

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

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

AGENDA

§501-c-9 Post-Retirement Medical Plan & Trust Tuesday, April 16, 2024 at 1:00 p.m. Independence Room: 1355 Capital Blvd. Reno, NV 89520 and Teleconference

MEMBERS OF THE PUBLIC MAY ATTEND TELPHONICALLY BY CALLING THE NUMBER LISTED BELOW.
(be sure to keep your phones on mute, and do not place the call on hold)

Phone: (775) 325-5404

Meeting ID: 253 033 570 051#

1. Roll call*
2. Public comment — limited to no more than three minutes per speaker*
3. Approval of the agenda (**For Possible Action**)
4. Approval of the January 16, 2024 minutes (**For Possible Action**)
5. Trustee Appointment of Mitchell “Kelly” McGlynn – Rosalinda Rodriguez*
6. Review and approval of Post-Retirement Medical Plan & Trust calculation for TMWA Retiree Kevin Comphel- Rosalinda Rodriguez (**For Possible Action**)
7. Review and approval of Post-Retirement Medical Plan & Trust calculation for TMWA Retiree Juan Esparza- Rosalinda Rodriguez (**For Possible Action**)
8. Review and consider for approval request(s) for premium reimbursements. —Rosalinda Rodriguez (**For Possible Action**)
9. Update regarding status of trust document revision —Rosalinda Rodriguez*
10. Discussion and possible Trustee direction regarding retiree premium reimbursement policy—Rosalinda Rodriguez
11. Review of Retirement Benefits Investment Fund (RBIF) performance review—Matt Bowman*
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), Sparks City Hall (431 Prater Way, Sparks), at <http://www.tmwa.com>, and State of Nevada Public Notice Website, <https://notice.nv.gov/>.
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 (775) 834-8294 at least 24 hours 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*



DRAFT January 16, 2024 MINUTES

The meeting of the TMWA Post-Retirement Medical Plan and Trust (Trust) Trustees was held on Tuesday, January 16, 2024 in person and through teleconference.

Matt Bowman, Chairman, called the meeting to order at 01:06 P.M.

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

A quorum was present.

Voting Members Present:

Matt Bowman
Juan Esparza
Pete Pribyl
Steve Enos

Voting Members Absent

Members Present

Rosalinda Rodriguez

Members Absent:

Jessica Atkinson
Mike Venturino
Gus Rossi

2. PUBLIC COMMENT

Ms. Rosalinda Rodriguez, HR Technician II, advised that a letter was received from Retiree Mary Bennett for the Trustees to consider making changes to the reimbursement policy. The letter was received after the Agenda had already been posted and could not be revised to add this for discussion.

Chairperson Matt Bowman advised he would request this be added to the agenda for the next meeting for further discussion.

3. APPROVAL OF THE AGENDA

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

4. APPROVAL OF THE OCTOBER 17, 2023 MINUTES

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the Trustees approved the October 17, 2023 minutes.

5. DISCUSSION AND ACTION ON SIGNING §501-c-9 POST RETIREMENT MEDICAL PLAN AND TRUST BOARD OF TRUSTEE ANNUAL PLEDGE OF PERSONAL COMMITMENT/DISCLOSURE FORM

Ms. Rodriguez provided copies of the annual pledge of personal commitment and the disclosure form that is required to be signed annually by trustees.

For informational purposes only, no action required.

6. REVIEW AND APPROVAL OF POST-RETIREMENT MEDICAL PLAN & TRUST CALCULATION FOR TMWA RETIREE STEPHEN VOLK

Ms. Rosalinda Rodriguez, HR Technician II, presented the benefits calculation for Stephen Volk. Mr. Clifton will retire on March 08, 2024, and with Trustee approval have a benefit effective date of April 01, 2024. Ms. Rosalinda Rodriguez confirmed she met with the retiree and confirmed the information on the benefit calculation form. Mr. Volk has elected to continue on TMWA coverages as a Retiree Only for medical, dental and vision coverages. Mr. Volk has elected for any remaining premium balance to be paid from his PERS check.

