FELRA & UFCW VEBA FUND

AGENDA

JUNE 22, 2021

(Approximately 11:00 a.m.)

I. CALL TO ORDER

II. MINUTES (pg. 1 - 21)
- A. REGULAR MEETING - MARCH 11, 2021
- B. APPEALS COMMITTEE MEETING - MARCH 10, 2021
- C. APPEALS COMMITTEE MEETING - APRIL 8, 2021
- D. APPEALS COMMITTEE MEETING - MAY 5, 2021
- E. APPEALS COMMITTEE MEETING - JUNE 7, 2021

III. FINANCIAL REPORT (pg. 22 - 23)
- A. PNC REPORT
- B. INVESTMENT PERFORMANCE SERVICES

IV. CONSULTANTS' REPORTS
- A. SEGAL COMPANY
  - 1. SYMETRA - PROPOSED CONTRACT RENEWAL
  - 2. SUPERIOR VISION - CONTRACT RENEWAL

V. ATTORNEYS' REPORT (pg. 24 - 64)
- A. REGULAR
- B. DELINQUENCY REPORT
- C. SUBROGATION

VI. ADMINISTRATIVE MANAGER'S REPORT - (1Q21) (pg. 65 - 130)

VII. INVOICES (pg. 131 - 134)

VIII. OTHER FUND BUSINESS
- A. GIANT/SAFEWAY MEMORANDUM OF AGREEMENT
- B. AUDITOR'S 2020 ENGAGEMENT PROPOSAL
- C. GIANT - CONTRIBUTION CREDIT REQUEST
- D. MAINTENANCE OF BENEFIT - STATUS UPDATE
- E. ASSOCIATED ADMINISTRATORS CONTRACT - STATUS UPDATE
- F. COBRA PREMIUM SUBSIDY - STATUS UPDATE
- G. DENTEGRA TRANSITION - STATUS UPDATE
- H. COVID-19 RELATED CLAIMS PROCESSING - STATUS UPDATE
- I. SAFEWAY PAYROLL AUDIT 2014-2017 - STATUS UPDATE
- J. MISCELLANEOUS CORRESPONDENCE

IX. NEXT MEETING DATE AND LOCATION (SEPTEMBER 23, 2021)

X. ADJOURNMENT

MINUTES

FELRA & UFCW Health & Welfare Plan

A Plan of the Food Employers Labor Relations Association
and United Food and Commercial Workers
VEBA Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (410) 683-6500
(800) 638-2972
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (301) 459-3020
(800) 638-2972
www.associated-admin.com

MINUTES OF THE MEETING OF THE BOARD OF TRUSTEES OF THE FELRA AND UFCW VEBA FUND VIA VIDEO CONFERENCE MARCH 11, 2021

The following Trustees were present:

Union Trustees
M. Federici – Secretary
J. Chorpenning
A. Hanson
J. Nazario

Employer Trustees
J. Paradis – Chairman
D. Dosenbach
M. Goble

Also present were:

W. Antoshak – Associated Administrators, LLC
Y. Anwar – UFCW Local 400
L. DuVall – Associated Administrators, LLC
N. Eid – Confidio
J. Hack – UFCW Local 27
J. Harrison – UFCW Local 27
J. Herishen – Calibre CPA Group, PLLC
T. Hipkins – UFCW Local 27
C. Hoffmann – UFCW Local 400
N. Jacobs – UFCW Local 400
D. Jensen – Associated Administrators, LLC
M. Kreps – Groom Law Group
C. McDonough – Investment Performance Services
R. McKnight – Associated Administrators, LLC
C. Murphy – Associated Administrators, LLC
S. Sanchez – Slevin & Hart, P.C.
A. Sims – Associated Administrators, LLC
B. Slevin – Slevin & Hart, P.C.
J. Timm – The Segal Company
L. Walsh – Associated Administrators, LLC
M. Wilson – UFCW Local 400

I. CALL TO ORDER

A quorum being present, the Chairman called the meeting to order.

II. MINUTES

The Trustees reviewed the minutes of the last regular meeting held on December 14, 2020, the special meeting held on December 21, 2020, and the Appeals Committee meetings of January 7, 2021 and February 8, 2021, all of which were pre-circulated.

On Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

> **RESOLVED, that the minutes of the regular meeting held on December 14, 2020, the special meeting held on December 21, 2020, and the Appeals Committee Meetings of January 7, 2021 and February 8, 2021 are approved, as presented.**

III. FINANCIAL REPORT

A. PNC Bank

1. Summary of Activity Report – ERISA Account – January 31, 2021

Mr. Jensen presented the PNC Summary of Activity report for the period January 1, 2021 through January 31, 2021. Such report indicated a beginning market value of $32,607,051, earnings of $28,509, receipts of $9,931,818, and disbursements of $10,606,410, producing an ending market value of $31,960,968 as of January 31, 2021.

2. Summary of Activity Report – Non-ERISA Account DDA – January 31, 2021

Mr. Jensen presented the PNC Summary of Activity report for the Non-ERISA account for the period January 1, 2021 through January 31, 2021. Such report indicated a beginning market value of $7,130,603, no earnings, receipts of $3,963,477, and disbursements of $9,926,120, producing an ending market value of $1,167,960 as of January 31, 2021.

3. Reserves

Mr. Jensen noted that as of January 31, 2021, the FELRA VEBA Fund had $32,232,460 in reserves, representing 3.03 months of reserves, compared to 3.62 months as of December 31, 2020. The average expense for the four quarters ending September 30, 2020 was $10,628,710.75.

Mr. Jensen explained that Safeway did not apply its approved contribution credit to its January contribution, as expected, and instead applied the credit to its February contributions. In preparation for the anticipated February expenses, $5,000,000 was transferred from investments to PNC cash to cover the lack of employer contributions. He noted that applying these changes reduces the Fund's reserve to 2.19 months, which is close to the 2.0 month reserves target.

B. Investment Performance Services

The Trustees welcomed Mr. Chris McDonough of Investment Performance Services ("IPS") to the meeting.

1. Master Consulting Report – December 31, 2020

Mr. McDonough reviewed the Master Consulting Report for the period ending December 31, 2020. Such report indicated a beginning market value of $40,282,665, a net cash flow of negative $8,594,502, and a net investment change of $918,802, resulting in an ending market value of $32,606,966. The year-to-date performance through December 31, 2020 was 5.0%, gross of fees.

2. Preliminary Performance Update – January 31, 2021

Mr. McDonough reviewed the Preliminary Performance Report for the period ending January 31, 2021. Such report indicated a beginning market value of $32,606,966, negative net cash flow of $1,420,242, and a net investment change of $28,486, resulting in an ending market value of $31,215,209. The year-to-date performance through January 31, 2021 was 0.1%, gross of fees.

3. Segall Bryant & Hamill – Assignment of Ownership to CI Financial Corporation

Mr. McDonough reported that on January 25, 2021, CI Financial Corporation entered into an agreement to acquire 100% of the business of Segall Bryant & Hamill, LLC ("SBH"). He stated that this transaction, which will result in the assignment of the investment advisory agreement with the Fund, requires investor consent. He stated that the acquisition of SBH will not affect the Fund's relationship with the manager, where the Fund's investments are held, the nature of the investment services provided by the manager, or the terms of the Fund's investment advisory agreement with the manager.

After discussion, on Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, to consent to the assignment of the Fund's investment advisory agreement with Segall Bryant & Hamill, LLC to CI Financial Corporation, as recommended by IPS.

4. Cybersecurity Liability Insurance – Amendment

Mr. Jensen noted that at the December 14, 2020 Board meeting, IPS proposed that the Fund amend its Investment Policy Statement to generally require investment managers to have cybersecurity insurance. The Amendment was reviewed by Fund counsel between Board meetings.

On Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, to approve the proposed cyber insurance Amendment to the Fund's Investment Policy Statement, as presented.

The Trustees thanked Mr. McDonough for his report and he was excused from the meeting.

IV. CONSULTANTS' REPORTS

The Trustees welcomed Mr. Josh Timm of The Segal Company ("Segal") and Ms. Nancy Eid of Confidio to the meeting.

A. The Segal Company

1. Coronavirus Disease 2019 (COVID-19) – Market Update

Mr. Timm presented an update on COVID-19 and its impact on welfare funds. He noted that the disease caused significant disruptions to the healthcare delivery system. He cited two major ways that health plan claims have been impacted: (1) direct costs for testing and treating of the disease, the cost of which is typically between 1% and 5% of annual medical expenses and can vary based on the demographics of the group, such as age and location and (2) indirect savings from reduced utilization of non-essential services, including the temporary suspension of many healthcare

services, such as routine office visits, chiropractic therapy, physical therapy, and elective surgeries. He noted that deferral of these services may increase Fund expenses in the future, but to date there has been no significant increase in expenses.

Mr. Timm reviewed the Fund's experience with COVID-19 claims. He said that the reduction in claims was most prevalent in the first half of 2020. Mr. Timm stated that the cost of testing and treatment for COVID-19 has been modest, which resulted in noticeable and significant declines in claims during March through May of 2020. He stated that claims for the period March 1, 2020 through May 31, 2020 represent an 18% decrease compared to the period March 1, 2019 through February 29, 2020. He reported that the Fund's per capita large claims have increased 29.1% due to COVID-19. However, in spite of the large claims experience and the additional costs of testing and treatment for COVID-19, the Fund's estimated incurred claims are down 6.4% on a per capita basis year over year through January 31, 2021 and down 7.9% on an aggregate basis.

Mr. Timm reported that the Coronavirus Aid, Relief, and Economic Security Act ("CARES Act") was passed on March 27, 2020, requiring employer-sponsored group health plans to provide coverage of COVID-19 testing at no cost-share, which included copays, deductibles and coinsurance. However, cost-sharing was still applicable for the treatment of COVID-19. He stated that three vaccines have been approved. He noted that as a non-grandfathered plan under the Affordable Care Act, the Fund is responsible for covering the administration fee for COVID vaccinations at no cost to Plan participants and beneficiaries.

2. COBRA Subsidy

Mr. Timm discussed the provision of the American Rescue Plan Act of 2021 that provides a 100% COBRA subsidy from April 1 through September 30, 2021 for persons involuntarily termed from employment or experiencing a reduction in work hours that resulted in a COBRA qualifying event. He stated that further guidance and a revised COBRA model notice would be forthcoming from government agencies.

3. Dentegra

Mr. Timm reported that the transition to Dentegra for Dental services is continuing to move forward.

4. **Extension of Deadlines**

Mr. Slevin and Mr. Timm discussed new DOL guidance relating to the extension of deadlines (e.g. COBRA, claims and appeals) due to COVID. Mr. Timm stated that Segal expects to share more information on the matter in a week or so.

After discussion and, on Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

> **RESOLVED, to delegate authority to Chairman and Secretary to make any decisions regarding a change to the current COVID-related deadline extensions in place under the Plan.**

B. Confidio

Ms. Eid presented a report titled "Managed Pharmacy Report March 2021."

1. Managed Pharmacy Report

Ms. Eid reviewed Confidio's Executive Summary - 2020 Key Performance Indicators. She noted that the Pharmacy Benefit Management ("PBM") Program indicated a per participant per month ("PPPM") drug trend of negative 0.6% for 2020. Ms. Eid stated that the Fund's three cost management programs are performing well, with cumulative savings for the period June 1, 2020 through February 1, 2021 of $2,876,654.00, or 83% of the estimated annualized goal.

Ms. Eid reviewed the key performance indicators, noting that the average membership declined from 20,196 in 2019 to 19,423 in 2020, representing a change of negative 3.8%, and the number of unique patients declined from 15,044 in 2019 to 14,158 in 2021, representing a change of negative 5.9%. The average member age for 2020 was 47. The Plan gross cost increased to $41,845,339 in 2020 compared to $40,761,617 in 2019. The Plan net cost declined in 2020 to $29,965,457 compared to $31,356,549 in 2019, a negative 4.4% difference. The Plan net cost PPPM declined to $128.57 in 2020 compared to $129.38 in 2019, a negative 0.6% difference.

Ms. Eid reviewed the actives vs. retirees 2020 key performance indicators. She noted that the active participant counts decreased by 4.1% and the net PPPM costs decreased by 2.1%. The retiree counts decreased by 1.6%, and the net cost PPPM increased by 3.9%.

She noted that the top three drivers of Plan costs were diabetes -- which accounted for 23% of all costs, trending up at 14.7% -- inflammatory conditions, which accounted for 16.6% of total costs, and cancer, which accounted for 11.7% of total costs due to increasing utilization and pricing of oral cancer medications.

Ms. Eid reviewed the Prescription Care Management ("PCM") Program activity and reported that there was a positive provider and participant response to the Program. She further mentioned new Transparency in Coverage Rules and the No Surprises Act. She noted that Confidio will take an active role in negotiating changes to the PBM contract amendments as needed, and will lobby the PBMs to absorb the majority of costs for compliance, or use Pharma dollars to offset their costs.

Ms. Eid reported that the Employer Group Waiver Program ("EGWP") implementation was successfully completed on December 31, 2020 and the EGWP Amendment to the Fund's existing Agreement with Express Scripts, Inc. ("ESI") was fully executed. She reported that ESI issued its first EGWP rebate check to the Fund. She said that Confidio and Associated Administrators will continue to track and manage ESI's compliance under the EGWP Amendment.

The Trustees thanked Mr. Timm and Ms. Eid for their reports and they were excused from the meeting.

V. ATTORNEY'S REPORT

A. Transparency in Coverage Final Rules

Ms. Sanchez reported on the Final Rule on Transparency in Coverage issued by HHS, DOL and Treasury on October 29, 2020.

B. No Surprises Act

Ms. Sanchez reported on the No Surprises Act enacted in 2021.

After discussion, and on Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

> **RESOLVED, to delegate authority to Chairman and Secretary to make any necessary decisions regarding implementation of the Transparency in Coverage Final Rule and the No Surprises Act.**

C. Consolidated Appropriations Act of 2021

Ms. Sanchez reported on the reporting and disclosure provisions of the Consolidated Appropriation Act of 2021.

D. Dentegra Insurance Company ("Dentegra")

Ms. Sanchez reported on the status of the Dentegra contract.

E. Temporary COBRA Subsidy

Ms. Sanchez reported on the subsidy of COBRA premiums under the American Rescue Plan Act of 2021.

F. COVID-19 Deadline Extensions

Ms. Sanchez reported on guidance relating to the COVID-related extension of deadlines.

G. EpiPen Class Action

Ms. Sanchez reported on the EpiPen class action filed on behalf of the Fund.

H. BlueCross BlueShield Class Action

Ms. Sanchez reported on a class action involving the Blue Cross Blue Shield Association.

I. EGWP Addendum

Ms. Sanchez reported that the EGWP contract Addendum with ESI had been fully executed.

J. Preventive Services List

Ms. Sanchez reported on the Fund's 2021 preventive services list.

K. **Summary of Material Modification ("SMM")**

Ms. Sanchez reported on SMMs being drafted.

L. **Summary Plan Descriptions ("SPD")**

Ms. Sanchez reported on the Fund's SPDs.

M. **Conifer Breach**

Ms. Sanchez reported on a potential data breach reported by Conifer.

N. **Subrogation Report**

Mr. Jensen stated that Slevin & Hart had reported subrogation recoveries of $58,504.84, with $11,700.97 payable to Slevin & Hart for the fourth quarter 2020.

VI. ADMINISTRATIVE MANAGER'S REPORT

A. **Fourth Quarter 2020 – Combined Fund Recap**

Mr. Jensen presented the Administrative Manager's Report for the Fourth Quarter 2020. For the combined VEBA Fund, Active and Retiree Plans, total income was $25,024,389. Expenses totaled $32,849,392, producing a net deficit of $7,825,003 for the Fourth Quarter 2020. Mr. Jensen noted that contributions were made on behalf of 15,739 active Plan participants.

Mr. Jensen presented a snapshot of work performed by Associated Administrators during the Fourth Quarter 2020. The report reflected the processing of 307 accident and sickness claims, 96 appeals, 28,471 participant service calls, the production of 508 COBRA notices, the processing of 76,815 medical claims, and mailings to 28,528 Plan participants.

B. **Administrative Services Contract Renewal**

Mr. Walsh stated that Associated Administrators' contract will expire March 31, 2021. She reported that Associated's contract renewal letter was recently posted to the Trustee web portal for consideration. She stated that Associated had intended to make the letter available earlier but was delayed in order to re-examine the rate requests in light of the recently announced legislative changes, such as new transparency and disclosure rules, No Surprises Act, and COBRA

subsidies. She offered to review the proposal with a subcommittee or any individual Trustee upon request and prior to April 1, 2021.

After discussion, on Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, to appoint a subcommittee of Trustees Federici, Chorpenning, Paradis and Dosenbach authority to decide Associated Administrators' contract renewal.

