8600 Confirmation# 4507513564		-187.43 ✓
08/05/21	UnitedHealthcare DES:PREMIUM ID:3430418891 PPD	D CO ID:1836282001	[redacted]
08/05/21	SYNCHRONY BANK DES:PAYMENT ID:1061537262 TEL	CO	-23.90 ✓
08/05/21	UnitedHCMedicare DES:MedInsPymt ID:000001023457271 ID:9000447048 PPD	D CO	
08/06/21	TRUCKEE MEADOWS WATER AUTHORITY Bill Payment		[redacted]
08/09/21	BANK OF AMERICA DES:MORTGAGE ID:PXXXXXXXXX TEL		
Total other subtractions			

[redacted] August 10, 2021 to September 8, 2021

Withdrawals and other subtractions - continued

Other subtractions

Date	Description	Amount
08/10/21	CITI CARDS Bill Payment	[redacted]
08/10/21	AAA N. CA, NV & UT Bill Payment	
08/11/21	Waste Management of Nevada Bill Payment	
08/12/21	Citi Cards Bill Payment	
08/13/21	CARDMEMBER SERVICE Bill Payment	
08/13/21	City of Sparks Bill Payment	
08/16/21	Washoe County Treasurer NV Bill Payment	
08/16/21	EDWARD JONES DES:INVESTMENT ID:26843 XXXXXXXXX IND [redacted] CO ID:3430345811 PPD	
08/16/21	Washoe County Treasurer NV Bill Payment	[redacted]
08/16/21	Catholic Services Appeal Bill Payment	
08/17/21	Little Flower Ca DES:DONATION [redacted] CO ID:6470751402 WEB	
08/24/21	MACY'S Bill Payment	
08/31/21	STATE FARM BANK Bill Payment	
09/01/21	CITI CARD ONLINE DES:PAYMENT ID:42052530710165 [redacted] CO ID:CITICTP WEB	
09/01/21	NV ENERGY Bill Payment	
09/02/21	AT&T LOCAL AND LONG DISTANCE Bill Payment	
09/03/21	TRUCKEE MEADOWS WATER AUTHORITY Bill Payment	
09/03/21	Online scheduled payment to LOC 8600 Confirmation# 0966756259	-187.43 ✓
09/07/21	UnitedHealthcare DES:PREMIUM I[redacted] D CO ID:1836282001 PPD	[redacted]
09/07/21	SYNCHRONY BANK DES:PAYMENT ID:650172443226603 [redacted] CO ID:1061537262 TEL	-23.90 ✓
09/07/21	UnitedHCMedicare DES:MedInsPymt ID:000001030024663 [redacted] D CO ID:9000447048 PPD	[redacted]
09/07/21	BANK OF AMERICA DES:MORTGAGE ID:P3125913[redacted] CO ID:PXXXXXXXXX TEL	[redacted]
09/08/21	B's Lawn & Pest Control Svcs Bill Payment	[redacted]
Total other subtractions		

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

DATE RANGE From July 2021
To Sept. 2021

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
July, Aug.	Monthly Premium	United HealthCare	$187.43 x 3 mos =	$ 562.29
Sept.		(Supplemental)		$ -
				$ -
				$ -
				$ -
				$ -
			$0.00	

Medicare Eligible? X YES ____NO Dollars owed [redacted] = $479.76 **Total** $ 562.29

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:** 9/14/21

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.