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

7. REVIEW AND CONSIDERATION FOR APPROVAL OF REQUEST(S) FOR REIMBURSEMENT OF PREMIUMS

Ms. Rodriguez presented a reimbursement request received for employee # 50064, for premiums for Medicare premiums paid directly by the retiree through Social Security.

Upon motion made and seconded, and carried by unanimous consent by the Trustee's present, the reimbursement request for employee # 50064 for Medicare premiums paid directly by the retiree through Social Security was approved.

Ms. Rodriguez presented a reimbursement request for employee # 50078 for supplemental coverage through United Healthcare and supplemental prescription coverage also through United Healthcare 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 employee #50078 for supplemental coverage through United Healthcare and supplemental prescription coverage also through United Healthcare paid for directly by the retiree was approved.

Ms. Rodriguez presented a reimbursement request received for employee # 50057 for Medicare premiums paid for through Social Security.

Upon motion made and seconded, and carried by unanimous consent by the Trustee's present, the reimbursement request for employee # 50057 for Medicare premiums paid through Social Security was approved.

Ms. Rodriguez presented a reimbursement request for employee # 50077 for Blue Cross Blue Shield premiums, Metlife Dental, and VSP Vision coverages 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 employee # 50077 for Blue Cross Blue Shield premiums, Metlife Dental, and VSP Vision coverages paid for directly by the retiree was approved.

Ms. Rodriguez presented a reimbursement request for employee # 50055 for Medicare premiums paid for through Social Security and supplemental coverages through Humana and AARP 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 employee # 50055 for Medicare premiums paid through Social Security, and supplemental coverages through Humana and AARP paid for directly by the retiree was approved.

Ms. Rodriguez presented a reimbursement request employee # 50049 for Medicare premiums paid through Social Security, and supplemental coverage through United Health care 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 employee # 50049 for Medicare premiums paid through Social Security, and supplemental coverage through United Health care paid for directly by the retiree was approved.

8. UPDATE REGARDING STATUS OF TRUST DOCUMENT REVISION

During the October 18, 2022 meeting Ms. Stefanie Morris, Director of Legal & Regulatory Affairs reviewed the Trust Plan document in regards to interpretation of plan language as it relates to Nevada Revised Statute (NRS) 287.023 and questions regarding MPAT plan eligibility based on current plan document language. Trustees requested that staff review the Trust document and ensure it complies with the NRS and bring it back to the Trustee' addressed concerns and interpretation reviewed.

During the January 17, 2023 meeting A draft of proposed changes was brought for Trustee review, which were approved pending discussion with the City of Reno Plan administrators on interpretation of the Nevada Revised Statute that relates to retiree life insurance eligibility.

During the July 25, 2023: Ms. Rodriguez advised that we are still waiting to meet with the City of Reno regarding an outstanding question on whether or not an individual needs to be enrolled in our health plans to continue on the life insurance plans.

During the October 17, 2023: Ms. Rodriguez advised that this is still outstanding pending meeting with the City of Reno regarding an outstanding question on whether or not an individual needs to be enrolled in our health plans to continue on the life insurance plans.

Update January 16, 2024: Ms. Rodriguez Advised this is still outstanding pending meeting with the City of Reno.

For informational purposes only, no action required.

9. PRESENTATION OF THE BUDGET FOR CALENDAR YEAR 2024

Sr. Accountant, Veronica Galindo, presented the Budget for Calendar year 2024.

Ms. Galindo advised that the most recent actuarial valuation determined that TMWA does not need to contribute anything to the trust, so the budget for Employer Contributions is zero. TMWA conducts a full actuarial analyses every two years to make sure funding levels are adequate.

Net appreciation (Depreciation) in Fair Value of Investments is not budgeted as unrealized gains and losses are difficult to accurately predict.

The budget for Investment Earnings assumes similar market activity to calendar year 2023; actual results will likely differ.

The budget for Benefits Paid is \$516,000 and covers health premiums, life insurance premiums, and reimbursements to retirees for outside coverage.

Trust activity is projected to result in a net increase of \$284,590 primarily due to the estimated increase in Investment Earnings.