VII. INVOICES

The Trustees reviewed the lists of invoices for the Active Plan and Retiree Plan dated March 11, 2021. It was noted there were no additions, deletions or changes to the lists.

Mr. Jensen presented an invoice in the amount of $10,610.00 for work performed by Associated Administrators in implementing EGWP for the FELRA Medicare Retirees effective January 1, 2021.

On Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, that the invoices on the lists dated March 11, 2021 for the Active Plan and Retiree Plan are approved for payment.

FURTHER RESOLVED, to approve payment of Associated's invoice for work performed in implementing EGWP.

VIII. OTHER FUND BUSINESS

A. Cheiron – 2021 Retainer Fee

Mr. Jensen presented Cheiron's retainer fee request for 2021. He noted that Cheiron proposed a retainer fee of $44,700 ($3,725 per month), with the non-retainer fees ranging from $107 to $515 per hour for 2021.

The Trustees reviewed the engagement request by Cheiron. After discussion and,

On Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, to approve Cheiron's 2021 engagement proposal, as presented.

B. Maintenance of Benefit ("MOB") – Preliminary Calculation

The Trustees discussed the preliminary calculation of MOB rates by the Administrative Manager in light of the effect of COVID-19 and how best to address future projections.

On Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

RESOLVED, to appoint a subcommittee of Trustees Federici, Chorpenning, Paradis and Dosenbach to review the MOB projections and make a decision on the MOB rates to be effective June 1, 2021 between Board meetings.

C. Dependent Spouse Audit – Update

Ms. Walsh reported on completion of the dependent spousal audit. She stated that 181 spouses had been terminated as a result of the audit.

D. Scholarship Program Termination – Update

Ms. Walsh reported that nineteen scholarship applicants met the criteria outlined by the VEBA Fund Trustees at the last Board meeting. She said that Associated is ready to make the final scholarship award payments in July and August 2021. She noted that there is a contract addendum posted on the Trustee web portal for review, extending administrative services to August 31, 2021 at a reduced fee of $833 per month.

E. Dentegra Transition – Status

Mr. Jensen reported that the Dentegra implementation was moving forward.

F. COVID-19 Related Claims Processing – Status

Mr. Jensen provided a summary of COVID-19 medical claims experience for the period March 1, 2020 through January 31, 2021.

G. Safeway Payroll Audit – Status

Mr. Jensen reported that that Calibre CPA Group informed the Fund office that the payroll audit of Safeway for the period of 2014-2017 had been finalized with both sides agreeing that the amount owed to the Fund is $38,141.60. The Fund will send a request for payment to Safeway.

H. Giant Food Contribution Credit Request

Mr. Jensen noted that Giant Food requested a contribution credit in the amount of $18,056 for mistaken contributions remitted for dependent coverage on behalf of a Plan participant for the period September 2018 through December 2020. After discussion and,

On Motion made and seconded, the Trustees voted approval of the following resolution:

RESOLVED, to approve the contribution credit request submitted by Giant Food in the amount of $18,056.

Trustees Paradis and Goble abstained from the vote.

I. Miscellaneous Correspondence

1. ESI Rebate Checks

Mr. Jensen reported that the Fund had received a rebate check from ESI for the fourth quarter 2020 in the amount of $87,591.56. He further reported that the Fund had received a rebate check from ESI related to EGWP in the amount of $84,358.00.

2. Madoff Victim Fund

Mr. Jensen reported that the Fund had received a check in the $101,990.27 from the Madoff Victim Fund.

IX. ADOPTION OF COMMITTEE RECOMMENDATIONS

After review of the recommendations made by the Severance, Legal and Scholarship Committees during their meetings,

On Motion made and seconded, the Trustees voted unanimous approval of the following resolution:

> **RESOLVED, that the recommendations made by the Severance, Legal and Scholarship Committees are adopted.**

X. NEXT MEETING DATE AND LOCATION

The Trustees noted that the next meeting was scheduled for June 22, 2021 and will be held via video conference. It was further noted that the September 2, 2021 meeting had been changed to September 23, 2021 and will be held in the offices of UFCW Local 400, if COVID-19 restrictions are lifted to allow in-person meetings.

XI. ADJOURNMENT

There being no further business to come before the Trustees, the meeting was adjourned.

Respectfully submitted,
Mark Federici, Secretary

FELRA & UFCW Health & Welfare Plan
A Plan of the Food Employers Labor Relations Association
and United Food and Commercial Workers
VEBA Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (410) 683-6500
(800) 638-2972
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (301) 459-3020
(800) 638-2972
www.associated-admin.com

APPEALS EMAILED TO THE APPEALS SUBCOMMITTEE OF THE FELRA & UFCW VEBA FUND ON MARCH 10, 2021 AND RESOLVED VIA EMAIL

The following Committee members made determinations on the appeals:

UNION TRUSTEES
Y. Anwar
T. Hipkins

EMPLOYER TRUSTEE
M. Goble

Also present was:
C. Brown – Associated Administrators, LLC

APPEALS
The following appeals were reviewed by the Trustees:

Local 27 – February 2021

Code	Issue	Decision
E21/111-1582	Initial Enrollment	Denied
E21/104-7632	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
M21/139-9392	Routine Services (Cologuard)	Denied
M21/144-9915	Routine Services (Cologuard)	Denied
M21/138-7293	Routine Services (Cologuard)	Denied
M21/137-5648	Routine Services (Cologuard)	Denied
M21/147-3916	CRNA	Denied
M21/158-5000	CRNA	Denied

Local 400 – February 2021

Code	Issue	Decision
A21/101-2448	Accident & Sickness – Not Eligible	Denied
E21/110-0235	Initial Enrollment	Denied
E21/119-6926	Initial Enrollment	Denied
E21/112-1669	Initial Enrollment	Denied
E21/122-3614	Dependent Spouse Eligibility Audit *(Late and **incomplete**)*	Denied
E21/102-6017	Dependent Spouse Eligibility Audit *(Late and **incomplete**)*	Denied
E21/121-7612	Dependent Spouse Eligibility Audit *(Late and **incomplete**)*	Denied
E21/107-2689	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved

E21/113-1713	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
M21/143-4081	Routine Services (Cologuard)	Denied
M21/141-5957	Routine Services (Cologuard)	Denied
M21/140-1042	Routine Services (Cologuard)	Denied
M21/142-7246	Routine Services (Cologuard)	Denied
M21/162-4365	Routine Services (Cologuard)	Denied
M21/145-9507	CRNA	Denied
M21/148-4652	CRNA	Denied
M21/156-5861	Experimental/Investigational (Avastin)	#1 Approved #2 Approved

Respectfully submitted,

Chris Brown, Appeals Supervisor

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (410) 683-6500
(800) 638-2972
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (301) 459-3020
(800) 638-2972
www.associated-admin.com

APPEALS EMAILED TO THE APPEALS SUBCOMMITTEE OF THE FELRA & UFCW VEBA FUND ON APRIL 8, 2021 AND RESOLVED VIA EMAIL

The following Committee members made determinations on the appeals:

UNION TRUSTEES
Y. Anwar
T. Hipkins

EMPLOYER TRUSTEE
M. Goble

Also present was:
C. Brown – Associated Administrators, LLC

APPEALS
The following appeals were reviewed by the Trustees:

Local 27 – March 2021

Code	Issue	Decision
E21/135-8932	Initial Enrollment	Denied
E21/129-4481	Initial Enrollment	Denied
E21/141-5956	Initial Enrollment	Denied
E21/139-2254	Open Enrollment (Dependent Coverage)	Approved Non-precedent
E21/140-4605	Retiree Dependent Coverage	Denied
E21/124-6010	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
M21/183-3844	Late Filing (Services incurred in 2018)	Denied
M21/168-3530	CRNA	Denied
M21/172-8129	CRNA	Denied
M21/165-7489	Chiropractic Benefit Maximum	Denied
RAP21/144-2576	Continuation of Stipend Beyond Age 65	Denied

Local 400 – March 2021

Code	Issue	Decision
E21/125-9367	Initial Enrollment	Denied
E21/137-4092	Reinstatement of Kaiser HMO	Denied
E21/138-9562	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved

E21/143-3459	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
E21/127-8503	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
E21/132-6937	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
E21/131-5102	Dependent Spouse Eligibility Audit *(Late and **incomplete**)*	Denied
E21/133-5072	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
E21/142-9617	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
E21/134-2653	Dependent Spouse Eligibility Audit *(Late and **incomplete**)*	Denied
Rx21/123-1362	Brand Name (Synthroid)	Approved
Rx21/130-0176	Brand Name (Cymbalta)	#1: Approved #2: Denied
Rx21/117-7282	Prior Authorization (Tradjenta)	Denied
M21/160-7589	Late Filing (Services incurred in 2017)	Denied
M21/157-6014	Laboratory Services	Denied
M21/181-0377	Routine Services (Cologuard)	Denied
M21/176-3067	CRNA	Denied
M21/163-4454	Excluded Services (Speech Therapy)	Denied
M21/179-1936	Outpatient Dental Services	Denied
M21/166-1067	Part Time Coordination of Benefits	Approved
M21/173-5995	Work-Related	Denied
M21/177-4618	Overpayment, Excess of UCR	#1: Denied #2: Denied

Respectfully submitted,

Chris Brown, Appeals Supervisor

FELRA & UFCW Health & Welfare Plan

A Plan of the Food Employers Labor Relations Association
and United Food and Commercial Workers
VEBA Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (410) 683-6500
(800) 638-2972
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (301) 459-3020
(800) 638-2972
www.associated-admin.com

APPEALS EMAILED TO THE APPEALS SUBCOMMITTEE OF THE FELRA & UFCW VEBA FUND ON MAY 5, 2021 AND RESOLVED VIA EMAIL

The following Committee members made determinations on the appeals:

UNION TRUSTEES
Y. Anwar
T. Hipkins

EMPLOYER TRUSTEE
M. Goble

Also present was:
C. Brown – Associated Administrators, LLC

APPEALS
The following appeals were reviewed by the Trustees:

Local 27 – April 2021

Code	Issue	Decision
E21/151-6196	Dependent Coverage	Approved
M21/178-7907	Pre-Service, Nonparticipating Provider	Denied
M21/196-1408	CRNA	Denied
M21/188-7245	CRNA	Denied

Local 400 – April 2021

Code	Issue	Decision
E21/145-6787	Initial Enrollment	Denied
E21/150-1966	Initial Enrollment	Denied
E21/149-5428	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
E21/147-0958	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
Rx21/1320-7625	Brand Name (Apriso)	Approved
M21/193-3564	Laboratory Services	Denied
M21/194-0066	Nonparticipating Provider	Denied
M21/203-7676	CRNA	Denied
M21/201-9840	CRNA	Denied
M21/184-6193	Excluded Services	Denied

M21/186-5819	Ambulance Services	Tabled
M21/189-7998	Part Time Coordination of Benefits	Approved

Respectfully submitted,

Chris Brown, Appeals Supervisor

FELRA & UFCW Health & Welfare Plan

A Plan of the Food Employers Labor Relations Association
and United Food and Commercial Workers
VEBA Fund

911 Ridgebrook Road
Sparks, Maryland 21152-9451
Telephone: (410) 683-6500
(800) 638-2972
www.associated-admin.com

8400 Corporate Drive, Suite 430
Landover, Maryland 20785-2361
Telephone: (301) 459-3020
(800) 638-2972
www.associated-admin.com

APPEALS EMAILED TO THE APPEALS SUBCOMMITTEE OF THE FELRA & UFCW VEBA FUND ON JUNE 7, 2021 AND RESOLVED VIA EMAIL

The following Committee members made determinations on the appeals:

UNION TRUSTEES
Y. Anwar
T. Hipkins

EMPLOYER TRUSTEE
M. Goble

Also present was:
C. Brown – Associated Administrators, LLC

APPEALS
The following appeals were reviewed by the Trustees:

Local 27 – May 2021

Code	Issue	Decision
M21/220-8532	Pre-Service, Medical Necessity	Denied
M21/225-2832	Routine Services (Cologuard)	Denied
M21/217-7976	Routine Services (Cologuard)	Denied
M21/207-5552	Schedule of Benefits for Surgical Procedure	Denied
M21/209-9713	Excluded Services	Denied

Local 400 – May 2021

Code	Issue	Decision
E21/154-5458	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
E21/157-3201	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
E21/152-3346	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
E21/153-0877	Dependent Spouse Eligibility Audit *(Late but **complete**)*	Approved
E21/158-6854	Dependent Spouse Eligibility Audit *(Late and **incomplete**)*	Denied
E21/148-6672	Dependent Spouse Eligibility Audit *(Late and **incomplete**)*	Denied
E21/161-0491	Reinstatement of Kaiser HMO	Denied
M21/222-5746	Routine Services (Cologuard)	Denied
M21/219-3255	Routine Services (Cologuard)	Denied
M21/221-5055	Laboratory Services	Denied
M21/224-0074	CRNA	Denied

M21/208-3159	Experimental/Investigational (Avastin)	#1 Approved #2 Approved
M21/212-7941	Excluded Services	Denied
M21/205-6685	Work-Related, No Response to Requests for Information	Denied

Respectfully submitted,
Chris Brown, Appeals Supervisor

FINANCIAL REPORT

FELRA & UFCW VEBA WELFARE FUND
SUMMARY OF ACTIVITY
JANUARY 1, 2021 to MAY 31, 2021

Item	Amount
Market Value 01/01/2021	$32,607,051
Earnings	$465,986
Receipts	$39,380,746
Disbursements	($54,769,048)
Market Value 5/31/2021	$17,684,735

PNC BANK, NA

FELRA & UFCW VEBA WELFARE FUND - NON ERISA DDA
SUMMARY OF ACTIVITY
JANUARY 1, 2021 to MAY 31, 2021

Item	Amount
Market Value 01/01/2021	$7,130,603
Earnings	-
Receipts	$34,424,990
Disbursements	($40,714,013)
Market Value 05/31/2021	$841,580

PNC BANK, NA

ATTORNEY'S REPORT

SLEVIN & HART, P.C.
Attorneys at Law
WWW.SLEVINHART.COM

1625 Massachusetts Avenue, NW, Suite 450
Washington, DC 20036

14 Wall Street, 20th Floor
New York, NY 10005

MEMORANDUM

To: Health Fund Clients

From: Slevin & Hart, P.C.

Date: June 16, 2021

Re: Guidance—Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act of 2021

This memorandum summarizes recent guidance issued by the Department of Labor ("DOL"), the Department of Health and Human Services ("HHS"), and the Department of the Treasury (collectively, the "Agencies") regarding the provisions of the Consolidated Appropriations Act of 2021 ("CAA") that amend the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). As we previously advised in our March 9, 2021 memorandum regarding the health plan transparency and disclosure requirements under the CAA, the CAA amended the MHPAEA to impose new requirements for group health plans and insurance carriers ("issuers") to perform, document, and disclose a comparative analysis of any non-quantitative treatment limitations ("NQTLs") on mental health or substance use disorder ("MH/SUD") benefits ("Comparative Analysis"). On April 2, 2021, the Agencies released joint guidance in the form of Frequently Asked Questions ("Guidance") regarding implementation of the new MHPAEA provisions under the CAA. These are discussed below.

I. Summary

The Guidance provides additional clarity on what must be included in a Comparative Analysis of NQTLs, provides examples of what would not be sufficient, and strongly encourages plans to use the DOL's Self-Compliance Tool (available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf) as a guide for performing the analyses. The Guidance also lists the four NQTLs that the DOL expects to focus on, although it notes that plans should be prepared to provide documented comparative analyses of all NQTLs. The Guidance also clarifies that the Comparative Analyses must be provided to participants and beneficiaries upon request.

As noted in our prior memorandum, given the complexity of the Comparative Analyses and that the obligation became effective February 10, 2021, we continue to recommend that, if this review has not already commenced, health plans immediately begin

working with their consultants and other appropriate vendors to perform the Comparative Analyses. In addition, to the extent that a plan's mental health benefits are insured, the plan will need to work with the insurer and other appropriate vendors on the completion of the Comparative Analyses for the contracted benefits since only the insurer likely is in a position to perform the Comparative Analyses and will need to do so for the policies it offers to its customer plans.

II. Requirements for Comparative Analysis

The Guidance emphasizes that plans that carefully apply the guidance in the DOL's Self-Compliance Tool will "be in a strong position" to comply with the Comparative Analysis requirement. According to the Guidance, a Comparative Analysis satisfies the requirements of the CAA if it contains a detailed, written, and reasoned explanation of the specific plan terms and practices at issue and includes the bases for the plan's conclusion that the NQTLs comply with MHPAEA. The analysis must include a "robust discussion" of the following nine items (listed in the Guidance):

1. A clear description of the specific NQTL, plan terms, and policies at issue;
2. Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical;
3. Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data relied upon;
4. To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources;
5. The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation;
6. If the application of the NQTL turns on specific decisions in plan administration, the plan or issuer should identify the nature of the decisions, the decision maker(s), including qualifications and the timing of the decisions;
7. If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or insurer ultimately relied on the expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits;
8. A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered

and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA; and

9. The date of the analyses and the name, title, and position of the person or persons who performed or participated in the comparative analyses.