Withdrawals and other subtractions - continued

Other subtractions

Date	Description	Amount
06/14/21	CARDMEMBER SERVICE Bill Payment	[redacted]
06/15/21	EDWARD JONES DES:INVESTMENT ID:26843 XXXXXXXXX [redacted] CO ID:3430345811 PPD	
06/16/21	Little Flower Ca DES:DONATION ID: [redacted] CO ID:6470751402 WEB	
06/17/21	CITI CARDS Bill Payment	
06/25/21	Catholic Services Appeal Bill Payment	
06/30/21	STATE FARM BANK Bill Payment	
07/02/21	NV ENERGY Bill Payment	
07/02/21	BANK OF AMERICA CREDIT CARD Bill Payment	
07/02/21	AT&T LOCAL AND LONG DISTANCE Bill Payment	
07/06/21	TRUCKEE MEADOWS WATER AUTHORITY Bill Payment	-187.43 ✓
07/06/21	UnitedHealthcare DES:PREMIUM [redacted] D CO ID:1836282001 PPD	
07/06/21	SYNCHRONY BANK DES:PAYMENT I[redacted] CO ID:1061537262 TEL	[redacted]
07/06/21	Online scheduled payment to LOC 8600 Confirmation# 3156957000	
07/06/21	B's Lawn & Pest Control Svcs Bill Payment	-23.90 ✓
07/06/21	UnitedHCMedicare DES:MedInsPymt [redacted] D CO ID:9000447048 PPD	
07/07/21	BANK OF AMERICA DES:MORTGAGE ID:P27795634[redacted] CO ID:PXXXXXXXXX TEL	[redacted]
Total other subtractions		[redacted]

Checks

Date	Check #	Amount
06/22/21	6498	[redacted]
06/25/21	6499	
06/25/21	6500	
06/23/21	6501	
06/25/21	6502	
06/28/21	6503	
Total checks		
Total # of checks		6

[redacted] | July 9, 2021 to August 9, 2021

Withdrawals and other subtractions

ATM and debit card subtractions

Date	Description			Amount
07/14/21	BKOFAMERICA ATM 07/14 #000009736 WITHDRWL RALEYS MAYBERRY	RENO	NV	[redacted]
07/16/21	BKOFAMERICA ATM 07/16 #000009905 WITHDRWL RALEYS MAYBERRY	RENO	NV	
08/04/21	BKOFAMERICA ATM 08/04 #000002273 WITHDRWL RALEYS MAYBERRY	RENO	NV	
Total ATM and debit card subtractions				

Other subtractions

Date	Description		Amount
07/14/21	CARDMEMBER SERVICE Bill Payment		[redacted]
07/15/21	EDWARD JONES DES:INVESTMENT ID:26843 XXXXXXXXX ID:3430345811 PPD	CO	
07/16/21	CITI CARDS Bill Payment		
07/16/21	Little Flower Ca DES:DONATION ID:	CO ID:6470751402 WEB	
07/20/21	Catholic Services Appeal Bill Payment		
07/30/21	State Farm Bank Bill Payment		
08/03/21	NV ENERGY Bill Payment		
08/03/21	AT&T LOCAL AND LONG DISTANCE Bill Payment		
08/04/21	Online scheduled payment to LOC 8600 Confirmation# 4507513564		-187.43 ✓
08/05/21	UnitedHealthcare DES:PREMIUM ID:3430418891 PPD	D CO ID:1836282001	[redacted]
08/05/21	SYNCHRONY BANK DES:PAYMENT ID:1061537262 TEL	CO	-23.90 ✓
08/05/21	UnitedHCMedicare DES:MedInsPymt ID:000001023457271 ID:9000447048 PPD	D CO	
08/06/21	TRUCKEE MEADOWS WATER AUTHORITY Bill Payment		[redacted]
08/09/21	BANK OF AMERICA DES:MORTGAGE ID:PXXXXXXXXX TEL		
Total other subtractions			