As of December 2023, PRMPT provides benefits to 69 retirees.

Upon motion made and seconded, and carried by unanimous consent of the Trustees present, the budget for calendar year 2024 was approved.

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

Mr. Bowman reviewed the RBIF dated September 30, 2023 as the fourth quarter has not yet been provided by RBIF. The overall performance was not great in the third quarter. The total fiscal year to date return is -3% loss and the overall market return was -3.1% loss.

For informational purposes only, no action required.

11. TRUSTEE COMMENTS AND REQUEST FOR FUTURE AGENDA ITEMS*

Reimbursement Requests

Discussion of reimbursement policy

12. PUBLIC COMMENT

13. ADJOURNMENT

With no further business to discuss, Chairman Bowman adjourned the meeting at 1:25 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 July 2023
To Dec 2023

RETRIEE INFORMATION:

Name: _____

Employee #: 50022

Address: _____

Phone #: _____

Expenses

2023
2023
2023

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
Jul-Dec	Medicare	Social Security	\$164.90	\$ 989.40 -
Jul-Dec	Anthem BC+BS	Supplemental coverage	\$141.00	\$ 846.00 -
Jul-Dec	Wellcare	Rx coverage	\$11.10	\$ 66.60 -
				\$ -
				\$ -
				\$ -
			\$0.00	
Medicare Eligible? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				Total \$ 1902.00

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: _____

Date: 23 Feb 2023

PRMPT Approval*: _____

Date: _____

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

Accounting Approval***: _____

Date: _____

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

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

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.

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

Need more help?

1. Visit www.ssa.gov for fast, simple, and secure online service.
2. Call us at 1-800-772-1213, weekdays from 8:00 am to 7:00 pm. If you are deaf or hard of hearing, call TTY 1-800-325-0778. Please mention this letter when you call.
3. You may also call your local office at 800-772-1213.

SOCIAL SECURITY
1170 HARVARD WAY
RENO, NV 89502

How are we doing? Go to www.ssa.gov/feedback to tell us.

Social Security Administration





Anthem Blue Cross and Blue Shield
P.O. Box 60007
Los Angeles, CA 90060-0007



November 20, 2023

Member Identification No.



This letter is in response to the request for the total amount of premiums paid toward your **Anthem Blue Cross and Blue Shield Medicare Supplement** from 7/1/2023 to 12/31/2023. The total amount of premiums paid was \$846.60.

We appreciate your business and are pleased to be of service to you. If you have any questions, please call 1-866-438-9969, 8:00 a.m. to 6:00 p.m. PT Monday - Friday. TTY users may call 711.

Sincerely,

Medicare Supplement Services

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc. Independent licensee of the Blue Cross Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.



20231121 000148 Env [247] 1 of 2

000148020101

#



Check View

[Redacted]

5247
99-88223212

6-26 2023

pay to the order of Wellcare \$ 66.60

Sixty Six dollars + 60/100 dollars

SIERRA PACIFIC EMPLOYEES
FEDERAL CREDIT UNION
6100 NEIL ROAD

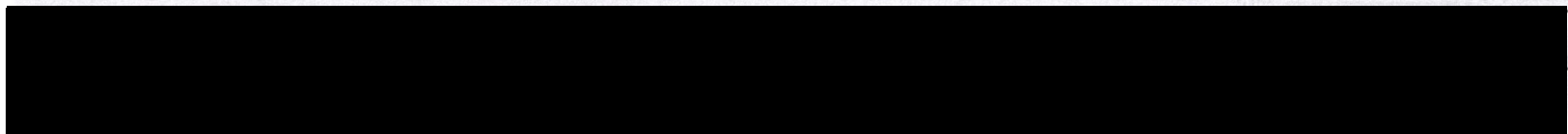
[Redacted]



[Redacted]

CHECK BOX FOR MOBILE
ADDITIONAL FINANCIAL IN

[Redacted]



OK

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

DATE RANGE From JAN. 2024
To MAR 2024

RETRIEE INFORMATION:

Name: 

Employee #: 50078

Address: 

Phone #: 