The Guidance also provides examples of reasons that a Comparative Analysis could be viewed as insufficient. For example, a general statement of compliance, coupled with a conclusory reference to broadly stated processes, strategies, standards, or other factors is not sufficient. Additionally, the Guidance lists the following six practices and procedures that plans should avoid when producing their Comparative Analysis:

1. Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis;
2. Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations;
3. Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis;
4. Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice;
5. Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application; or
6. Analysis that is outdated due to the passage of time, a change in plan structure, or for any other reason.

III. Other Documents That Must Be Made Available Upon Request

In addition to the Comparative Analyses, the Guidance describes the types of documents that plans must be prepared to make available to the Agencies to support the analysis and conclusions reached in their Comparative Analyses.

The Guidance provides that the plan or insurer should be prepared to provide documentation of any studies, testing, claims data, reports, or other consideration in defining or applying factors (such as meeting minutes or reports) referenced in the comparative analyses. The Guidance also specifies the following types of documentation, highlighted in the DOL's Self-Compliance Tool, that plans or insurers should have available to support their Comparative Analyses:

1. Records documenting NQTL processes and detailing how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under state law;
2. Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan has relied upon to determine that the NQTLs apply no more stringently to MH/SUD benefits than to medical/surgical benefits. Plans and issuers should include available details as to how the standards were

applied, and any internal testing, review, or analysis done by the plan or issuer to support its rationale;
3. Samples of covered and denied MH/SUD and medical/surgical benefit claims; and
4. Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of some or all MH/SUD benefits to another entity).

IV. Enforcement Priorities

While the Guidance reiterates that plans and insurers should be prepared to provide Comparative Analyses of all applicable NQTLs, it also provides that, initially, the DOL expects to focus its enforcement efforts on the following four NQTLs:

1. Prior authorization requirements for in-network and out-of-network inpatient services;
2. Concurrent review for in-network and out-of-network inpatient and outpatient services;
3. Standards for provider admission to participate in a network, including reimbursement rates; and
4. Out-of-network reimbursement rates (plan methods for determining usual, customary, and reasonable charges).

The Guidance emphasizes that this initial focus does not limit the Agencies' ability to request or review different or additional NQTL analyses for compliance, and plans and insurers are required to compare all NQTLs that apply to MH/SUD benefits. To the extent the Agencies become aware of potential violations of MHPAEA or receive complaints of noncompliance regarding specific NQTLs, they may request a Comparative Analyses of those specific NQTLs. If this occurs, plans should be prepared to make available to the Agencies a list of all other NQTLs for which they have prepared a Comparative Analysis, and a general description of any documentation that exists regarding each analysis.

V. Requests by Participants, Beneficiaries, and State Regulators

The Guidance notes that plans and insurers also must provide the Comparative Analyses to a participant, beneficiary, enrollee, or, for insurers and insured plans, a state regulator, upon request. The Guidance references the requirement under ERISA, the 2013 final regulations implementing the MHPAEA, and previous Agency guidance that participants and beneficiaries in ERISA-covered plans are entitled to comparative information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical and MH/SUD benefits under the plan, as a basis for the requirement to disclose the Comparative Analyses to those individuals. Since the final regulations implementing the MHPAEA clarify that this information is considered an "instrument under which the plan is established" under ERISA Section 104, the information, including the Comparative Analyses, is required to be furnished to a requesting participant or beneficiary within 30 days of receipt of a written request. These disclosure requirements are subject to the existing civil penalties under ERISA Section 502(c)(1), so a plan's failure to timely provide Comparative Analyses may result in a court imposing liability for up to $110 per day from the date of the failure to provide the documents.

Plans and insurers should therefore be prepared to timely provide the Comparative Analyses upon request to participants, beneficiaries, enrollees, and state regulators (for insurers and insured plans), as well as the Agencies.

VI. Next Steps and Future Guidance

As noted in our prior memorandum, we continue to recommend that group health plans that impose any NQTLs on mental health or substance use disorder benefits reach out to their consultants, medical benefits administrators, insurers (to the extent a plan has insured mental health benefits), or other appropriate providers for assistance with performing the required Comparative Analyses. Depending on the facts and circumstances, including availability of data on the NQTLs, associated costs, and applicable providers, there are a number of approaches health plans may take to complete their Comparative Analyses. For example, for some health plans, the medical benefits administrator(s) may be best positioned to complete the Comparative Analyses, while other plans may require the assistance of a benefits consultant, plan office, or third party administrator to prepare and/or coordinate completion of the Comparative Analyses. We are happy to assist with obtaining the Comparative Analyses as needed.

The Agencies advise in the Guidance that they will engage with stakeholders to determine what additional guidance might be needed. We will continue to monitor developments regarding the requirements described in this memorandum and look forward to discussing these requirements with you.

cc: Co-Counsel (if any)
Benefits Consultant (if any)

20980012v1

SLEVIN & HART, P.C.
Attorneys at Law
WWW.SLEVINHART.COM

1625 Massachusetts Avenue, NW, Suite 450
Washington, DC 20036

14 Wall Street, 20th Floor
New York, NY 10005

MEMORANDUM

To: Health Fund Clients

From: Slevin & Hart, P.C.

Date: June 9, 2021

Re: IRS Guidance Regarding COBRA Subsidy Under ARPA

In follow-up to our previous memoranda on the American Rescue Plan Act's ("ARPA") temporary 100% COBRA premium subsidy for eligible participants and dependents and the FAQs and model notices issued by the DOL on April 7, 2021, this memorandum will describe additional key information and clarifications relating to the COBRA subsidy that were issued by the IRS on May 18, 2021 in the form of FAQs ("Guidance").

I. Summary of Significant Terms

A. Involuntary Termination of Employment Defined: An involuntary termination of employment, for purposes of determining COBRA subsidy eligibility, is defined as a severance from employment due to the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request, where the employee was willing and able to continue performing services. As described further below, while the Guidance provides several examples of involuntary terminations, as well as additional examples of what constitutes a reduction in hours for purposes of determining subsidy eligibility, the determination of whether a termination is involuntary largely will be based on the facts and circumstances of each particular case.

B. Reliance on Self-Certification of Eligibility is Permissible: A fund may accept a participant's or beneficiary's self-certification or attestation that they are subsidy-eligible due to an involuntarily termination or a reduction in hours, unless the fund has actual knowledge to the contrary. For example, an individual's completion of, and signature on, the DOL's model Request for Treatment as an Assistance Eligible Individual Form would be a self-certification or attestation of eligibility.

C. Second Qualifying Events and Disability Determinations: The premium subsidy is available to individuals who elected, and have remained on, COBRA for an

extended period due to a disability determination or second qualifying event if the additional period of coverage falls between April 1, 2021 and September 30, 2021 and the original qualifying event was a reduction in hours or an involuntary termination of employment.

D. Reimbursement of Subsidized Premiums: All funds requesting subsidized premium reimbursements from the federal government, including those without employees, must use Form 941, Employer's Quarterly Federal Tax Return, to request such reimbursements.

E. Documentation Needed for Reimbursement Requests: In order to request a reimbursement from the federal government of COBRA premiums subsidized by the fund, the fund must maintain documentation substantiating each individual's classification as an assistance eligible individual ("AEI") under ARPA. This may be accomplished by retaining the individual's subsidy application form on which they self-certified that they are eligible for the premium subsidy and any employment records supporting each individual's qualification as an AEI.

F. Failure to Elect Retroactive Coverage Waives Right to Such Coverage: AEIs who: (i) experienced a qualifying event prior to April 1, 2021; (ii) receive notice from the fund of ARPA's extended COBRA election period; and (iii) elect COBRA coverage with premium assistance, must also elect or decline COBRA coverage retroactive to their original qualifying event within 60 days of receiving notice of the extended election period, regardless of the existing COVID-19 deadline extension. If an AEI who elects subsidized COBRA does not also elect any available retroactive unsubsidized COBRA coverage within the same 60-day window, they cannot later elect such unsubsidized COBRA coverage. However, if an AEI does not apply for subsidized COBRA, it appears that they would continue to be able to elect unsubsidized COBRA retroactive to their original qualifying event, subject to the existing COVID-19 deadline extensions.

G. Plans Eligible for Premium Subsidy: The COBRA premium subsidy is available for coverage under vision-only or dental-only group health plans, as well as health reimbursement arrangements and retiree health coverage, provided the retiree coverage is offered under the same plan as the coverage made available to similarly situated active employees.

II. Eligibility for the COBRA Premium Subsidy

A. Reduction in Hours or Involuntary Termination of Employment

As discussed in our prior memoranda, to be eligible for the COBRA premium subsidy under ARPA, an individual must have lost group health plan coverage as a result of the participant's reduction in hours or involuntary termination of employment.

i. Involuntary Termination of Employment

The Guidance addresses a question left open by ARPA and the DOL's guidance by defining an involuntary termination of employment as a severance from employment due to the independent exercise of the unilateral authority of the employer to terminate the employment, other than due to the employee's implicit or explicit request to be terminated, in instances where the employee was willing and able to continue performing services. The Guidance clarifies that the determination of whether a termination is involuntary is based on the facts and circumstances of a particular case.

An employee-initiated termination of employment would constitute an involuntary termination for COBRA subsidy eligibility purposes if the termination is for "good reason" due to employer action that results in a "material negative change" in the employment relationship. Additional examples of involuntary termination for COBRA subsidy purposes include situations in which: (i) an employee resigns as a result of a material change in the geographic location of employment or an involuntary material reduction in hours; (ii) an employee participates in a designated severance window that, among other requirements, is made available to employees who terminate employment during a limited timeframe; or (iii) the employer terminates the individual's employment while the employee is absent due to illness or disability if, before the termination, there is a reasonable expectation that the employee will return to work after the illness or disability has subsided. This suggests that a termination due to total and permanent disability would not be an involuntary termination since there would not be a reasonable expectation that the employee will return to work.

The Guidance also clarifies that retirement is generally considered a voluntary termination unless the facts and circumstances indicate that, absent the employee's decision to retire: (i) the employer would have terminated the employee; (ii) the employee was willing and able to continue employment; and (iii) the employee had knowledge that he would be terminated absent the retirement. Further, an employee's termination for cause is considered an involuntary termination, unless the termination is due to gross misconduct (as defined in the COBRA rules). The Guidance provides that an employee's decision to terminate employment based on general concerns about workplace safety (such as a concern for their health due to COVID-19) or an inability to locate childcare is <u>not</u> considered an involuntary termination unless the employee can demonstrate that the employer's actions or inactions resulted in a material negative change in the employment relationship (e.g., because the employer failed to take a required action or provide a reasonable accommodation for the employee).

Finally, an employer's decision not to renew an employee's employment contract is considered an involuntary termination if the employee was otherwise willing and able to continue the employment relationship and was willing to execute a new contract with similar terms or to continue employment without a contract. However, the Guidance clarifies that if the parties understood at the time they entered into the contract, and throughout the duration of the contract, that the contract was for services over a set term that would not be renewed, the employer's failure to renew the contract is not an involuntary termination of employment.

ii. Reduction in Hours

The Guidance provides that a furlough will be considered a reduction in hours regardless of whether the employer initiated the furlough, or the individual chose to participate in a furlough process similar to a severance window program. The Guidance defines a furlough as a temporary loss of employment or complete reduction in hours with a reasonable expectation of return to employment or resumption in hours such that the employer and employee intend to maintain the employment relationship. The Guidance also provides that a reduction in hours includes a work stoppage that is either the result of a lawful strike initiated by employees or their representative or a lockout initiated by the employer, provided the employer and employee intend to maintain the employment relationship at the time the work stoppage began.

B. Individual Self-Certification or Attestation of Eligibility for Premium Subsidy

The Guidance clarifies that a fund may, but is not required to, obtain a self-certification or attestation of COBRA subsidy eligibility from any individual requesting subsidized COBRA. This self-certification could be as simple as the individual's completion of, and signature on, the DOL's model Request for Treatment as an Assistance Eligible Individual Form ("Request Form"), described in our previous memorandum. Further, unless the fund has actual knowledge that the individual's attestation is incorrect, it may rely on this self-certification to determine whether the applicant is an AEI, provided the fund retains a copy of the completed Request Form. Therefore, it appears that the fund is not required to obtain independent verification (e.g., from the applicant's former employer or union) that the applicant experienced an involuntary termination or a reduction in hours, unless the fund has knowledge that the applicant's self-certification of eligibility is not correct. However, the fund still may request such confirmation from the individual's employer or union if it prefers to do so. In such case, it would be important for the fund to maintain a copy of any information it receives from the employer or union in response to its request.

C. Eligibility for Individuals with Secondary Qualifying Events

Under federal law, in some cases, individuals may have their 18-month COBRA continuation coverage period extended if they become disabled or experience a second qualifying event while covered under COBRA. The Guidance provides that, in these situations, if the individual's initial COBRA qualifying event was the reduction in hours or involuntary termination of employment and their COBRA extension continues into the period between April 1, 2021 and September 30, 2021, that individual would be eligible for the COBRA premium subsidy, provided that individual has remained covered under COBRA since the initial COBRA election. However, if a qualified beneficiary's initial COBRA eligibility was based on a qualifying event that was not a reduction in hours or involuntary termination of employment, a later reduction in hours or involuntary termination of employment would not trigger eligibility for the COBRA subsidy. For example, assume that an employee's spouse became eligible for, and elected, COBRA coverage effective November 1, 2020 as a result of the spouse's divorce from the employee. If the employee is subsequently involuntarily terminated and becomes eligible for COBRA coverage effective January 1, 2021, the spouse will not be eligible for the COBRA subsidy because the spouse's original qualifying event was the divorce and not the employee's involuntary termination of employment. The employee, on the other hand, would be eligible for the subsidy beginning April 1, 2021.

D. Termination of Subsidy Eligibility

Under ARPA, an individual is not eligible for subsidized COBRA coverage if they are, or become, eligible for coverage under any other group health plan or Medicare. The Guidance clarifies that, if the other coverage for which the individual is eligible is COBRA continuation coverage under another plan, that coverage will not disqualify the individual from eligibility for the premium subsidy. In addition, if the other coverage is retiree health coverage that is offered under the same plan, the availability of retiree coverage does not disqualify a potential AEI from receiving the subsidy for COBRA premiums under the active plan coverage that is part of the same plan as the retiree coverage. However, if the individual is offered retiree health coverage under a separate group health plan (such as a standalone retiree-only plan), the individual is not eligible for the COBRA subsidy under the plan for active participants, which has the effect of requiring the individual to choose between unsubsidized COBRA coverage under the active plan and retiree coverage under the standalone retiree-only plan.

Further, the Guidance provides that if a potential AEI previously declined COBRA coverage and instead enrolled in another group health plan, but is no longer covered by, or eligible for, that group health plan as of April 1, 2021, the individual would be eligible to receive subsidized COBRA, provided the individual otherwise qualifies.

As discussed in our March 26th memorandum, AEIs are required to notify the fund if they become eligible for other group health plan coverage or Medicare while receiving subsidized COBRA and, if they fail to provide such notice, they will be subject to a penalty. The Guidance clarifies that this penalty is payable to the federal government and not to the plan.

E. Plans Subject to ARPA's Requirements

The Guidance clarifies that, in addition to more traditional group health plans, the COBRA premium subsidy is available for COBRA coverage under vision-only or dental-only group health plans, health reimbursement arrangements, and retiree health coverage, but only if the retiree coverage is offered under the same group health plan as the coverage made available to similarly situated active employees. However, the premium subsidy is not available for health flexible savings accounts offered under a cafeteria plan or for any non-health benefits, such as group-term life insurance.

Further, funds must, during the extended election period under ARPA, offer their potential AEIs COBRA coverage for any health coverage the individual was enrolled in prior to their qualifying event and for which the individual was not enrolled as of April 1, 2021, even if the individual previously elected COBRA coverage with respect to only a portion of the available coverage. For example, if a potential AEI was previously offered COBRA coverage for health, dental-only, and vision-only and the individual elected dental-only coverage, the fund must now offer that AEI the opportunity to elect health and vision-only COBRA coverage as well.

III. Interaction of COBRA Subsidy Deadline with COVID-19 Deadline Extensions

As reflected in the DOL guidance issued on April 7th, ARPA's extended election period for subsidized COBRA coverage does not eliminate any preexisting right an individual may have to retroactively elect COBRA continuation coverage under the extended timeframes provided under the IRS and DOL's COVID-19 deadline extension.