[redacted] August 10, 2021 to September 8, 2021

Withdrawals and other subtractions - continued

Other subtractions

Date	Description	Amount
08/10/21	CITI CARDS Bill Payment	[redacted]
08/10/21	AAA N. CA, NV & UT Bill Payment	
08/11/21	Waste Management of Nevada Bill Payment	
08/12/21	Citi Cards Bill Payment	
08/13/21	CARDMEMBER SERVICE Bill Payment	
08/13/21	City of Sparks Bill Payment	
08/16/21	Washoe County Treasurer NV Bill Payment	
08/16/21	EDWARD JONES DES:INVESTMENT ID:26843 XXXXXXXXX IND [redacted] CO ID:3430345811 PPD	
08/16/21	Washoe County Treasurer NV Bill Payment	[redacted]
08/16/21	Catholic Services Appeal Bill Payment	
08/17/21	Little Flower Ca DES:DONATION [redacted] CO ID:6470751402 WEB	
08/24/21	MACY'S Bill Payment	
08/31/21	STATE FARM BANK Bill Payment	
09/01/21	CITI CARD ONLINE DES:PAYMENT ID:42052530710165 [redacted] CO ID:CITICTP WEB	
09/01/21	NV ENERGY Bill Payment	
09/02/21	AT&T LOCAL AND LONG DISTANCE Bill Payment	
09/03/21	TRUCKEE MEADOWS WATER AUTHORITY Bill Payment	
09/03/21	Online scheduled payment to LOC 8600 Confirmation# 0966756259	-187.43 ✓
09/07/21	UnitedHealthcare DES:PREMIUM I[redacted] D CO ID:1836282001 PPD	[redacted]
09/07/21	SYNCHRONY BANK DES:PAYMENT ID:650172443226603 [redacted] CO ID:1061537262 TEL	-23.90 ✓
09/07/21	UnitedHCMedicare DES:MedInsPymt ID:000001030024663 [redacted] D CO ID:9000447048 PPD	[redacted]
09/07/21	BANK OF AMERICA DES:MORTGAGE ID:P3125913[redacted] CO ID:PXXXXXXXXX TEL	[redacted]
09/08/21	B's Lawn & Pest Control Svcs Bill Payment	[redacted]
Total other subtractions		

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

DATE RANGE From July, 2021
To Sept, 2021

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
July	Monthly Premium	Medicare		$ 207 90
aug	" "	Medicare		$ 207 90
Sept	" "	Medicare		$ 207 90
July	" "	United Health Care		$ 114 35
aug	" "	United Health Care		$ 114 35
Sept	" "	United Health Care		$ 114 35

Medicare Eligible? ✓ YES ____ NO **Total** $ 966 75

$ 805.04 reimbursable

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.

I

Retiree Signature: [redacted] Date: 9/15/21

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 basi 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.

0101BEV710SWN94 CCM.M72.BEV71.R210910

Social Security Administration
Benefit Verification Letter

Date: September 9, 2021

[redacted]

[redacted]

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 April 2021, the full monthly Social Security benefit before any deductions is [redacted].

We deduct $207.90 for medical insurance premiums each month. July aug & Sept

The regular monthly Social Security payment is [redacted]
(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 third Wednesday of each month.

Type of Social Security Benefit Information

You are entitled to monthly retirement benefits.

Medicare Information

You are entitled to hospital insurance under Medicare beginning April 2021.

You are entitled to medical insurance under Medicare beginning April 2021.

Your Medicare number is [redacted] You may use this number to get medical services while waiting for your Medicare card.

If you have any questions, please log into Medicare.gov, or call 1-800-MEDICARE (1-800-633-4227).

See Next Page

Premium Payment History

Payment history for [redacted]
Plan name(s): AARP MEDICARE SUPPLEMENT PLAN
Member ID: [redacted]
From: June 04, 2021
To: September 01, 2021

Payment Date	Amount	Status	Payment Method
09/01/2021	$114.35	Processed	EFT
08/01/2021	$114.35	Processed	EFT
07/01/2021	$114.35	Processed	EFT
Total Amounts	$343.05		

Description	Debit	Credit	Balance
September 7, 2021			
PREMIUM UnitedHealthcare PREMIUM, 09-07-2021 @ : 0 Trace #:021000022269630	-$114.35		$1,892.08
August 5, 2021			
PREMIUM UnitedHealthcare PREMIUM, 08-05-2021 @ : 0 Trace #:021000029018881	-$114.35		$1,836.28
July 6, 2021			
PREMIUM UnitedHealthcare PREMIUM, 07-06-2021 @ : 0 Trace #:021000028660591	-$114.35		$1,848.24

Checking Withdrawal
Sierra Pacific Credit Union
Medicare Supplement with
United HealthCare

Human Resources
Truckee Meadows Water Authority

Re: PRMPT Reimbursement Request

Hi All:

In advance of the October Trust meeting, I am attaching a request for reimbursement for medical insurance premiums paid in July, August and September of 2021. I have Medicare deducted from my Social Security check in the amount of $207.90 per month and I have supplemental insurance through United Health Care in the amount of $114.35 per month.

I realize the total for three months is larger than my available credit and I have indicated that on the form. I trust the documentation provided will be sufficient, but if you have any questions or concerns, I have left all contact information below.