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
JAN-Mar	Mo. Premium	United Healthcare	\$234.60 x 3 mos.	\$ 703.80
				\$ -
JAN-Mar	Mo. Premium (Prescriptions)	United Healthcare	\$78 x 3 mos.	\$ 234.00-
				\$ -
				\$ -
				\$ -
			\$0.00	\$ -
Medicare Eligible? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				Total \$ <u>937.80-</u>

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: 3/19/24

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 - continued

Date	Description	Amount
01/02/24	[REDACTED]	[REDACTED]
01/02/24	[REDACTED]	[REDACTED]
01/03/24	[REDACTED]	[REDACTED]
01/05/24	[REDACTED]	[REDACTED]
01/05/24	UnitedHealthcare DES:PREMIUM PPD [REDACTED]	-234.60 ✓
01/05/24	UnitedHCMedicare DES:MedInst ID:9000447048 PPD [REDACTED]	-78.00 ✓
01/05/24	[REDACTED]	[REDACTED]
Total other subtractions		[REDACTED]

Checks

Date	Check #	Amount	Date	Check #	Amount
12/07/23	[REDACTED]	[REDACTED]	12/28/23	[REDACTED]	[REDACTED]
12/18/23	[REDACTED]	[REDACTED]			
Total checks			[REDACTED]		
Total # of checks			[REDACTED]		

* There is a gap in sequential check numbers

Braille and Large Print Request - You can request a copy of this statement in Braille or Large Print by calling 800.432.1000 or going to bankofamerica.com and enter Visually Impaired Access from the home page.

Withdrawals and other subtractions - continued

Other subtractions

Date	Description	Amount
01/12/24	[REDACTED]	[REDACTED]
01/16/24	[REDACTED]	[REDACTED]
01/17/24	[REDACTED]	[REDACTED]
01/18/24	[REDACTED]	[REDACTED]
01/22/24	[REDACTED]	[REDACTED]
01/23/24	[REDACTED]	[REDACTED]
01/24/24	[REDACTED]	[REDACTED]
02/02/24	[REDACTED]	[REDACTED]
02/05/24	UnitedHealthcare DES:PREMIUM PPD [REDACTED]	-234.60 ✓
02/05/24	UnitedHCMedicare DES:MedInsf ID:9000447048 PPD [REDACTED]	-78.00 ✓
02/06/24	[REDACTED]	[REDACTED]
02/06/24	[REDACTED]	[REDACTED]
Total other subtractions		[REDACTED]

Checks

Date	Check #	Amount	Date	Check #	Amount
01/25/24	[REDACTED]	[REDACTED]	01/22/24	[REDACTED]	[REDACTED]
01/25/24	[REDACTED]	[REDACTED]	01/22/24	[REDACTED]	[REDACTED]
01/16/24	[REDACTED]	[REDACTED]			
Total checks					\$7,002.50
Total # of checks					5

* There is a gap in sequential check numbers

Braille and Large Print Request - You can request a copy of this statement in Braille or Large Print by calling 800.432.1000 or going to bankofamerica.com and enter Visually Impaired Access from the home page.

Withdrawals and other subtractions - continued

Other subtractions

Date	Description	Amount
02/12/24	[REDACTED]	[REDACTED]
02/13/24	[REDACTED]	[REDACTED]
02/13/24	[REDACTED]	[REDACTED]
02/14/24	[REDACTED]	[REDACTED]
02/15/24	[REDACTED]	[REDACTED]
02/16/24	[REDACTED]	[REDACTED]
02/16/24	[REDACTED]	[REDACTED]
02/21/24	[REDACTED]	[REDACTED]
02/27/24	[REDACTED]	[REDACTED]
02/27/24	[REDACTED]	[REDACTED]
03/05/24	[REDACTED]	[REDACTED]
03/05/24	[REDACTED]	[REDACTED]
03/05/24	UnitedHealthcare DES:PREMIUM PPD [REDACTED]	-234.60 ✓
03/05/24	UnitedHC Medicare DES:MedInsPym ID:9000447048 PPD [REDACTED]	-78.00 ✓
03/06/24	[REDACTED]	[REDACTED]
03/06/24	[REDACTED]	[REDACTED]
03/06/24	[REDACTED]	[REDACTED]