However, the Guidance further clarifies that if an AEI whose original qualifying event was prior to April 1, 2021 decides to elect subsidized COBRA coverage, the individual must also elect or decline COBRA coverage retroactive to their original qualifying event within 60 days of receiving the notice of the extended election period. If such individual does not elect retroactive COBRA coverage within that 60-day period, they may not later elect such retroactive COBRA coverage, regardless of any existing COVID-19 deadline extension. If an AEI does not apply for subsidized COBRA, it appears that they would continue to be able to elect unsubsidized COBRA retroactive to their original qualifying event, subject to the existing COVID-19 deadline extensions.

For example, assume an employee's health coverage ended on January 31, 2021 as a result of involuntary termination, the individual did not elect COBRA and the individual received an extended COBRA election period notice from the Fund on May 1, 2021. This individual has 60 days from May 1 (until June 30, 2021) to elect: (i) subsidized COBRA effective April 1, 2021; (ii) subsidized COBRA prospective from the date of their election; or (iii) unsubsidized COBRA retroactive to February 1, 2021, with subsidized coverage beginning April 1, 2021. If the individual timely elects to receive subsidized COBRA effective either April 1, 2021 or from the date of their election, the individual will be precluded from later electing unsubsidized COBRA retroactive to February 1, 2021 once their 60-day COBRA subsidy election period expires. Alternatively, if the individual does not elect subsidized coverage within the 60-day election period, it appears that the individual could, at a later date, still elect unsubsidized coverage retroactive to February 1, 2021, provided the individual's election is made within the existing deadline under the COVID-19 deadline extension. However, the individual would not be entitled subsidized COBRA between April 1, 2021 – September 30, 2021.

The Guidance also provides that if an individual elects retroactive COBRA coverage under the COVID-19 deadline extension but has not yet paid all premiums owed for that retroactive (pre-April 1, 2021) COBRA coverage, the individual will not be disqualified from subsidized coverage for the period between April 1, 2021 and September 30, 2021. If the individual ultimately fails to make such retroactive premium payments when due, the fund may assume that the individual has instead elected only subsidized COBRA coverage effective as of April 1, 2021 and is not required to cover claims incurred before April 1, 2021.

IV. Reimbursement of Subsidized Premium Amounts

As discussed in our March 26th memorandum, the entity that provides the COBRA coverage and normally would receive the premium payments from qualified beneficiaries ("premium payees") may seek a reimbursement of subsidized COBRA premiums through a credit against its quarterly payroll taxes. As anticipated, the IRS has clarified that premium payees must claim the credit by reporting the amount of the subsidized premiums, and the number of individuals receiving subsidized COBRA, on the designated lines of the payee's employment tax return,

usually IRS Form 941, Employer's Quarterly Federal Tax Return. When Form 941 is filed, premium payees may request that any overpayment (including overpayments due to the payment of subsidized premiums) either be applied to the payee's next quarterly return or refunded to the payee. In addition, premium payees may reduce deposits of federal employment taxes that would otherwise be required, up to the amount of the anticipated credit for premium subsidies. Premium payees also may request an advance refund of the anticipated credit amount using IRS Form 7200, Advance Payment of Employer Credits Due to COVID-19, and any advance payments received by the payee must be reported on Form 941.

The Guidance clarifies that if a fund does not have any employment tax liability (e.g., because it does not have employees), the fund still should claim the credit on Form 941 and report any advance payments received in anticipation of the credit. The fund may wish to consult with its accountant or outside auditor regarding the completion of these forms.

The amount of the credit to be claimed each quarter should equal the premiums not paid by AEIs for COBRA coverage during the quarter, based on the premium amount charged for COBRA coverage to other similarly situated qualified beneficiaries, including any administrative costs otherwise allowed under COBRA. The credit for premium assistance under a health reimbursement account is limited to 102% of the premium amount actually reimbursed with respect to a particular AEI.

If a fund or employer would have subsidized an individual's COBRA coverage, by paying all or part of the premium, even if the individual was not receiving an ARPA COBRA subsidy, the amount of the credit must be equal to the amount that would have actually been charged to the individual. For example, if the applicable premium for COBRA coverage is $1,000 per month but, absent the ARPA COBRA subsidy, the fund would have only required a qualified beneficiary to pay $500 per month, the fund's allowable monthly credit is $500.

In order to request a reimbursement of premiums subsidized by the fund, the fund must maintain documentation substantiating each individual's classification as an AEI. This can be accomplished by retaining the individual's subsidy application form on which they self-certified that they are eligible for the premium subsidy and any employment records supporting each individual's qualification as an AEI.

Finally, if an AEI fails to inform the fund that he or she is no longer eligible for the COBRA subsidy because of eligibility for other group health plan coverage or Medicare, the fund is still entitled to receive a credit from the federal government for the subsidy it provided to the individual during any period of ineligibility, provided the fund did not know of the individual's ineligibility.

We will continue to monitor related guidance as it is issued and will notify you as additional information becomes available. In the meantime, please feel free to contact us with any questions.

cc: Co-Counsel (if any)

20977787v1

SLEVIN & HART, P.C.
Attorneys at Law
WWW.SLEVINHART.COM

1625 Massachusetts Avenue, NW, Suite 450
Washington, DC 20036

14 Wall Street, 20th Floor
New York, NY 10005

MEMORANDUM

To: Food Employers Labor Relations Association and United Food and Commercial Workers VEBA Fund

From: Barry S. Slevin
Sarah E. Sanchez
Andrew R. Dietrich

Date: April 12, 2021

Re: COBRA Subsidy Guidance and Model Notices Under the ARPA

This memorandum summarizes the guidance ("Guidance") and model notices ("Model Notices") issued by the Department of Labor ("DOL") on April 7, 2021 regarding the COBRA premium subsidy and extended COBRA election period under the American Rescue Plan Act of 2021 ("ARPA").

As described in our March 26, 2021 memorandum, the ARPA provides a temporary 100% COBRA premium subsidy for certain COBRA eligible participants and dependents referred to as "Assistance Eligible Individuals," effective April 1, 2021 through September 30, 2021. The ARPA also extends the COBRA election period for Assistance Eligible Individuals who would have been eligible for COBRA as of April 1, 2021 but did not elect, or chose to terminate, such coverage.

New DOL Guidance

A. Premium Subsidy Eligibility Requirements

As discussed in our March 26, 2021 memorandum, to be eligible for the premium subsidy, an individual must have lost group health plan coverage due to the participant's involuntary termination of employment or a reduction in hours. The Guidance clarifies that while a participant's termination must have been involuntary to trigger eligibility for the subsidy, a reduction in hours does not need to have been involuntary to trigger such eligibility. In addition, the Guidance provides a few examples of what would qualify as a reduction in hours, including reduced hours due to changes in a business's hours of operations, a change from full-time to part-time status, taking a temporary leave of absence, or an individual's participation in a lawful labor strike, provided the individual remains an employee at the time that hours are reduced.

Unfortunately, the Guidance does not provide any additional detail regarding what constitutes an "involuntary" termination for purposes of COBRA subsidy eligibility, except to state that an employee's termination for "gross misconduct," is not considered to be "involuntary."

Also, under the ARPA, an individual is not eligible for subsidized COBRA coverage if he is, or becomes, eligible for coverage under any other group health plan or Medicare. However, the Guidance clarifies that an Assistance Eligible Individual's participation in Medicaid or an individual health insurance plan through a state or federal marketplace does not make them ineligible to apply for subsidized COBRA coverage. That said, if such individual chooses to enroll in subsidized COBRA coverage, he will no longer qualify for the premium tax credit or health insurance tax credit to which he otherwise may have been entitled through the marketplace or Medicaid during such period of subsidized COBRA coverage.

B. Extended COBRA Election Period

The Guidance clarifies that the ARPA's extended election period does not extend an individual's period of COBRA coverage beyond the original maximum coverage period (generally 18 months for a reduction in hours or involuntary termination of employment). In addition, when an eligible individual elects COBRA coverage under the ARPA's extended election period, the individual has the option to begin coverage prospectively from the date of his or her election or, if an individual had a qualifying event on or before April 1, 2021, retroactively to April 1, 2021.

The DOL also has provided important clarifications in the Guidance regarding the interaction between the ARPA's COBRA provisions and the DOL's previously publicized extensions of certain COBRA-related deadlines due to COVID-19. Specifically, the ARPA's extended COBRA election period for subsidized COBRA coverage does not change an individual's preexisting right to elect COBRA continuation coverage under the extended timeframes provided in the DOL's COVID-19 deadline extensions. As a result, Assistance Eligible Individuals who are otherwise eligible, under the existing COVID-related deadline extensions, to elect COBRA coverage retroactively due to a qualifying event before April 1, 2021 have the option to elect COBRA coverage either: (a) beginning as early as April 1, 2021 (with premium assistance); or (b) beginning retroactive to their original loss of coverage (without premium assistance for any coverage periods prior to April 1, 2021).

However, the Guidance makes clear that the DOL's preexisting COVID-related deadline extensions do not apply to the 60-day window to elect subsidized COBRA coverage. Therefore, potential Assistance Eligible Individuals must elect COBRA coverage within 60 days of receipt of the Fund's notice regarding the availability of subsidized COBRA coverage or risk forfeiting the right to receive such subsidized coverage.

C. Penalties for Compliance Failures

Both the Guidance and the text of the ARPA appear to provide that any failure by the Fund to satisfy the ARPA's COBRA provisions may constitute a failure to satisfy the general COBRA continuation coverage requirements under federal law, thereby subjecting the Fund to a potential excise tax under Section 4980B of the Internal Revenue Code. This excise tax may be up to $100

per qualified beneficiary, but not more than $200 per family, for each day the Fund is in violation of the requirements.

Notices to Participants and Beneficiaries

In addition to the Guidance described above, the DOL also has released Model Notices the use of which would satisfy the notice obligations imposed on group health plans under the ARPA. Attached are customized versions of these Model Notices for use by the Fund. We have highlighted in yellow the sections of each notice that will need to be personalized for each qualified beneficiary. The Notices and their purposes are as follows.

A. General Election Notice

This notice must be sent to all qualified beneficiaries who have qualifying events occurring between April 1, 2021 and September 30, 2021, regardless of the nature of the qualifying event. Below are a few important notes:

- Based on our understanding that participants do not have the ability to choose between different coverage options, we have eliminated the paragraphs relevant to such a choice.
- The instruction box for the Election Form currently provides that the only way to submit the form is by regular mail. If the Fund Office currently allows for other submission options (e.g., fax, email, hand delivery, etc.), those should be added.
- The Fund Office must include a copy of the Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021 (see 3 below) with this General Election Notice.

B. Extended Election Period Notice

This notice must be sent to: (a) qualified beneficiaries currently enrolled in COBRA continuation coverage due to a reduction in hours or involuntary termination of employment (i.e., Assistance Eligible Individuals); and (b) those who would currently be Assistance Eligible Individuals if they had previously elected and/or maintained COBRA continuation coverage. Unless the Fund Office receives information on whether an individual is COBRA eligible due to a reduction in hours or an involuntary termination of employment, we suggest that the Fund Office send this Notice to anyone who is currently enrolled in COBRA or who had a qualifying event on or after November 1, 2019 and, therefore, could have been receiving COBRA as of April 1, 2021 if they had previously enrolled in (or not dropped) coverage. Below are a few important notes:

- This Extended Election Period Notice must be distributed to the individuals described above no later than May 31, 2021.
- Based on our understanding that participants do not have the ability to choose between different coverage options, we have eliminated the paragraphs relevant to such a choice.

- The instruction box for the Election Form currently provides that the only way to submit the form is by regular mail. If the Fund Office currently allows for other submission options (e.g., fax, email, hand delivery, etc.), those should be added.
- The Fund Office must include a copy of the Summary of the COBRA Premium Assistance Provisions under the American Rescue Plan Act of 2021 (see 3 below) with this Extended Election Period Notice.

C. Attachment to General Notice and Extended Election Period Notice

As noted above, this document must be sent along with both the General Election Notice and Extended Election Period Notice. Neither the ARPA, this Attachment, nor the Guidance specifically state that the Fund is responsible for verifying the applicant's attestation that he or she meets the definition of an Assistance Eligible Individual. However, the Attachment includes a section for the Fund to complete, indicating whether the application is approved or denied and, if denied, the specific reason for the denial. Therefore, in order to fill out this section once a completed application is received by the Fund Office, we suggest that the Fund Office coordinate with the applicant's employer/former employer and/or the Union, to verify that the individual (or the relevant participant in the case of a dependent applicant) experienced a reduction in hours or involuntary termination of employment. If the Fund determines that the applicant did not have a reduction in hours and was not involuntarily terminated, then the Fund must note that on the Attachment and send a copy of the marked-up Attachment back to the applicant. While not entirely clear, we think a fair reading of this Attachment is that the Fund does not need to return a marked-up version to the applicant if the Fund determines that the individual is entitled to receive subsidized coverage.

D. Notice of Termination of Subsidy

This notice must be sent to Assistance Eligible Individuals who are receiving subsidized COBRA coverage within 15-45 days before their subsidy period expires.

Please let us know if you have any questions or concerns regarding the attached Notices or the DOL's recent Guidance.

BSS:SES:ARD:2585.01

Enclosures

cc: Michael P. Kreps (w/encl., via email)

20960051v1

SLEVIN & HART, P.C.
Attorneys at Law
WWW.SLEVINHART.COM

1625 Massachusetts Avenue, NW, Suite 450
Washington, DC 20036

14 Wall Street, 20th Floor
New York, NY 10005

MEMORANDUM

To: Health Fund Clients

From: Slevin & Hart, P.C.

Date: March 26, 2021

Re: COBRA Subsidy Under the American Rescue Plan Act of 2021

As part of the federal government's economic aid to families and businesses in response to the COVID-19 pandemic, the American Rescue Plan Act of 2021 ("ARPA"), signed into law on March 11, 2021, provides a temporary 100% COBRA premium subsidy for COBRA eligible former participants and dependents who experience an involuntary termination of employment or reduction in hours, effective April 1, 2021 through September 30, 2021. In connection with this subsidy, the ARPA extends the COBRA election period for individuals who would have been eligible for the premium subsidy but did not elect, or chose to terminate, COBRA coverage prior to April 1, 2021.

I. Summary and Action Items

- **Premium-Free Coverage:** The Fund must provide up to a maximum of six months of premium-free COBRA coverage to Assistance Eligible Individuals who elect such coverage, beginning April 1, 2021 and continuing through September 30, 2021. To be eligible, the participant must lose group health plan coverage due to the participant's involuntary termination of employment or reduction in hours. The Fund is required to subsidize the cost of the COBRA premiums for these individuals during the subsidy period, and then may seek reimbursement from the federal government for these subsidy amounts. The subsidy will end earlier than the six-month window if the COBRA coverage period for the applicable individual otherwise would end (such as if the person becomes eligible for Medicare, the 18-month COBRA period ends, etc.). To the extent that the Fund does not already have information on whether an individual's COBRA qualifying event was attributable to an involuntary termination of employment or reduction in hours, the Fund will need to implement a process of coordinating with contributing employers and/or participating unions to determine whether a termination of employment was attributable to an involuntary termination of employment or reduction in hours.

- **COBRA Election Period Extension:** The COBRA enrollment period available to Assistance Eligible Individuals who were eligible to elect COBRA coverage for

any part of the period from April 1, 2021 to September 30, 2021 but are not enrolled in COBRA as of April 1, 2021 has been extended. These Assistance Eligible Individuals now may elect COBRA coverage within 60 days following the date the individual receives a COBRA eligibility notice from the Plan, retroactive to April 1, 2021.

- **Required Notices:** The Fund must timely distribute the ARPA's required notices to individuals eligible for the COBRA subsidy. The first notice, regarding the availability of the subsidy, must be sent by May 31, 2021 and the DOL is required to issue a model notice for this purpose by April 10, 2021. The second notice, regarding termination of the subsidy, must be sent at least 15 days prior to each individual's subsidy termination date and the DOL is required to issue a model notice for this purpose by April 25, 2021. We will work with the Fund office to customize these notices to the extent necessary, so that the initial eligibility notice can be sent as soon as possible. In the meantime, we recommend that the Fund office immediately begin to compile a list of the former participants and dependents who may be eligible to receive the COBRA subsidy, as described in Section II below.

- **Optional Change In Coverage:** To the extent that the Fund permits active participants to choose between more than one benefit program option, the Trustees have the option, but are not required to, permit all Assistance Eligible Individuals to enroll in, or change their current COBRA election to, a different, but not more expensive, benefit program option from the one in which they were enrolled when coverage was lost.