I hope everyone is well.

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

DATE RANGE From 4/1/2021
To 5/31/2021

RETRIEE INFORMATION:

Name: [redacted]

Employee #: 50055

Address: [redacted]

Phone #: [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
2/24/2021	Medicare Premium	US Dept of Health & Human Services CMS	$148.50	$297.00 -
3/24/2021	Prescription Pt D	Humana	$17.20	$34.40 -
4/1 & 5/1/2021	Medicare Supplement	AARP United Healthcare	$102.99	$205.98 -
				$ -
				$ -
				$ -

Medicare Eligible? _____YES _____NO

Total $537.38 -

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:** 10/14/2021

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

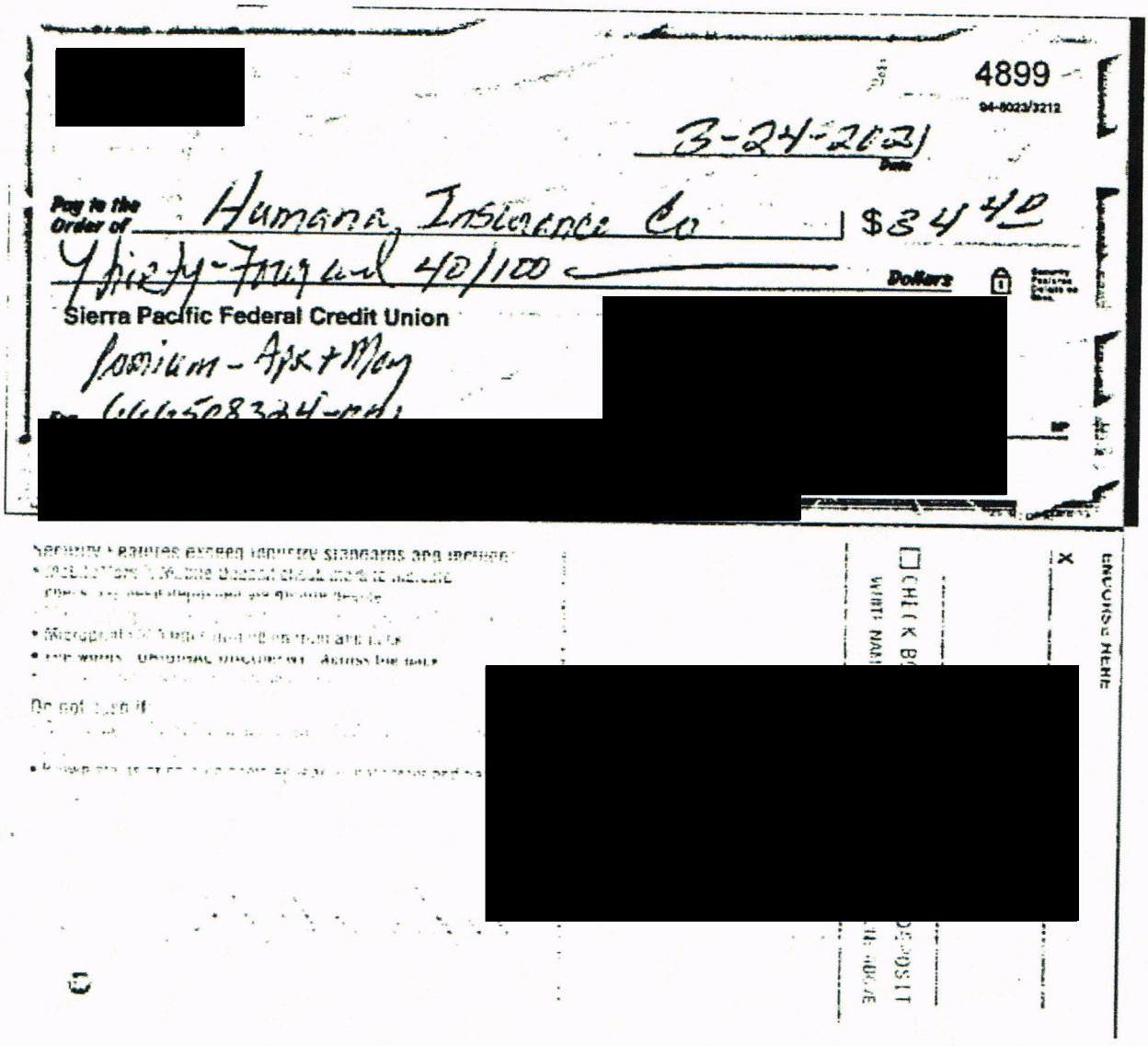
Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

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.