Total other subtractions [REDACTED]

Checks

Date	Check #	Amount	Date	Check #	Amount
02/13/24	[REDACTED]	[REDACTED]	02/28/24	[REDACTED]	[REDACTED]
02/26/24	[REDACTED]	[REDACTED]	03/06/24	[REDACTED]	[REDACTED]
Total checks				[REDACTED]	
Total # of checks				4	

* There is a gap in sequential check numbers

Service fees

Date	Transaction description	Amount
[REDACTED]	[REDACTED]	[REDACTED]
Total service fees		[REDACTED]

Note your Ending Balance already reflects the subtraction of Service Fees.

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

DATE RANGE From 01/01/2024
To 3/31/2024

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
1/1-3/3/2024	Medicare Premium	US Dept of Health & Human Services CMS	\$257.50	\$772.50 -
1/1-3/3/2024	Prescription Pt D	Humana	\$49.90	\$149.70 -
1/1-3/3/2024	Medicare Supplement	AARP United Healthcare	\$116.93	\$350.79 -
				\$ -
				\$ -
				\$ -
Total				\$1,272.99 -

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: [REDACTED]

Date: March 31, 2024

PRMPT Approval*: [Signature]

Date: _____

Accounting Approval**: _____

Date: _____

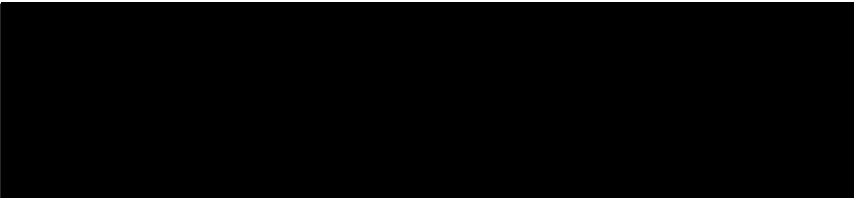
* Indicates the reimbursement request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

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

Social Security Administration

Important Information

Date: November 22, 2023

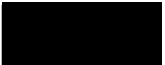




We review Social Security benefits each year to make sure they keep up with the cost of living. Your Social Security benefits will increase by 3.2% in 2024 because of a rise in the cost of living.

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 with our decision or your situation has changed. The information below shows your monthly benefit amount before and after deductions:

- Your new 2024 monthly benefit amount before deductions is: - 
- Your 2024 monthly deduction for the Medicare Part B premium is: - \$244.60
 - \$174.70 for the standard Medicare premium, plus
 - \$69.90 for the Medicare Part B IRMAA based on your 2022 income tax return
- Your 2024 deduction for Medicare Part D IRMAA based on your 2022 income tax return is: - \$12.90
- Your deduction for voluntary tax withholding is: - 
- Your benefit amount after deductions that will be deposited into your bank account or sent in your check on January 10, 2024 is: - 

0301R5A00013982 CCM.M15.54SXV.R231117 000000000 00036106336268611987.89502539730

0283635





03/26/2024

Prescription Drug

Balance as of today:

Transaction Type: All Date Range: 01/01/2024 to 12/31/2024

Transaction date	Description	Amount	Coverage period
03/21/2024	PREMIUM	\$49.90	04/01/2024
03/02/2024	DEBIT CARD PAYMENT, #6317	-\$49.90	
02/21/2024	PREMIUM	\$49.90	03/01/2024
02/02/2024	DEBIT CARD PAYMENT, #6317	-\$49.90	
01/21/2024	PREMIUM	\$49.90	02/01/2024
01/02/2024	DEBIT CARD PAYMENT, #6317	-\$49.90	

Sum of listed transactions: \$0.00

Premium Billing History

Billing history for: [REDACTED]
Member ID: [REDACTED]
From: **December 29, 2023**
To: **March 26, 2024**
Plan: **AARP MEDICARE SUPPLEMENT PLAN**
Effective date: **March 1, 2021**