II. Eligibility for the Subsidy

The ARPA mandates the availability of a six-month, 100% COBRA premium subsidy, from April 1, 2021 through September 30, 2021, for former group health plan participants and dependents if the loss of group health plan coverage results from the participant's involuntary termination of employment or reduction in hours and:

- The individual becomes eligible for, and elects, COBRA coverage on or after April 1, 2021 and before September 30, 2021; or

- The individual became eligible for COBRA before April 1, 2021 and the period of COBRA coverage to which he would be entitled (generally 18 months) includes any month between April 2021 and September 2021, even if the individual did not elect COBRA when initially offered or previously elected COBRA but discontinued coverage prior to April 1, 2021.

Individuals meeting these criteria are referred to as Assistance Eligible Individuals. As noted above, an individual will only qualify as an Assistance Eligible Individual if his loss of coverage is due to an involuntary termination of employment or a reduction in hours. Therefore, under these criteria, if the individual's eligibility for coverage is not conditioned on a participant's current employment (e.g. retiree coverage), a COBRA subsidy is not available upon termination of such coverage. Since COBRA is available to employees who voluntarily resign from

employment, the Fund Office will need to identify and carefully review the basis for each individual's eligibility for COBRA in order to determine if the individual is an Assistance Eligible Individual.

Although the maximum period for the COBRA subsidy under the ARPA is the six-month window between April and September 2021, the subsidy will end earlier for anyone whose regular period of COBRA coverage ends before September 2021 or who becomes eligible for coverage under any other group health plan[1] or Medicare before September 30. The ARPA requires individuals to notify the Fund if they become eligible for other coverage, and the Fund must include a summary of this requirement in the required notice relating to the COBRA subsidy, as discussed further below.

An individual who fails to provide notice of the availability of other coverage to the Fund (such as a new job with full health benefits) is subject to a penalty of $250.00 unless the individual can show that such failure was due to reasonable cause and not willful neglect. However, the ARPA does not define reasonable cause, so further guidance on this point is needed. Further, in the event an individual intentionally and fraudulently fails to notify the Fund of the availability of other coverage, the individual instead will be subject to a penalty equal to the greater of $250.00 or 110% of the premium assistance provided by the Fund after termination of eligibility for the subsidy. The ARPA does not specify whether the above penalties are payable to the federal government or the Fund.

III. COBRA Election Period Extension

As noted above, the ARPA extends the COBRA enrollment period available to Assistance Eligible Individuals who were eligible to elect COBRA coverage for any month from April 1, 2021 to September 30, 2021 but are not enrolled in COBRA as of April 1, 2021. This includes individuals with a qualifying event who never made a COBRA election or who previously made an election but later discontinued coverage. Such Assistance Eligible Individuals will have a new opportunity to elect COBRA coverage within 60 days following the date the individual receives a COBRA eligibility notice from the Fund. COBRA coverage for Assistance Eligible Individuals who elect COBRA during this election period extension will begin retroactively on April 1, 2021 (and not earlier) and will terminate as of the end of the individual's original COBRA continuation period (i.e., the period that would have applied had the individual elected COBRA coverage during their initial election window or had not terminated their COBRA coverage early).

Example: If an Assistance Eligible Individual became eligible to elect COBRA for sixty-days from December 1, 2019 as a result of her involuntary termination of employment, her 18-month COBRA coverage period, if elected, would have extended through May 2021. If this individual now decides to elect COBRA during the ARPA's extended election period, she would be entitled to commence COBRA coverage as of April 1, 2021 and would receive 100% subsidized COBRA coverage for the months of April and May 2021. The ARPA does not appear to impose any requirement for an Assistance Eligible Individual to pay retroactive premiums for the period going back to when such individual first became eligible for COBRA as a condition of obtaining the subsidized coverage as of April 1, 2021. This is a significant departure from the long-standing

[1] Eligibility for coverage under another group health plan would not result in termination of the subsidized COBRA benefit if the other group health plan coverage is: (a) limited to excepted benefits (e.g. dental, vision); (b) a standalone health flexible spending arrangement; or (c) a qualified small employer health reimbursement arrangement.

COBRA guidance that allows the Fund to require that the person pay for the entire period of coverage (back to December 1, 2019 in this example) and prohibits individuals from choosing months within the 18-month COBRA coverage period. This likely will increase the impact of adverse selection on the Fund.

The ARPA does not address how this extended election period operates in connection with the DOL's extension of certain deadlines due to COVID-19, as discussed in our May 13, 2020 memorandum and February 26, 2021 email. Specifically, the ARPA leaves open whether individuals may elect COBRA coverage effective as of a date prior to April 1, 2021 pursuant to the DOL's extension of COBRA deadlines and whether premiums are owed for such periods. Pursuant to the DOL's COVID-19 deadline extension, effective March 1, 2020, the deadline for individuals to elect COBRA or make COBRA premium payments must, at a minimum, be tolled until the earlier of (a) one year from the date the individual was first eligible to elect COBRA; or (b) 60 days after the end of the federally-declared National Emergency.

However, because the ARPA does not expressly alter the DOL's prior COVID-19 deadline extension, it appears that Assistance Eligible Individuals who also qualify for the existing COVID-19 deadline extension have the option to elect COBRA coverage either: (a) beginning April 1, 2021 and continuing through their original end date, as permitted under the ARPA; or (b) retroactive to their original COBRA eligibility date, as permitted under the DOL's existing COVID-19 deadline extension guidance. Under option (b), the Fund presumably could require that the individual pay COBRA premiums for coverage periods before April 1, 2021. It is possible that future guidance will be issued to clarify the interaction between the ARPA and the DOL's deadline extension rule.

IV. Changing COBRA Elections

The ARPA provides that, if applicable, a plan sponsor may, but is not required to, allow all Assistance Eligible Individuals to elect COBRA coverage in, or change current COBRA elections to, a benefit program offered by the plan sponsor that is different than the benefit program in which the individual was enrolled when coverage was lost. For an Assistance Eligible Individual to be eligible to make this election change, the Fund must decide to offer this option and: (1) the premium for the different benefit program may not exceed the premium for the benefit program in which the individual was enrolled when active coverage terminated; (2) the different benefit program option must be available to similarly situated active employees; and (3) the different benefit program option must not: (i) be limited to excepted benefits, (ii) be a qualified small employer health reimbursement arrangement, or (iii) be a flexible spending arrangement. If permitted by the plan sponsor, Assistance Eligible Individuals may change their coverage election within 90 days of receiving notice from the Plan of such option. If a plan sponsor decides to make this option available to Assistance Eligible Individuals, the availability of such option must be included in the required notices.

V. Notice Requirements for Plans

Group health plans must provide a notice to all Assistance Eligible Individuals regarding the availability of the temporary COBRA subsidy and the extended election period no later than May 31, 2021. The DOL is required to issue a model notice for this purpose by April 10, 2021 and we will work with the Fund office to adapt this notice for the Fund, if necessary, so that it may

be sent as soon as possible but no later than May 31st. As noted above, the Fund may not be aware of whether an individual's COBRA qualifying event was attributable to an involuntary termination of employment or reduction in hours. Thus, as a threshold matter, the Fund will need to implement a process of coordinating with contributing employers and/or participating unions to determine whether a termination of employment was attributable to an involuntary termination of employment or reduction in hours, as opposed to a voluntary termination, resignation, or retirement, which would not qualify for the COBRA subsidy. A possible approach is to include in the notice a requirement that an individual attest that the loss in coverage was a result of an involuntary termination of employment or reduction in hours and acknowledge that the Fund will follow up to confirm that this is correct. Also, it is possible that additional guidance will be forthcoming as to what constitutes an involuntary termination as was the case in 2009 when similar credits for COBRA premium subsidies were offered under the American Recovery and Reinvestment Act of 2009 ("ARRA").

Group health plans also must continue to provide the required notice of eligibility to any individual who becomes entitled to elect COBRA coverage between April 1, 2021 and September 30, 2021, regardless of the individual's eligibility for the premium subsidy, and this notice must continue to satisfy COBRA's existing requirements. However, this notice also must be revised to advise of the availability of the premium subsidy and, if applicable, the option to enroll in a different benefit program option. The DOL is required to issue a model notice for this purpose by April 10, 2021 as well. When Congress enacted similar COBRA premium subsidies under the ARRA, which included similar notice requirements for plans, the DOL issued an entirely new model notice of eligibility to be used by plans during the applicable premium subsidy period. If the DOL follows the same approach here, it is likely that the Fund's existing notice of COBRA eligibility will need to be revised for use between April 1 and September 30, 2021, instead of adding a reference to the new subsidy provisions in the Fund's existing notice of eligibility.

Finally, plans must notify Assistance Eligible Individuals who elect COBRA of the termination of their premium subsidy. This notice must: (1) be sent no less than 15 days and no more than 45 days prior to the subsidy's end date; (2) clearly identify the date the subsidy will expire; and (3) inform the individual that further coverage without premium assistance may be available through COBRA or another group health plan. Plans are not required to provide this notice if an individual's premium subsidy ends because the individual becomes eligible for other group health plan coverage or Medicare.

As with the subsidy availability notice, the DOL is required to issue a model subsidy termination notice, though the deadline for issuance of this model notice is April 25, 2021. We will work with the Fund office to adapt this notice for the Fund's use, as necessary. Also, since the Fund may have participants who are eligible to receive the COBRA subsidy only for the month of April 2021, we will work with the Fund to craft a termination notice for such individuals in advance of the model's issuance.

VI. Reimbursement to Fund of Premium Amounts

Group health plans must treat Assistance Eligible Individuals who elect COBRA coverage as having paid the full amount of required COBRA premiums for the months of April through September 2021. Therefore, if an Assistance Eligible Individual makes COBRA premium payments for periods of coverage between April 1, 2021 and September 30, 2021 but was not

required to do so under the ARPA, the plan must refund such payment to the individual within 60 days of when the individual made the payment.

Under the ARPA, plans, employers, and insurers may seek a reimbursement of the subsidized COBRA premiums through a credit against quarterly payroll taxes. If the credit (i.e., the amount of the premium subsidy paid by the Fund) exceeds the amount of payroll taxes due, the remainder of credit will be treated as an overpayment subject to refund by the federal government. The credit also may be advanced under rules that will be issued by the Treasury Department. The identity of the entity (i.e., the plan, employer, or insurer) that will receive a reimbursement for the subsidized COBRA premiums from the federal government depends on the plan structure:

- In the case of multiemployer plans (both insured and self-insured), the plan itself must apply for the tax credit.

- For non-multiemployer plans that are self-insured and/or subject to federal COBRA requirements, the sponsoring employer must apply for the credit.

- For non-multiemployer plans that are fully insured and are not subject to federal COBRA requirements, the insurer must apply for the credit.

It appears likely that plans with employees, employers, and insurers, as applicable, will use IRS Form 941, Employer's Quarterly Federal Tax Return, to claim the credit for the amount of premium subsidy paid, as was the process in 2009 for similar credits for COBRA premium subsidies offered under the ARRA.

For multiemployer plans without employees that do not typically file Form 941, the plan presumably still will be able to request a refund from the federal government of the subsidized COBRA premium amounts, but the ARPA does not explain how this reimbursement process will work. Instead, the ARPA specifically requires that regulations be issued regarding the application of its premium assistance provisions to multiemployer plans.

We will continue to monitor related guidance as it is issued and will notify you as additional information, and the model notices, become available. In the meantime, please feel free to contact us with any questions.

cc: Co-Counsel (if any)

20956145v1

SLEVIN & HART, P.C.
Attorneys at Law
WWW.SLEVINHART.COM

1625 Massachusetts Avenue, NW, Suite 450
Washington, DC 20036

14 Wall Street, 20th Floor
New York, NY 10005

MEMORANDUM

To: Health Fund Clients

From: Slevin & Hart, P.C.

Date: March 9, 2021

Re: Consolidated Appropriations Act of 2021, Health Fund Transparency and Disclosure Rules

---

The Consolidated Appropriations Act of 2021 ("CAA"), signed into law on December 27, 2020, amends ERISA, the Public Health Service Act ("PHSA"), and the Internal Revenue Code ("Code") to impose a number of new obligations on group health plans. Our March 3, 2021 memorandum discusses new obligations under the No Surprises Act, which is part of the CAA. This memorandum will address additional transparency and disclosure rules under the CAA that apply to group health plans. Although many provisions of the CAA are not effective immediately and will require further guidance from the Department of Labor ("DOL"), the Department of Health and Human Services, and the Department of the Treasury (the "Agencies"), given the significance of the changes, we suggest that plans begin discussions with their professionals now to develop a plan for compliance. Some of the requirements are effective now and need to be addressed immediately.

I. Summary

- **General Applicability.** The rules regarding disclosure of analyses of non-quantitative treatment limitations, prohibitions on "gag clauses" in certain provider agreements, reporting requirements on pharmacy benefits and drug costs, and service provider fee disclosures apply to insured and self-insured group health plans, regardless of the plan's grandfathered status under the Affordable Care Act ("ACA"). The health plan service provider fee disclosure requirements, added under ERISA Section 408(b)(2), apply to all health plans subject to ERISA. The other requirements discussed in this memorandum appear to exclude retiree-only plans and "excepted benefits" under ERISA. Guidance is expected to be issued to confirm this point.

- **Mental Health Parity: Disclosure of Analyses of Non-Quantitative Treatment Limitations.** In order to help enforce the existing requirements for mental health parity with medical benefits, the CAA imposes new requirements for group health plans and insurance carriers to perform and document comparative analyses of any Non-

Quantitative Treatment Limitations ("NQTLs") on mental health or substance use disorder benefits and to provide those analyses, along with additional information, to the Agencies upon request, beginning February 10, 2021. Since this requirement is effective now, the plan should begin working immediately with its benefits consultant on documenting the analyses and potentially modify any benefit rules or practices that do not comply with the current law.

- **Prohibitions on "Gag Clauses" in Certain Provider Agreements.** Effective December 27, 2020, the CAA prohibits group health plans, and health insurers of insured plans, from entering into agreements with certain providers that include "gag clauses" that restrict the plans from accessing and providing certain information to certain parties, including referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries, and requires group health plans and insurers to submit annual attestations that they are in compliance with this requirement. The CAA does not specify whether this requirement applies only prospectively to new and future provider agreements or whether it also applies to existing provider agreements in effect as of December 27, 2020. As clarifying guidance is issued, we will review any impacted contracts to confirm compliance with this rule.

- **Reporting Requirements on Pharmacy Benefits, Drug Costs, and Other Benefits and Costs.** Effective December 27, 2021, the CAA imposes new annual reporting requirements on group health plans and health insurers that require them to submit information on pharmacy benefits, drug costs, and certain other benefits and costs to the Agencies.

- **Service Provider Fee Disclosures.** The CAA amends the provider disclosure requirements under ERISA Section 408(b)(2) that are currently applicable to pension plans to extend these disclosure rules to certain covered service providers of group health plans that receive compensation from the plan that exceeds certain dollar thresholds. Specifically, the CAA requires service providers that provide certain brokerage or consulting services to group health plans and reasonably expect to receive $1,000 or more in compensation related to those services to provide certain disclosures related to their compensation and fees. The disclosure requirement is effective December 27, 2021, but only applies to service providers with a contract executed, extended, or renewed, on or after December 27, 2021.

II. Mental Health Parity: Disclosure of Analyses of Non-Quantitative Treatment Limitations

Effective February 10, 2021, the CAA imposes new disclosure requirements on group health plans and health insurers subject to the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") to document their compliance with the nonquantitative treatment limitation ("NQTL") requirements under the MHPAEA. For insured plans, both the plan sponsor and the insurer are responsible for documenting the plan's compliance.

The MHPAEA generally prohibits group health plans that cover the treatment of mental health conditions or substance use disorders from imposing any NQTL (*e.g.*, medical management techniques) on mental health or substance use disorder benefits in any of six classifications, unless the processes, strategies, evidentiary standards, or other factors used to apply the NQTL to mental health or substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying that NQTL with respect to medical/surgical benefits in the same classification. Please see our April 9, 2014 memorandum regarding the final regulations under the MHPAEA for more information regarding these requirements.

The CAA does not change the substantive requirements for mental health parity, but requires group health plans and insurers that impose NQTLs on their mental health or substance use disorder benefits to document their comparative analyses of the design and application of the NQTLs on the mental health and substance use disorder coverage, as compared to the NQTLs that apply to medical/surgical benefits. Plans that have not previously documented these analyses must now document them, and all plans must now provide the comparative analyses and the following information to the Agencies upon request:

1. The specific plan, coverage, or other relevant terms regarding the NQTLs and a description of all mental health or substance use disorder and medical or surgical benefits to which the terms apply in each of the six classifications of benefits;

2. The factors used to determine that the NQTLs will apply to mental health or substance use disorder benefits and medical or surgical benefits;

3. The evidentiary standards used for the above factors, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to mental health or substance use disorder benefits and medical or surgical benefits;

4. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, those used to apply the NQTLs to medical or surgical benefits in the benefits classification; and

5. The specific findings and conclusions reached by the plan or insurer, including any results of the comparative analyses that indicate that the plan or coverage is or is not compliant with the MHPAEA.