Description	Draft# 4884
Detail Description	CMS MEDICARE PAYMENT, 02-24-2021 @ : [redacted]
Date	Feb 24, 2021
Transaction Amount	-$445.50
New Balance	[redacted]
Reference Number	4884

Premium for April & May


[redacted]
4899
94-8023/3212
3-24-2021
Date
Pay to the Order of Humana Insurance Co
$34 40
Thirty-Four and 40/100
Dollars
Sierra Pacific Federal Credit Union
Psoriasis - Apr + May
[redacted]
[redacted]
[redacted]

AARP | Supplemental and Personal Health
from UnitedHealthcare

PO BOX 30607
Salt Lake City, UT 84130-0607

Toll-Free # 1-800-523-5800

August 23, 2021

[redacted]

[redacted]

Dear [redacted]

I'm writing to you about your AARP® Supplemental or Personal Health Insurance Plan, from UnitedHealthcare.

At UnitedHealthcare, we try to provide the best possible experience to our insured members.

Why did you receive this letter?
UnitedHealthcare recently received a request regarding the status of this account.

The chart below summarizes coverage and payments for active coverage on the account.

Plan Name	Coverage Period	Monthly Amount Due	Number of Months	Total Amount Received
AARP Medicare Supplement Plan G	03/01/2021 08/31/2021	$102.99	6	$617.94

Please call UnitedHealthcare Customer Service if you have questions or need more information:

- For English-speaking representatives, please call **1-800-523-5800, TTY 711.**
- Representatives are available to help:
  - Weekdays from 7 a.m. to 11 p.m., Eastern Time
  - Saturday from 9 a.m. to 5 p.m., Eastern Time
- Para español: **1-800-822-0246.**
  - De lunes a viernes, de 7 a.m. a 11 p.m., hora del este
  - Los sábados de 9 a.m. a 5 p.m., hora del este

Thank you for being a valued customer.

Sincerely,

Member Services Department

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

DATE RANGE From 6/1/2021
To 8/31/2021

RETIREE INFORMATION:

Name: [redacted]

Employee #: 50055

Address: [redacted]

Phone # [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
5/20/2021	Medicare Premium	US Dept of Health & Human Services CMS	$148.50	$445.50 -
5/12/2021	Prescription Pt D	Humana	$17.20	$51.60 -
6/1 - 8/31/2021	Medicare Supplement	AARP United Healthcare	$102.99	$308.97 -
				$ -
				$ -
				$ -

Medicare Eligible? _____YES _____NO

Total $806.07 -

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:** 9/8/2021

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.

Description	Draft# 4911
Detail Description	CMS MEDICARE PAYMENT, 05-20-2021 @ : [redacted]
Date	May 20, 2021
Transaction Amount	-$445.50
New Balance	[redacted]
Reference Number	4911

June, July & August
Premium Amt.

[redacted]

4912

84-8023/3212

5/12/2021

Pay to the Order of Humana Insurance Co $ 51.60

Fifty-One and 60/100 Dollars

Security Features Details on Back.

Sierra Pacific Federal Credit Union

For June, July & August Premiums 06665083249-001

[redacted]

[redacted]

[redacted]

AARP | Supplemental and Personal Health from UnitedHealthcare

PO BOX 30607
Salt Lake City, UT 84130-0607

Toll-Free # 1-800-523-5800

August 23, 2021

[redacted]

[redacted]

Dear [redacted]

I'm writing to you about your AARP® Supplemental or Personal Health Insurance Plan, from UnitedHealthcare.

At UnitedHealthcare, we try to provide the best possible experience to our insured members.

Why did you receive this letter?
UnitedHealthcare recently received a request regarding the status of this account.

The chart below summarizes coverage and payments for active coverage on the account.