Bill due date	Amount	Status	Remaining amount
04/01/2024	\$116.93	Unpaid	\$116.93
03/01/2024	\$116.93	Paid	\$0.00
02/01/2024	\$116.93	Paid	\$0.00
01/01/2024	\$116.93	Paid	\$0.00
Total amounts			\$116.93

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

DATE RANGE From 4/1/24
To 3/30/24

RETRIEE INFORMATION:

Name: [Redacted]

Employee #: 50049

Address: [Redacted]

Phone #: [Redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
Jan, Feb, Mar	Monthly Premiums	Medicare deducted from Social Security	244.60 x 3 months	\$ 733.80
" "	" "	Part D deducted from Social Security	12.90 x 3 months	\$ 38.70
" "	" "	United Health Care Supplemental	117.99 x 3 months	\$ 353.97
" "	" "	United Health Care Part D coverage	54.10 x 3 months	\$ 162.30
				\$ -
				\$ -
				\$ -
Medicare Eligible? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				Total \$ <u>1,288.77</u>

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

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

Retiree Signature: [Redacted]

Date: 3/22/24

PRMPT Approval*: _____

Date: _____
* Indicates _____ the reimbursement

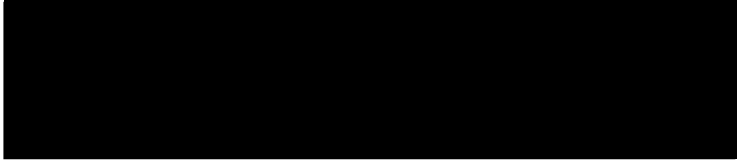
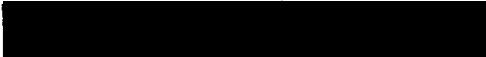
request & back up are sufficient and expenses qualify as eligible for reimbursement under the trust.

TRUCKEE MEADOWS
APR 02 2024
WATER AUTHORITY

Social Security Administration

Important Information

Date: November 22, 2023



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 3.2% in 2024 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 with our decision or your situation has changed. The information below shows your monthly benefit amount before and after deductions:

- Your new 2024 monthly benefit amount before deductions is: - ~~\$2,040.00~~
- Your 2024 monthly deduction for the Medicare Part B premium is: - \$244.60
 - \$174.70 for the standard Medicare premium, plus
 - \$69.90 for the Medicare Part B IRMAA based on your 2022 income tax return
- Your 2024 deduction for Medicare Part D IRMAA based on your 2022 income tax return is: - \$12.90
- Your deduction for voluntary tax withholding is: - ~~\$250.00~~
- Your benefit amount after deductions that will be deposited into your bank account or sent in your check on January 17, 2024 is: - ~~\$1,752.30~~

If you still get a paper check, you must visit the Department of the Treasury's website at www.godirect.gov to request electronic payments.



Premium Payment History

Payment history for:



Member ID:

From: **December 30, 2023**

To: **March 28, 2024**

Plan: **AARP MEDICARE SUPPLEMENT PLAN**

Effective date: **April 1, 2021**

Payment date	Amount	Status	Payment method	Reference number
03/01/2024	\$250.98	Processed	EFT	Not available for this payment
02/01/2024	\$250.98	Processed	EFT	Not available for this payment
01/01/2024	\$250.98	Processed	EFT	Not available for this payment
Total amounts	\$752.94			

*United bills per family
 250.98 is our total premium for husband & myself
 See attached from United showing \$117.99 as my
 portion of monthly.*

Go to top ↑

Your February 2024 premium breakdown

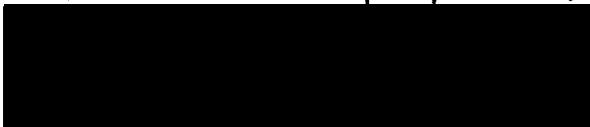
This is the amount of your household premium payment. It does not include any past due billed amounts or pending payments.

Household

Electronic Funds Transfer (EFT) discount **-\$2.00**

Household Total* **\$250.98**

*Includes all individual plan premiums, riders, household and individual discounts.