The CAA provides that the Agencies will request the comparative analyses and above information from plans or insurers that have potential violations or complaints regarding noncompliance with the MHPAEA's NQTL requirements. However, the law also permits the Agencies to request the analyses and information in any other instances that they determine appropriate. If the Agencies determine that the information received from the plans and insurers is not sufficient to review the analyses, they can require additional information from the plan or insurer.

If, after review, the Agencies determine that the plan or insurer is not in compliance with the MHPAEA, the plan or insurer must specify the actions it will take to comply and provide additional comparative analyses demonstrating compliance with the MHPAEA within 45 days after the Agencies' initial determination of noncompliance. If, after that 45-day period, the Agencies determine that the plan or insurer still is not in compliance with the MHPAEA, the plan or insurer must notify all individuals enrolled in the plan or coverage of the noncompliance within seven days after the Agencies' determination.

The CAA requires the Agencies to issue guidance on these requirements and to finalize any draft or interim guidance and regulations relating to the MHPAEA. This draft guidance is required to clarify the process and timeline for current and potential participants and beneficiaries to file complaints regarding a plan's or insurer's violation of the MHPAEA. In addition, the law requires the Agencies to update their MHPAEA compliance program guidance documents[1] to include instances of noncompliance that they discover. The current compliance program guidance document published by the DOL, its Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act, was updated most recently in October 2020. The Self-Compliance Tool includes guidance on complying with the NQTL requirements, including a step-by-step guide to the analysis that, in the DOL's view, plans should apply to each NQTL to determine its compliance with the MHPAEA.

The CAA requires the Agencies to submit to Congress by December 27, 2021, and annually by each October 1 thereafter, a report that contains information on the comparative analyses requested by the Agencies. This report will be publicly available and will include the names of the group health plans and insurers that were determined to be noncompliant with the MHPAEA. The DOL also must share its findings of compliance and noncompliance with the state where the group health plan is located.

As is the case with the other provisions of the MHPAEA, these requirements exist as parallel provisions of ERISA, the Code, and the PHSA. Therefore, an ERISA-covered plan that does not comply with these requirements will be in violation of both the Code and ERISA. The Code provides an excise tax of $100 per day per affected participant or beneficiary for noncompliance, and a plan is expected to report such noncompliance to the applicable Agencies or be subject to additional penalties for failure to report. However, the excise tax will not apply if the noncompliance was due to reasonable cause (not willful neglect) and is corrected within the 30-day period beginning on the first date the plan knew, or exercising reasonable diligence would have known, of the noncompliance. With respect to a violation of ERISA for failure to comply with the MHPAEA provisions, the DOL may raise such issues in an audit or bring an enforcement action against the plan. In addition, a participant or beneficiary may bring an action against the plan to recover benefits or enforce rights under a plan because of the MHPAEA, clarify rights to future benefits, or enjoin violations of the MHPAEA, as permitted under ERISA Section 502(a).

We expect that the guidance from the Agencies will clarify what will, and will not, satisfy the requirements for the required comparative analyses of NQTLs. However, since the law permits

[1] The current compliance program guidance document for the DOL may be found at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf.

the Agencies to request the comparative analyses from plans now, even before any additional guidance is issued, we recommend that group health plans that impose any NQTLs on mental health or substance use disorder benefits reach out to their consultants, medical benefits administrators, or other appropriate providers for assistance with performing the required comparative analyses. Plans also should consult the DOL's Self-Compliance Tool, discussed above, for guidance on the steps for completing the comparative analyses. We are also happy to assist with the comparative analyses as needed.

III. Prohibitions on "Gag Clauses" in Certain Provider Agreements

Effective December 27, 2020, group health plans and health insurers of insured plans may not enter into an agreement with a health care provider, network or association of providers, third-party administrator ("TPA"), or other service provider offering access to a network of providers, that would directly or indirectly restrict the plan or insurer from:

1. Providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, participants or beneficiaries, or individuals eligible to become participants or beneficiaries;

2. Upon request and consistent with applicable privacy regulations, electronically accessing de-identified claims information for each participant or beneficiary, including per-claim financial information, provider information, and service codes; or

3. Sharing the above-described data and information with a business associate as defined under the Health Insurance Portability and Accountability Act of 1996.

The above restrictions, or "gag clauses," can be found, for example, in contracts that provide access to a provider's network of medical providers or pharmacies, where the provider seeks to restrict disclosure of certain proprietary information, such as the rates it has negotiated with its in-network medical providers, to the plan.

Plans must submit annual attestations to the Agencies that they are in compliance with these requirements, but the CAA does not specify the form of the attestation or when the first and subsequent attestations must be submitted. We expect guidance will be issued regarding the form and requirements for the attestation prior to any due date.

The CAA also does not specify whether the prohibition applies only prospectively to new and future provider agreements or whether it also applies to existing provider agreements in effect as of December 27, 2020. We expect that guidance will be issued addressing these questions. In the interim, we recommend that any applicable new provider contracts or contract renewals that are entered into on or after December 27, 2020 comply with these rules. If the guidance clarifies that the rule applies to contracts in existence prior to December 27, 2020, we will review these applicable contracts for a prohibited gag clause and, if the contract has such a restriction, seek an amendment to the contract to comply with the CAA.

IV. Reporting Requirements on Pharmacy Benefits, Drug Costs, and Other Benefits and Costs

Effective December 27, 2021, the CAA imposes new annual reporting requirements for insured and self-insured group health plans and health insurers to submit information on pharmacy benefits, drug costs, and certain other benefits and costs to the Agencies. The first report is due no later than December 27, 2021, and subsequent reports are due by June 1 of each year thereafter. Group health plans and insurers must submit the following information with respect to the plan in the previous plan year:

1. The beginning and end dates of the plan year;

2. The number of participants and beneficiaries;

3. Each state in which the plan or coverage is offered;

4. The 50 brand prescription drugs most frequently dispensed by pharmacies for claims paid by the plan and the total number of claims paid for each such drug;

5. The 50 most costly prescription drugs with respect to the plan by total annual spending, and the annual amount spent by the plan or coverage for each such drug;

6. The 50 prescription drugs with the greatest increase in plan expenditures over the plan year preceding the reported plan year, and, for each such drug, the change in amounts expended by the plan or coverage in each such plan year;

7. Total spending on health care services by such group health plan broken down by (a) the type of costs, including (i) hospital costs, (ii) health care provider and clinical service costs, for primary and specialty care separately, (iii) costs for prescription drugs; and (iv) other medical costs, including wellness services, and (b) spending on prescription drugs by the health plan and the participants and beneficiaries;

8. The average monthly premium paid by employers on behalf of participants and beneficiaries, as applicable, and paid by participants and beneficiaries;

9. Any impact on premiums by rebates, fees, and any other remuneration paid by drug manufacturers to the plan or its administrators or service providers, with respect to prescription drugs prescribed to participants or beneficiaries in the plan, including (a) the amounts so paid for each therapeutic class of drugs and (b) the amounts so paid for each of the 25 drugs that yielded the highest amount of rebates and other remuneration under the plan or coverage from drug manufacturers during the plan year; and

10. Any reduction in premiums and out-of-pocket costs associated with rebates, fees, or other remuneration described in paragraph 9.

Within 18 months after the date on which the first report is due, and biannually after that, the Agencies must publish a report on prescription drug reimbursements under group health plans and health insurance coverage, prescription drug pricing trends, and the role of prescription drug costs in contributing to premium increases or decreases under such plans or coverage. The report will be aggregated so as not to include any plan-specific or confidential or trade secret information.

We expect that the Agencies will issue guidance on this reporting requirement. For example, since the reporting requirements also apply to insurers of insured plans, if a group health plan's prescription drug benefit is fully insured, the law is not clear on whether the plan, the insurer, or both must submit the above information. In addition, the Agencies are likely to clarify the plan year on which non-calendar year plans are required to report by December 27, 2021. For calendar-year plans, the plan year to be reported will presumably be the 2020 plan year since that is the "previous plan year." However, for plans with a plan year that is not based on the calendar year, it is unclear which plan year will apply for purposes of the information that must be submitted in the first year. Future guidance should address these questions.

The law does not address timing for regulations and guidance on these prescription drug reporting requirements, but we will continue to monitor for any additional guidance. In the meantime, to allow self-insured plans time to compile all the required information by the December 27, 2021 deadline, we recommend that the plan reach out to its applicable providers, such as PBMs, medical benefits administrators, and benefit consultants, immediately with a request for the required information and to confirm that the information will be timely provided. Alternatively, plans can amend their contracts with their PBMs, medical benefits administrators, or other vendors to delegate this reporting responsibility to the vendor. However, since plans are ultimately responsible for any failures by their vendors with respect to these reporting requirements, plans that delegate this responsibility should confirm they have indemnification provisions in their underlying agreements sufficient to shift liability for compliance onto the vendor. Insured plans should reach out to the insurer to confirm that the insurer will timely comply on the plan's behalf. In either case, the plan professionals will need to work with the plan office to identify the affected contracts and then amend the agreements to address compliance with this annual reporting requirement.

V. Service Provider Fee Disclosures

The CAA amends ERISA Section 408(b)(2) to require certain fee and compensation disclosures from service providers providing brokerage or consulting services to a group health plan. As background, ERISA Section 408(b)(2) provides an exemption from ERISA's prohibited transaction rules for a reasonable contract or arrangement for services that are necessary for the operation of the plan and only if reasonable compensation is paid. The original annual disclosure rules on reasonable compensation under Section 408(b)(2) applied only to pension funds. The CAA amends Section 408(b)(2) to extend the required annual disclosure of reasonable compensation to group health plans for providers of certain brokerage and consulting services. The disclosure requirements apply to contracts executed, or renewed or extended, on or after December 27, 2021. We will provide more detail on this obligation as guidance is issued.

1. Group Health Plan Covered Service Providers

The disclosure requirement applies to a service provider that reasonably expects to receive $1,000 (with discretion for the DOL to adjust this amount for inflation) or more in compensation, directly or indirectly, in connection with certain "covered services" under its contract or arrangement with a group health plan. For purposes of the $1,000 threshold, all compensation received by the service provider, its affiliates, and its subcontractors in connection with the covered services is aggregated.

The covered services fall into two categories: brokerage services and consulting services. Covered brokerage services are brokerage services with respect to the selection of insurance products (including dental and vision), recordkeeping services, medical management vendor, benefits administration (including dental and vision), stop-loss insurance, PBM services, wellness services, transparency tools and vendors, group purchasing organization preferred vendor panels, disease management vendors and products, compliance services, employee assistance programs, or TPA services. Covered consulting services are consulting services related to the development or implementation of plan design, insurance or insurance product selection, recordkeeping, medical management, benefits administration selection, stop-loss insurance, PBM services, wellness design and management services, transparency tools, group purchasing organization agreements and services, participation in and services from preferred vendor panels, disease management, compliance services, employee assistance programs, or TPA services. This would appear to include most consulting services received by health plans.

2. Compensation

The $1,000 compensation threshold refers to three types of compensation: direct, indirect, and compensation paid among related parties. Compensation is defined in the law as anything of monetary value, excluding non-monetary compensation valued at $250 (adjusted for inflation) or less, in the aggregate, during the term of the contract or arrangement (the "*de minimis* threshold"). "Direct" compensation means compensation received directly from the plan, and "indirect" compensation means compensation received from a source other than the plan, plan sponsor, covered service provider, or affiliate (including a subcontractor, unless the compensation is received in connection with services performed under an arrangement with a subcontractor). Finally, compensation paid among related parties refers to compensation that passes between the service provider and its affiliate or subcontractor that is determined on a transaction basis, such as commissions, finder's fees, or other similar incentive arrangements.

The CAA provides that the $1,000 compensation threshold for determining whether a provider is subject to the disclosure requirements, and the $250 *de minimis* threshold for excluding non-monetary compensation, are based on the compensation the provider expects to receive in connection with providing covered services under the provider's contract or arrangement with the plan. Thus, it appears that the $1,000 threshold and the $250 *de minimis* threshold are based on the term of the contract with the provider, not on a plan year or other basis. This creates disparity between providers with different contract terms. For example, in an instance in which a provider charges a flat fee for the term of the contract, a provider with a two-year contract has, in effect, an annual limit for disclosure purposes of $500, while a provider with a one-year contract term that

renews annually has a limit of $1,000 per year. This disparity could be addressed in future guidance.

3. Service Providers with No Fixed Contract Term

For service providers with contracts or arrangements with no stated term, the provider typically can be terminated by the plan at any time. This raises issues as to how to apply the $1,000 and $250 thresholds to determine if the provider is subject to the disclosure requirements. In the absence of guidance, one reasonable approach would be to consider compensation on a plan year basis for providers with no stated contract term.

4. Compliance Steps

Beginning December 27, 2021, when the plan hires new covered service providers or renews or extends existing contracts, the disclosures required by the CAA must be provided by the provider reasonably in advance of the date on which the contract or arrangement is entered into, extended, or renewed. The CAA does not define the terms "reasonably in advance" or the "date on which the contract or arrangement is entered into." However, in guidance found in the DOL regulations imposing similar disclosure requirements on pension plans, the DOL specifically rejected requests by commentators to use the date that the contract is signed as "the date on which the contract or arrangement is entered into." Absent guidance, we suggest that any requests for proposals for services covered by the law include a request for the required disclosures. We will work with the plan office to review and determine which of the current arrangements are covered by the disclosure requirements and then request that the providers provide the required information in advance of any request for a contract extension or renewal occurring on or after December 27, 2021.

We will continue to monitor developments regarding the requirements described in this memorandum and look forward to discussing these requirements with you.

cc: Co-Counsel (if any)
Benefits Consultant (if any)

20951153v1

SLEVIN & HART, P.C.
Attorneys at Law
WWW.SLEVINHART.COM

1625 Massachusetts Avenue, NW, Suite 450
Washington, DC 20036

14 Wall Street, 20th Floor
New York, NY 10005

MEMORANDUM

To: Self-Insured Health Fund Clients

From: Slevin & Hart, P.C.

Date: March 3, 2021

Re: The No Surprises Act

The No Surprises Act (the "Act"), part of the Consolidated Appropriations Act of 2021, places a number of new coverage and disclosure obligations on self-insured plans.

While many provisions of the Act will require further guidance from various government agencies before they can be implemented, given the significance of the changes, we suggest that the plan's administrative staff begin discussions with the plan's professionals regarding the necessary steps to comply.

Summary of Key Provisions/Actions to Take

- The Act applies to self-insured plans regardless of the plan's grandfathered status under the Affordable Care Act ("ACA"). The Act appears to exclude "excepted benefits" under ERISA and retiree-only plans. Guidance is expected to be issued to confirm this point.

- The Act's requirements are effective for plan years commencing on or after January 1, 2022, unless specifically stated otherwise below.

For Out-Of-Network Covered Services

- The Act provides protections for patients receiving out-of-network services against being balanced billed for the following four types of services ("Covered Services"): (1) out-of-network emergency room services; (2) out-of-network air ambulance services; (3) ancillary services (such as anesthesiology, pathology, radiology and diagnostic services) performed by out-of-network providers at in-network facilities; and (4) other out-of-network non-emergency services performed at in-network facilities when the provider fails to give the appropriate notice to, and does not obtain consent from, a patient.

- If a plan provides any coverage for emergency room services or air ambulance services, plans now must cover such services when performed out-of-network and that coverage must: (1) be subject to cost-sharing or other limitations that are no more restrictive than those that apply for in-network emergency room services (for air ambulance services, the out-of-network cost sharing must be the same as the cost sharing that applies to in-network services); and (2) count all participant cost sharing towards the plan's in-network deductible and in-network out-of-pocket maximum. For out-of-network emergency room services, no prior authorization may apply.

- The third category -- ancillary services -- now must be covered and that coverage must: (1) be subject to cost-sharing or other limitations that are no more restrictive than those that apply at equivalent in-network services; and (2) have all participant cost sharing count towards the plan's in-network deductible and in-network out-of-pocket maximum.

- The fourth category -- non-ancillary out-of-network services performed at in-network facilities if the provider fails to provide the required notice and obtain patient consent -- now must be covered under the same conditions as ancillary services.

- Although the Act gives plans discretion to decide how much should initially be paid for Covered Services, plans should review with their benefit consultants the current methodology for determining the allowed amount, given that: (1) the provider may seek the IDR process if a negotiated price cannot be reached; and (2) for Covered Services (except air ambulance services), the amount of participant cost sharing must be based on a "Recognized Amount" that the agencies are required to develop in guidance to be issued no later than July 1, 2021.