Plan Name	Coverage Period	Monthly Amount Due	Number of Months	Total Amount Received
AARP Medicare Supplement Plan G	03/01/2021 08/31/2021	$102.99	6	$617.94

Please call UnitedHealthcare Customer Service if you have questions or need more information:

- For English-speaking representatives, please call **1-800-523-5800, TTY 711.**
- Representatives are available to help:
  - Weekdays from 7 a.m. to 11 p.m., Eastern Time
  - Saturday from 9 a.m. to 5 p.m., Eastern Time
- Para español: **1-800-822-0246**.
  - De lunes a viernes, de 7 a.m. a 11 p.m., hora del este
  - Los sábados de 9 a.m. a 5 p.m., hora del este

Thank you for being a valued customer.

Sincerely,

Member Services Department

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

DATE RANGE From July 1, 2021
To Sept 30, 2021

RETRIEE INFORMATION:

Name: [redacted]

Employee # [redacted]50068

Address: [redacted]

Phone # [redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
July. - Sept.	Monthly Premium	Medicare "Part B"	$148.50 per month X three months	$445.50 -
				$0.00 -
				$0.00 -
				$0.00 -
				$0.00 -
				$0.00 -
				0.00
Medicare Eligible?		X YES ____NO	Total	$445.50 -

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: 10/07/2021

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.

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Social Security Administration
Benefit Verification Letter

Date: October 7, 2021

[redacted]

[redacted]

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 2020, the full monthly Social Security benefit before any deductions is [redacted]

We deduct $148.50 for medical insurance premiums each month. Medicare "Part B"

The regular monthly Social Security payment [redacted]
(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 2019 to November 2020, the full monthly Social Security benefit before any deductions was [redacted]

We deducted $144.60 for medical insurance premiums each month.

The regular monthly Social Security payment was [redacted]
(We must round down to the whole dollar.)

Type of Social Security Benefit Information

You are entitled to monthly retirement benefits.

Medicare Information

You are entitled to hospital insurance under Medicare beginning November 2014.

See Next Page

Retirement Benefits Investment Fund

June 30, 2021

Performance Gross of Fees

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	$ 413,539,906	50.5%	53.4%	40.7%	40.7%	18.6%	17.6%	14.8%	11.2%
Market Return				**40.8%**	**40.8%**	**18.7%**	**17.7%**	**14.8%**	**11.1%**
Int'l Stocks- MSCI World x US Index	$ 171,619,448	21.5%	22.2%	33.7%	33.7%	8.9%	10.7%	6.3%	4.1%
Market Return				**33.6%**	**33.6%**	**8.6%**	**10.5%**	**6.0%**	**3.9%**
U.S. Bonds- U.S. Bond Index	$ 184,332,344	28.0%	23.8%	0.1%	0.1%	5.8%	2.8%	3.3%	3.6%
Market Return				**0.1%**	**0.1%**	**5.7%**	**2.8%**	**3.2%**	**3.5%**
	$ 4,345,257	0.0%	0.6%						
Total RBIF Fund	**$ 773,836,955**	**100.0%**	**100.0%**	**27.5%**	**27.5%**	**13.7%**	**12.3%**	**9.9%**	**8.0%**
Market Return				**26.9%**	**26.9%**	**13.2%**	**12.0%**	**9.7%**	**7.9%**

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STAFF REPORT

TO: Board of Trustees
FROM: Rosalinda Rodriguez, HR Coordinator
DATE: October 19, 2021
SUBJECT: **Discussion and direction regarding meeting times and dates for 2022**

Recommendation

TMWA staff recommends that the Board of Trustees provide input on the schedule proposed for the TMWA §501-c-9 Post-Retirement Medical Plan & Trust meetings as well as confirmation of meeting times.

Discussion

The regular schedule for the TMWA §501-c-9 Post-Retirement Medical Plan & Trust meetings has traditionally been quarterly on the third Tuesday of the month.

Should these meetings also be posted as in person, or as a Hybrid (virtual and in person)?

Staff recommends continuing with the current reoccurring schedule as follows:

2021 Trustee Meeting Dates Proposed

Tuesday, January 18	1:00 p.m.
Tuesday, April 19	1:00 p.m.
Tuesday, July 19	1:00 p.m.
Tuesday, October 18	1:00 p.m.