AARP MEDICARE SUPPLEMENT PLAN **\$220.25**

Multi insured discount **-\$15.42**

Enrollment discount **-\$85.90**

Your portion of the Household Total* **\$117.99**

*Your portion of the household total reflects your monthly plan premium(s) individual discount(s) and your portion of any household discount(s) if applicable, and is specific to the individual signed in.

Other individuals within the household must sign in to see their portion of the household total.

Premium Payment History

Payment history for:



Member ID:

From:

December 21, 2023

To:

March 19, 2024

Plan:

AARP Medicare Rx Walgreens from UHC (PDP)

Payment date	Amount	Status	Payment method	Reference number
03/02/2024	\$54.10	Processed	EFT	Not applicable for this payment
02/02/2024	\$54.10	Processed	EFT	Not applicable for this payment
01/02/2024	\$54.10	Processed	EFT	Not applicable for this payment

*Serra Pacific
Credit Union checking*

Description

Debit Credit Amount Balance

March 5, 2024

MedInsPymt UnitedHCMedicare MedInsPymt, 03-05-2024 @ 0:00 Trace #:021001034831268	-\$54.10	-\$54.10	\$1,989.90
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February 5, 2024

MedInsPymt UnitedHCMedicare MedInsPymt, 02-05-2024 @ 0:00 Trace #:021001037114935	-\$54.10	-\$54.10	\$1,984.86
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January 5, 2024

MedInsPymt UnitedHCMedicare MedInsPymt, 01-05-2024 @ 0:00 Trace #:021001035484609	-\$54.10	-\$54.10	\$1,961.53
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Post Retirement Medical Plan & Trust - Medical Premium Expense Reimbursement Request

RETRIEE INFORMATION:

Name: [Redacted]
Address: [Redacted]

DATE RANGE From 01/01/2024
To 03/31/2024
Employee #: 50131
Phone #: [Redacted]

Expenses

Date Paid	Description (example: Monthly Premium)	Name of Provider (example: Anthem Blue Cross)	Cost	Total
01/18/2024	Monthly Medicare Premium A,B,D	Medicare	174.70	\$174.70 -
01/18/2024	Monthly Medicare Premium A,B,D	Medicare	174.70	\$174.70 -
02/12/2024	Monthly Medicare Premium A,B,D	Medicare	174.70	\$174.70 -
02/12/2024	Monthly Medicare Premium A,B,D	Medicare	174.70	\$174.70 -
03/13/2024	Monthly Medicare Premium A,B,D	Medicare	174.70	\$174.70 -
03/13/2024	Monthly Medicare Premium A,B,D	Medicare	174.70	\$174.70 -
				Total \$1,048.20 -

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: [Redacted]

Date: 4/5/24

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.

TRUCKEE MEADOWS
APR 08 2024
WATER AUTHORITY

Payment successful



 You're all set. It may take up to 5 business days to process your payment.

Payment details



Feedback

Payment date:

1/18/2024 08:32:16 AM

Payment amount:

\$174.70

Payment method:

Credit or debit card using Medicare.gov

[Back to My Premiums](#)

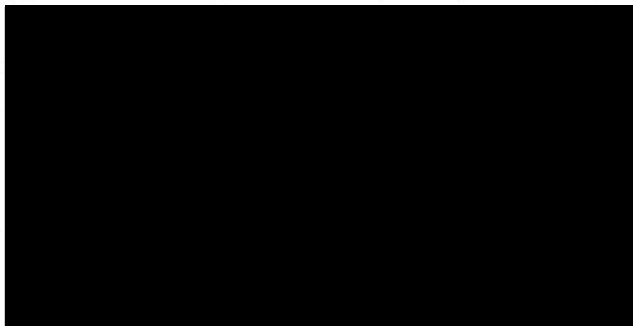


Payment successful



✔ You're all set. It may take up to 5 business days to process your payment.