- If there is a dispute over the plan's payment for these Covered Services, plans and providers can either negotiate an agreed-upon amount for those services or be subject to binding independent dispute resolution process ("IDR"). Plans should work with their claims administration vendor to determine the responsibilities associated with defending any IDR challenges to the plan's initial payment.

- Plans are required to make specific disclosures regarding the prohibition against balance billing for Covered Services (except for air ambulance claims). These disclosures must be publicly available upon request and posted on the plan's publicly available website. They also must be included in applicable Explanations of Benefits ("EOBs"), along with contact information to notify an appropriate state and federal agency if these requirements have been violated. Plans should discuss with their claims administration vendor (if not self-administered) how to implement this EOB change.

- Effective January 1, 2022, the ACA's external review requirements apply to Covered Services. Currently, this external review applies only to rescission of coverage and claims involving medical judgment.

Other Disclosure and Administration Requirements

- For all medical services, every provider will be required to send a good faith estimate of the expected charges to plans for any services scheduled at its facility for covered patients. Plans must then provide the patient, within one or three business days,

depending on the circumstances, a paper or electronic copy of an "Advanced Explanation of Benefits" that includes certain information about the expected charges, as well as the provider's estimate. Plans should discuss with their claims administration vendor (if not self-administered) how they will implement this new disclosure.

- Plans must notify participants who are "continuing care patients" when an in-network provider leaves the network and also must permit that participant to elect to continue care with the provider as if the provider was still in-network for at least 90 days. Plans will have to work with their PPO and claims administration vendor to develop a process to implement this requirement.

- Plans must make an in-network provider directory available on a public website; the Act does not specify whether a plan could simply link to a PPO vendor's website containing the provider directory. Plans also must develop a process to update this directory at least every 90 days with current provider information, as well as a process to comply with the obligation to timely revise the directory with updated information received from a provider within two business days of receipt. Finally, plans must also develop a procedure to respond to requests from participants or dependents regarding a provider's in-network status. Failure to comply with these requirements results in a plan being unable to charge cost sharing amounts in excess of what would be charged for an in-network provider and therefore paying more than what is otherwise required under the plan.

- Plans must offer price comparison guidance by telephone and make available a price comparison tool for participants on their website.

- Identification cards issued to participants must include applicable deductibles, out-of-pocket maximums, and a telephone number and internet website where a participant can seek consumer assistance information. If ID cards are generated by a vendor, plans will have to work with that vendor to make sure the ID cards are updated for this requirement.

- Since certain information required under the Act appears to have to be posted on the plan's website, further guidance will be needed to determine if plans must host and maintain its own website or can simply post the information on a third-party vendor's website to satisfy the Act's requirements.

Analysis of Key Provisions/Actions to Take

I. Preventing Surprise Balance Billing for Out-of-Network Covered Services

A. Coverage Rules

1. Emergency Services and Air Ambulance

If a plan provides any coverage for emergency room services or air ambulance services, it also must cover such services if performed by an out-of-network provider. Out-of-network emergency room services must be covered: (1) with cost-sharing that is no greater than the cost-sharing applicable to in-network services (for air ambulance services, cost sharing must be the same); (2) without limitations that are more restrictive than those that would apply to the same

services if rendered at an in-network emergency room; and (3) with any participant cost sharing counting towards the plan's in-network deductible and in-network out-of-pocket maximum (if the in-network deductible and/or out-of-pocket maximum apply to in-network emergency room services). The Act does not explicitly require those cost-sharing amounts (or the cost-sharing amounts for other Covered Services noted below) to also apply to any out-of-network deductible and out-of-network out-of-pocket maximums, and future guidance may clarify this point. The plan also must cover emergency services without any prior authorization requirements. The Act does not appear to extend these rules to ground ambulance services.

Plans that provide coverage for these services should review with their consultants the economic impact of complying with the Act and discuss the impact with the Trustees. Plans will also need to work with their consultants and PPO networks to modify their summary plan descriptions and plan documents as applicable to reflect these new coverage requirements.

2. Out-of-Network Ancillary Services at In-Network Facilities

The Act also applies coverage requirements to "ancillary services" performed by out-of-network providers at a "participating health care facility". A "participating health care facility" means generally an in-network facility and includes a hospital (inpatient or outpatient department) or ambulatory surgery center that has a direct or indirect contractual relationship with the plan. "Ancillary services" are defined as services related to emergency medicine as well as non-emergency anesthesiology, pathology, radiology, neonatology, diagnostic services (including radiology and laboratory services), and specialty practitioner services. (The Act contemplates that additional services may be added as "ancillary services" in future guidance.) Like other Covered Services, these services also may not be subject to any cost-sharing that is greater than the in-network cost-sharing amounts, and all cost-sharing amounts must be counted towards any in-network deductible and/or in-network out-of-pocket maximum (if the in-network deductible and/or out-of-pocket maximum would apply to these services if performed in-network). The coverage requirements also appear to apply to these services when there is no in-network provider available to perform the services at such a facility, though the Act does not specify what this means. Further clarification will be needed regarding which specific out-of-network services at in-network facilities are subject to these requirements.

3. Out-Of-Network Non-Emergency Services at In-Network Facilities Without Notice and Consent

The Act also applies these coverage requirements to other non-emergency services performed by an out-of-network provider at a "participating health care facility" if the provider fails to provide the notice and obtain the consent required under the Act. Like other Covered Services, these services also cannot be subject to greater cost-sharing than the in-network cost-sharing and all cost-sharing amounts must be counted towards any in-network deductible and/or in-network out-of-pocket maximum (if the in-network deductible and/or out-of-pocket maximum would apply if performed in-network).

This requirement appears to mean that, for example, if a facility does not provide the appropriate notice that a surgeon is out-of-network, the provider cannot balance bill the patient and the plan must cover those services as if they were in-network. Absent further guidance, a plan could end up paying more towards a claim because of the provider's failure to give the required information and obtain the required consent.

Consequently, unless a service is a Covered Service under A(2) or A(3) above, the out-of-network services at in-network facilities will not be subject to the Act's requirements. Therefore, if a participant knowingly chooses (i.e., after being given appropriate disclosures) to undergo non-emergency surgery with an out-of-network provider rather than with an in-network provider, it appears that plans can continue to apply their current out-of-network benefit structure (including not covering the charge at all if out-of-network services are generally excluded under the plan), even if it results in a balance bill to the participant.

B. Rules on Calculating Cost Sharing and "Recognized Amount" Allowed for Covered Services

Unless the plan is subject to state law pricing rules, the Act does not specify minimum payment standards regarding the initial amount plans must pay to out-of-network providers for Covered Services (other than the minimum amounts that non-grandfathered plans are required to pay for out-of-network emergency services under the ACA). For self-insured plans, such state laws generally would be preempted under ERISA.

However, for Covered Services (except for air ambulance services), the Act does require that the participant cost sharing amounts be determined as if the total amount paid to the provider is based on a "Recognized Amount." This is generally defined as the median of the in-network rates under the plan's network for a similar item or service provided by a provider in the specialty and located in the same geographic area as the item furnished, consistent with the Secretary's methodology (which has yet to be released). The Act has additional rules regarding how this amount is set when there is no appropriate in-network benchmark under the plan available, but more guidance will be needed to understand exactly how plans are required to implement this rule. The Act requires that guidance be issued no later than July 1, 2021 on the "Recognized Amount" on which a participant's cost sharing must be based.

Once that guidance is issued, the plan will need to work with its benefits consultant and claims administration vendor to: (1) determine whether the methodology required to be used to determine a participant's cost-sharing amount also should be used for determining the plan's initial payment of Covered Services (except for air ambulance services), or if an alternative methodology is appropriate; and (2) amend the summary plan description and plan document as applicable to define the plan's allowed amount for Covered Services consistent with these rules and whatever decisions are made with respect to the methodology.

C. Payment of Initial Claim and Independent Dispute Resolution ("IDR") Process

Once the Act takes effect, providers can no longer balance bill patients for Covered Services. When a plan receives a bill for a Covered Service, it must make payment or issue a denial notice to the provider within 30 days of receipt. (This generally is not a change from current law for post-service claims under the DOL's claims regulations, but it does not appear to allow the additional extended periods for certain circumstances currently permitted under the DOL's claims regulations.) Once the initial payment or denial letter is received, the provider has 30 days to engage in informal negotiations with the plan. Unless the plan and provider are subject to a state law or an All-Payer Agreement under the Social Security Act mandating a specific payment (in which case the IDR appears to be inapplicable), if an agreement is not reached, either the plan or provider will have four days after the end of the 30-day negotiation

period to initiate the IDR process by submitting a notification to the other party and to HHS. The independent decisionmaker's ruling is binding on both parties. The parties can continue to negotiate throughout the IDR process until the IDR entity makes a determination. Since the plan will have already has made its full undisputed payment, as a practical matter, in most cases the provider, and not the plan, will be initiating IDR.

The Act appears to require that the plan and provider each submit an offer, and that the IDR entity, within 30 days, choose one of the two offers as the payment amount. (The Act does not appear to give the IDR entity discretion to select a different amount.) The plan must pay that amount to the provider within 30 days of when the IDR entity makes its decision, minus any required participant cost-sharing. It appears that the party whose offer does not prevail is responsible to pay all administrative costs of the IDR process. However, if the parties settle the matter before the IDR decision, the cost will be split evenly between the parties.

The Act requires that regulations be issued by December 27, 2021 regarding the IDR process. The Act is not clear whether this IDR process must be disclosed in plan documents or otherwise made available to participants. Plans that are subject to the IDR process will need to work with their claims administration vendor to determine the responsibilities associated with handling an IDR inquiry.

II. EOB Disclosures on Protections Against Balance Billing

For Covered Services other than air ambulance services, plans must make information about the prohibitions against balance billing publicly available and posted on the plan's public website. In addition, this information must be included in any EOB issued by a plan for these services, along with contact information for an appropriate state and/or federal agency to be notified if a provider violates the Act's prohibition on balance billing.

Guidance will be needed regarding the exact information that is required for posting on the plan's website and to clarify how the disclosure is to be made "publicly available" since the Act requires that it be posted on a public website. Plans will need to work with their claims administration vendors (if applicable) and website providers to include these required disclosures.

III. Cost Estimates

All healthcare providers, whether in-network or out-of-network, will be required to notify plans of any scheduled service for a covered individual and provide a good faith estimate of the expected charges for services within one business day after the service is scheduled. (If the service is scheduled at least ten business days in advance, the provider will have three business days after the service is scheduled to provide notice.) At the time notice is provided, the provider also must inquire if the patient is covered under the plan and whether the service will be covered.

No later than one business day after receiving the provider's notification (or three business days if the procedure was scheduled at least ten business days prior to the date the service is scheduled to occur), the plan must provide an "Advanced Explanation of Benefits" to the participant in electronic form (with a paper copy if requested) that advises:

- Whether the provider is an in-network provider or facility and,
    - If so, the contracted rate for the item or service,
    - If not, a description of how the participant may obtain information on in-network providers;
- The good faith cost estimate received from the provider;
- A good faith estimate of the amount the plan is responsible for paying for the items or services;
- A good faith estimate of the participant's cost sharing requirements;
- A good faith estimate of the amount the participant has accumulated towards his/her annual deductible and out-of-pocket maximum as of the date of notification;
- To the extent applicable, a disclaimer that coverage for the item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols);
- A disclaimer that the information provided in the notification is only an estimate based on the items and services reasonably expected, at the time of scheduling (or requesting) and is subject to change; and
- Any other information or disclaimer the plan determines appropriate.

For an item or service with low utilization and significant variation in costs, the Act gives HHS the authority to modify the timing requirement for providing this notice.

Absent future guidance to the contrary, this notification is in addition to any disclosures required under the final rule under the ACA regarding Transparency in Coverage, which do not take effect until plan years beginning on or after January 1, 2023.

This is a significant new burden on plan operations, both in terms of the information that must be provided and the one-business-day turnaround for the plan. It is not clear under the Act exactly how the process will work, particularly when the provider does not provide the estimate. Therefore, further guidance is needed to review how to implement this requirement.

IV. Continuity of Care

The Act generally requires that, if an in-network provider leaves the network, plans will be obligated to "timely" notify "a continuing care patient" of the provider's change in status and will be required to allow that participant to continue treatment with that provider for up to 90 days as if the provider were still in-network. While the Act appears to require that the patient notify the plan that he or she wishes to continue treatment, it does not specify when the patient must do this, nor does it define the term "timely" for the purpose of providing this notice. A "continuing care patient" is an individual that is: (1) receiving a course of treatment for a "serious and complex condition;" (2) scheduled to undergo non-elective surgery (including any

post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; or (4) determined to be terminally ill and receiving treatment for the illness. The Act defines a "serious and complex condition" as an acute illness requiring specialized treatment to avoid the reasonable possibility of death or permanent harm, or a chronic illness that is life-threatening, degenerative, potentially disabling, or congenital, and which requires treatment over a prolonged period of time. More guidance will be needed to fully understand the scope of these terms.

Plans will likely need to amend their contracts with PPO network providers to require that the PPO network administrator either provide these notices to participants on behalf of the plan or notify the plan's administrative staff immediately upon a provider leaving the network, along with a list of all covered "continuing care patients" of that provider.

V. Provider Directory Requirements

The Act requires plans to establish a provider directory on a public website listing each provider or facility with which the plan has a direct or indirect contractual relationship. For this purpose, an indirect relationship with a provider appears to exist when a plan contracts with a PPO vendor to provide a network of providers. The provider directory on the public website must include certain information about each in-network provider or facility, including its name, address, specialty, phone number and digital contact information. The Act does not specify whether a plan could simply link to a PPO vendor's website containing the provider directory.

In addition, the plan appears to have two obligations under the Act with respect to updating this provider directory—to develop a process to update and verify the providers at least once every 90 days (along with a procedure to remove a provider when the plan cannot verify its information), and to update the provider information when it is received from a provider. It is not clear from the Act how the plan is expected to independently "verify" that a provider continues to be in the network. However, providers have an independent obligation under the Act to notify plans when their network arrangement begins, when it terminated, and when there are material changes to their contact information that must be provided in the directory. Upon receiving such a notice, the plan must update the directory within two business days.

Plans are also required to update any print copy of the directory with a disclaimer advising that the information was accurate as of the date of publication and that the participant or dependent should consult the provider directory on the public website for the most up-to-date information. We hope further guidance will be issued to clarify whether plans must maintain and furnish print directories given that PPO vendors typically provide access to such directories online.

The plan also has an obligation to respond to an individual inquiring as to a provider's in-network status. If a covered individual requests information regarding a provider's status (whether by telephone, email or otherwise), the plan must respond within one business day in writing (either paper or electronically) and must maintain a record of the communication in the participant's file for at least two years. Plans that are administered by an outside claims administration vendor may delegate this obligation to that vendor in a contract amendment.

Finally, if a plan provides incorrect provider information to a participant or dependent, including as a result of the plan's failure to timely update the provider directory, the plan is prohibited from imposing any cost-sharing requirements that are greater than the cost sharing for

the same service in-network. This cost sharing amount must also be counted towards any required in-network deductible and in-network out-of-pocket maximum.

Many of these requirements will require further guidance to clarify how these requirements must be implemented. Since the PPO vendor typically controls the creation of a provider directory and first knows when a provider ceases to be in-network, we anticipate that plans will have to amend their contracts with PPO vendors to delegate these responsibilities to the PPO vendor, including holding the plan harmless for any violations of this requirement that affect the amount of cost sharing the plan can charge.

VI. Disclosure of OOP Maximums and Deductibles on ID Cards

The Act requires plans to provide updated identification cards that include the following information:

- Any applicable deductible for the plan or coverage;
- Any out-of-pocket maximum limitation applicable to the plan or coverage; and
- A telephone number and internet website where participants may seek consumer assistance information, such as information related to which hospitals and urgent care facilities have a contractual relationship with the plan.

Self-insured plans that rely on outside vendors to provide ID cards will have to confirm that the vendor will comply with these requirements.

VII. In-Network Provider Price Comparison Tool

The Act requires plans to provide price comparison information over the telephone and through an internet tool so that covered individuals can compare their expected out-of-pocket costs for a particular item or service with various in-network providers. Though the Act's language suggests that the tool is applicable only to in-network provider information, we would expect future guidance to clarify whether the tool must cover out-of-network providers as well.

Some of these rules appear to overlap with the requirements of the final rule under the ACA regarding Transparency in Coverage. However, while the ACA transparency rules apply only to non-grandfathered plans, the Act applies to both grandfathered and non-grandfathered plans. Since the Act provides little information regarding how this internet tool is intended to work, future guidance is needed on this requirement, including the interaction with the final rule under the ACA regarding Transparency in Coverage.