Payment details



Feedback

Payment date:

2/12/2024 01:56:35 PM

Payment amount:

\$174.70

Payment method:


Credit or debit card using Medicare.gov

[Back to My Premiums](#)

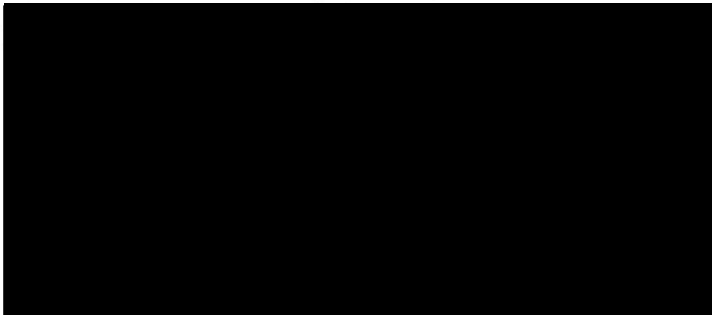


Payment successful



 You're all set. It may take up to 5 business days to process your payment.

Payment details



Feedback

Payment date:

3/13/2024 04:03:32 PM

Payment amount:

\$174.70


Payment method:

Credit or debit card using Medicare.gov

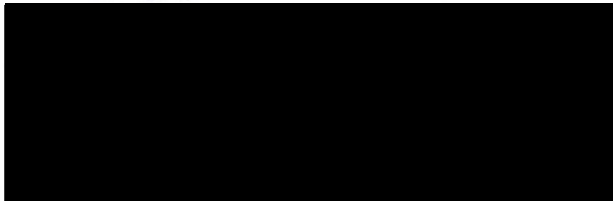


Payment successful



 You're all set. It may take up to 5 business days to process your payment.

Payment details



Name:

Dennis E DOBYNS

Payment date:

1/18/2024 08:33:41 AM

Payment amount:

\$174.70

Payment method:

Credit or debit card using Medicare.gov


Feedback

[Back to My Premiums](#)

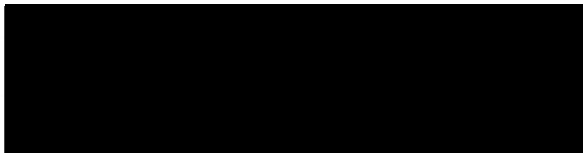


Payment successful



 You're all set. It may take up to 5 business days to process your payment.

Payment details



Name:

Dennis E DOBYNS

Payment date:

2/12/2024 01:54:44 PM

Payment amount:

\$174.70

Payment method:

Credit or debit card using Medicare.gov


[Back to My Premiums](#)

Feedback

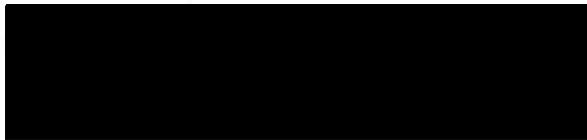


Payment successful



 You're all set. It may take up to 5 business days to process your payment.

Payment details



Name:

Dennis E DOBYNS

Payment date:

3/13/2024 04:07:32 PM

Payment amount:

\$174.70

Payment method:

Credit or debit card using Medicare.gov



Feedback



Retirement Benefits Investment Fund

December 31, 2023

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	\$ 418,414,893	49.5%	49.9%	8.0%	26.2%	10.0%	15.7%	12.0%	10.3%
Market Return				8.0%	26.3%	10.0%	15.7%	12.0%	10.3%
Int'l Stocks- MSCI World x US Index	\$ 160,517,016	19.5%	19.2%	6.0%	18.2%	4.7%	8.7%	4.7%	3.7%
Market Return				6.0%	17.9%	4.4%	8.5%	4.4%	3.5%
U.S. Bonds- U.S. Bond Index	\$ 229,591,524	28.0%	27.4%	2.4%	4.0%	-0.9%	2.5%	2.3%	2.9%
Market Return				2.4%	4.1%	-1.1%	2.3%	2.2%	2.7%
	\$ 29,228,591	3.0%	3.5%						
Total RBIF Fund	\$ 837,752,024	100.0%	100.0%	6.0%	18.3%	6.1%	11.0%	8.0%	7.2%
Market Return				6.0%	18.0%	5.8%	10.7%	7.8%	7.2%