VIII. Penalties

The Act does not specify what, if any, penalties can be assessed against a plan for failure to comply with the Act. However, under the Internal Revenue Code, there is a $100 per day excise tax penalty imposed on plans that generally fail to comply with the requirements of the Code that apply to group health plans. Since many provisions of the Act are incorporated into both ERISA and the Code, it would appear that this $100 per day excise tax could be assessed

against a plan that fails to comply with those requirements. We expect further guidance to confirm this point.

IX. External Review of Services Subject to No Surprises Act

The ACA previously required non-grandfathered plans to implement an external review process for denials involving rescissions of coverage and claims involving medical judgment. Effective January 1, 2022, the Act requires non-grandfathered plans to expand the external review process for determinations concerning Covered Services. The Act makes clear that the external review process covers a review of whether a claim is or is not subject to the Act's requirements. This could involve participants challenging the cost-sharing applied to them as incorrect under the Act or a balance bill that the participant believes should have been subject to the prohibitions on balance billing under the Act. Grandfathered plans remain exempt from external review requirements. If the plan's summary plan description or plan document specifies the types of claims that are subject to external review procedures, it will need to be updated.

We will continue to keep you updated as guidance is issued. In the meantime, please contact us with any questions.

cc: Co-Counsel (if any)

20949557v1

ADMINISTRATIVE MANAGER'S REPORT

FELRA & UFCW

ACTIVE HEALTH PLAN

FIRST QUARTER 2021

ADMINISTRATIVE MANAGER'S REPORT

PLAN I
FULL TIME
FIRST QUARTER 2021

CONTRIBUTIONS

COMPANY	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT[1]	$1,834.50	318	$631,741
SAFEWAY[1]	$1,840.97	215	84,512
EMPLOYER CONTRIBUTION INCOME - RETIREE PLAN[2]			3,944,050
TOTAL		533	$4,660,303

[1]CREDIT APPLIED BASED ON THE REDUCTION TO A TWO-MONTH RESERVE AS NEGOTIATED 12/2020 - GIANT - $574,199, SAFEWAY - $393,968

[2]PLAN I RETIREE RELATED INCOME THAT IS INCLUDED IN PLAN X MOB CALCULATION IS REPORTED ON THE PLAN INCOME PAGE, AS IT IS PLAN I RELATED INCOME.

PLAN I
FULL TIME
FIRST QUARTER 2021

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL BENEFIT 24	$4.95	$4,594		309 PART
OPTICAL BENEFIT 12	$6.95	4,748		228 PART
TOTAL OPTICAL		$9,342	$5.84	
DENTAL INDIVIDUAL[1]	$27.76	$21,347		256 PART
DENTAL FAMILY[1]	$55.02	46,273		280 PART
TOTAL DENTAL		$67,620	$42.29	
DRUG	$.80/SCRIPT	$489,609	$306.20	4,569 SCRIPTS
HMO KAISER	$2,260.77	$20,347		3 PART
HOSPITAL		1,700		
SURGICAL		16,085		
DIAGNOSTIC		17,893		
MAJOR MEDICAL		1,328,882		
MEDICAL ADMINISTRATION	$14.58	23,255		532 PART
TOTAL MEDICAL		$1,408,162	$880.65	
BEHAVIORAL HEALTH	$2.59	$4,144	$2.59	533 PART
BEHAVIORAL HEALTH		$84,575	$52.89	
E.A.P	$.67	$1,072	$0.67	533 PART
UM/DM	$1.03/2.80	$11,276	$7.05	531 PART
PRESCRIPTION CARE MNGMT	$0.65	$1,774	$1.11	534 PART
P.P.O. CAREFIRST FLEXLINK[1]	$23.55	$10,308	$6.45	143 PART
P.P.O. CAREFIRST NETWORK[1]	$4.66	$5,583	$3.49	399 PART
HRGI/A&G CLAIM DISCOUNTER		$812	$0.51	
LIFE-AD&D	$.183/.018/1000	$5,274	$3.30	541 PART
A & S		$140,586	$87.92	
SUB TOTAL		$2,240,137	$1,400.96	

OPERATING EXPENSES

ADMINISTRATION	$14.23	$24,206	$15.14	566 PART
MISCELLANEOUS		$11,959	$7.48	
SUB TOTAL		$36,165	$22.62	

TOTAL	**$2,276,302**	**$1,423.58**

[1]RATE CHANGE EFFECTIVE JANUARY 2021

PLAN I
FULL TIME
FIRST QUARTER 2021

QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTR - ACTIVE	$1,221,714				$1,221,714
EMPLOYER CONTR - RETIREE	3,438,589				3,438,589
MISC. INCOME - RETIREE	862,085				862,085
-LOA	0				0
-COBRA	4,314				4,314
-HMO COPAY	7,079				7,079
TOTAL	$5,533,781	$0	$0	$0	$5,533,781
EXPENSES					
MEDICAL	$1,408,162				$1,408,162
RETIREE	3,293,195				3,293,195
A & S	140,586				140,586
DENTAL	67,620				67,620
DRUG	489,609				489,609
BEHAVIORAL HEALTH	88,719				88,719
OPTICAL	9,342				9,342
LIFE & AD & D	5,274				5,274
UM/DM	11,276				11,276
PRESCRIPTION CARE MNGMT	1,774				1,774
E.A.P.	1,072				1,072
P.P.O.	16,703				16,703
OPERATING EXPENSE	36,165				36,165
TOTAL EXPENSE	$5,569,497	$0	$0	$0	$5,569,497
SURPLUS (DEFICIT)	**($35,716)**	**$0**	**$0**	**$0**	**($35,716)**
AVERAGE INCOME	$3,461	$0	$0	$0	3461
AVERAGE EXPENSE	$3,483	$0	$0	$0	3483
SURPLUS (DEFICIT)	($22)	$0	$0	$0	($22)
TOTAL PARTICIPANTS	533				533

PLAN I
FULL TIME
2020

QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTR - ACTIVE	$2,525,401	$2,567,773	$2,705,912	$2,117,700	$9,916,786
EMPLOYER CONTR - RETIREE	3,596,382	3,493,381	3,517,327	3,509,736	14,116,826
MISC. INCOME-DENTAL	0	0	0	0	0
-RETIREE	896,294	875,631	873,258	865,020	3,510,203
-LOA	0	0	0	0	0
-COBRA	6,721	11,201	6,516	2,876	27,314
-HMO COPAY	8,821	11,026	9,216	10,387	39,450
TOTAL	$7,033,619	$6,959,012	$7,112,229	$6,505,719	$27,610,579
EXPENSES					
MEDICAL	$1,348,808	$1,387,643	$1,048,873	$1,794,324	$5,579,648
RETIREE	4,081,068	3,076,447	3,861,042	3,282,215	14,300,772
A & S	214,514	159,050	115,290	154,855	643,709
DENTAL	77,374	76,353	64,156	71,722	289,605
DRUG	734,244	478,191	536,468	440,933	2,189,836
BEHAVIORAL HEALTH	30,175	73,365	43,802	68,261	215,603
OPTICAL	10,171	10,064	9,768	9,513	39,516
LIFE & AD & D	5,735	5,676	5,566	5,381	22,358
UM/DM	12,683	12,527	11,404	11,637	48,251
PRESCRIPTION CARE MNGMT	0	655	1,918	1,848	4,421
E.A.P.	1,172	1,158	1,124	1,094	4,548
P.P.O.	16,844	16,533	15,773	15,563	64,713
OPERATING EXPENSE	34,389	41,066	33,132	33,263	141,850
TOTAL EXPENSE	$6,567,177	$5,338,728	$5,748,316	$5,890,609	$23,544,830
SURPLUS (DEFICIT)	**$466,442**	**$1,620,284**	**$1,363,913**	**$615,110**	**$4,065,749**
AVERAGE INCOME	$4,042	$4,098	$4,287	$3,914	$4,085
AVERAGE EXPENSE	$3,774	$3,144	$3,465	$3,544	$3,482
SURPLUS (DEFICIT)	$268	$954	$822	$370	$603
TOTAL PARTICIPANTS	580	566	553	554	563

PLAN I
FULL TIME
2021

QUARTERLY RECAPS - ACTIVE

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTR - ACTIVE	$1,221,714				$1,221,714
MISC. INCOME - LOA	0				0
-COBRA	4,314				4,314
-HMO COPAY	7,079				7,079
TOTAL	$1,233,107	$0	$0	$0	$1,233,107
EXPENSES					
MEDICAL	$1,408,162				$1,408,162
A & S	140,586				140,586
DENTAL	67,620				67,620
DRUG	489,609				489,609
BEHAVIORAL HEALTH	88,719				88,719
OPTICAL	9,342				9,342
LIFE & AD & D	5,274				5,274
UM/DM	11,276				11,276
PRESCRIPTION CARE MNGMT	1,774				1,774
E.A.P.	1,072				1,072
P.P.O.	16,703				16,703
OPERATING EXPENSE	36,165				36,165
TOTAL EXPENSE	$2,276,302	$0	$0	$0	$2,276,302
SURPLUS (DEFICIT)	**($1,043,195)**	**$0**	**$0**	**$0**	**($1,043,195)**
AVERAGE INCOME	$771				771
AVERAGE EXPENSE	$1,424				1424
SURPLUS (DEFICIT)	($653)	$0	$0	$0	($653)
TOTAL PARTICIPANTS	533				533

PLAN I
PART TIME
FIRST QUARTER 2021

CONTRIBUTIONS

COMPANY	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT[1]	$1,022.25	72	$33,982
SAFEWAY[1]	$1,028.72	18	(46,555)
EMPLOYER CONTRIBUTION INCOME - RETIREE PLAN[2]			665,975
TOTAL		90	$653,402

[1]CREDIT APPLIED BASED ON THE REDUCTION TO A TWO-MONTH RESERVE AS NEGOTIATED 12/2020 - GIANT - $72,580, SAFEWAY - $17,488

[2]PLAN I RETIREE RELATED INCOME THAT IS INCLUDED IN PLAN X MOB CALCULATION IS REPORTED ON THE PLAN INCOME PAGE, AS IT IS PLAN I RELATED INCOME.

PLAN I
PART TIME
FIRST QUARTER 2021

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL BENEFIT 24	$4.95	$752		51 PART
OPTICAL BENEFIT 12	$6.95	660		35 PART
TOTAL OPTICAL		$1,412	$5.23	
DENTAL INDIVIDUAL[1]	$27.76	$3,609		43 PART
DENTAL FAMILY[1]	$55.02	7,098		43 PART
TOTAL DENTAL		$10,707	$39.66	
DRUG	$.80/SCRIPT	$47,925	$177.50	771 SCRIPTS
HMO KAISER	$2,158.91	$0		
HOSPITAL		0		
SURGICAL		2,948		
DIAGNOSTIC		3,625		
MAJOR MEDICAL		199,066		
MEDICAL ADMINISTRATION	$14.58	3,732		85 PART
TOTAL MEDICAL		$209,371	$775.45	
BEHAVIORAL HEALTH	$2.59	$668	$2.47	86 PART
BEHAVIORAL HEALTH		$2,645	$9.80	
E.A.P.	$.67	$172	$0.64	86 PART
UM/DM	$1.03/2.80	$1,673	$6.20	85 PART
PRESCRIPTION CARE MNGMT	$0.65	$265	$0.98	85 PART
P.P.O. CAREFIRST FLEXLINK[1]	$23.55	$1,709	$6.33	24 PART
P.P.O. CAREFIRST NETWORK[1]	$4.66	$899	$3.33	64 PART
HRGI/A&G CLAIM DISCOUNTER		$138	$0.51	
LIFE-AD&D	$.183/.018/1000	$365	$1.35	87 PART
A & S		$8,741	$32.37	
SUB TOTAL		**$286,690**	$1,061.82	

OPERATING EXPENSES

ADMINISTRATION	$14.23	$4,013	$14.86	94 PART
MISCELLANEOUS		$2,020	$7.48	
SUB TOTAL		$6,033	$22.34	

TOTAL	**$292,723**	**$1,084.16**

[1]RATE CHANGE EFFECTIVE JANUARY 2021

PLAN I
PART TIME
FIRST QUARTER 2021

QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTR - ACTIVE	$109,815				$109,815
EMPLOYER CONTR - RETIREE	543,587				543,587
MISC. INCOME - RETIREE	183,461				183,461
-LOA	0				0
-COBRA	0				0
-HMO COPAY	0				0
TOTAL	$836,863	$0	$0	$0	$836,863
EXPENSES					
MEDICAL	$209,371				$209,371
RETIREE	592,548				592,548
A & S	8,741				8,741
DENTAL	10,707				10,707
DRUG	47,925				47,925
BEHAVIORAL HEALTH	3,313				3,313
OPTICAL	1,412				1,412
LIFE & AD & D	365				365
UM/DM	1,673				1,673
PRESCRIPTION CARE MNGMT	265				265
E.A.P.	172				172
P.P.O.	2,746				2,746
OPERATING EXPENSE	6,033				6,033
TOTAL EXPENSE	$885,271	$0	$0	$0	$885,271
SURPLUS (DEFICIT)	**($48,408)**	**$0**	**$0**	**$0**	**($48,408)**
AVERAGE INCOME	$3,099	$0	$0	$0	3099
AVERAGE EXPENSE	$3,279	$0	$0	$0	3279
SURPLUS (DEFICIT)	($180)	$0	$0	$0	($180)
TOTAL PARTICIPANTS	90				90

PLAN I
PART TIME
2020

QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTR - ACTIVE	$423,815	$343,261	$220,971	$153,533	$1,141,580
EMPLOYER CONTR - RETIREE	629,409	568,297	542,227	555,884	2,295,817
MISC. INCOME-DENTAL	0	0	0	0	0
-RETIREE	188,985	184,950	185,890	185,145	744,970
-LOA	0	0	0	0	0
-COBRA	0	0	0	0	0
-HMO COPAY	0	0	0	0	0
TOTAL	$1,242,209	$1,096,508	$949,088	$894,562	$4,182,367
EXPENSES					
MEDICAL	$223,373	$87,453	$260,383	$365,486	$936,695
RETIREE	657,758	523,097	605,049	572,277	2,358,181
A & S	9,735	10,382	13,941	5,007	39,065
DENTAL	12,633	12,293	9,979	11,549	46,454
DRUG	61,341	31,376	52,173	42,360	187,250
BEHAVIORAL HEALTH	5,933	6,707	2,095	3,520	18,255
OPTICAL	1,737	1,705	1,596	1,569	6,607
LIFE & AD & D	416	415	394	381	1,606
UM/DM	1,876	1,835	2,173	1,776	7,660
PRESCRIPTION CARE MNGMT	0	94	282	283	659
E.A.P.	201	196	185	181	763
P.P.O.	2,851	2,826	2,788	2,631	11,096
OPERATING EXPENSE	6,242	7,234	5,616	5,565	24,657
TOTAL EXPENSE	$984,096	$685,613	$956,654	$1,012,585	$3,638,948
SURPLUS (DEFICIT)	**$258,113**	**$410,895**	**($7,566)**	**($118,023)**	**$543,419**
AVERAGE INCOME	$3,906	$3,730	$3,439	$3,172	$3,562
AVERAGE EXPENSE	$3,095	$2,332	$3,466	$3,591	$3,121
SURPLUS (DEFICIT)	$811	$1,398	($27)	($419)	$441
TOTAL PARTICIPANTS	106	98	92	94	98

PLAN I
PART TIME
2021

QUARTERLY RECAPS - ACTIVE

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTR - ACTIVE	$109,815				$109,815
MISC. INCOME - LOA	0				0
-COBRA	0				0
-HMO COPAY	0				0
TOTAL	$109,815	$0	$0	$0	$109,815
EXPENSES					
MEDICAL	$209,371				$209,371
A & S	8,741				8,741
DENTAL	10,707				10,707
DRUG	47,925				47,925
BEHAVIORAL HEALTH	3,313				3,313
OPTICAL	1,412				1,412
LIFE & AD & D	365				365
UM/DM	1,673				1,673
PRESCRIPTION CARE MNGMT	265				265
E.A.P.	172				172
P.P.O.	2,746				2,746
OPERATING EXPENSE	6,033				6,033
TOTAL EXPENSE	$292,723	$0	$0	$0	$292,723
SURPLUS (DEFICIT)	**($182,908)**	**$0**	**$0**	**$0**	**($182,908)**
AVERAGE INCOME	$407				407
AVERAGE EXPENSE	$1,084				1084
SURPLUS (DEFICIT)	($677)	$0	$0	$0	($677)
TOTAL PARTICIPANTS	90			0	90

PLAN X
FULL TIME
FIRST QUARTER 2021

CONTRIBUTIONS

COMPANY	RATE	PARTICIPANTS	CONTRIBUTIONS
ASSOCIATED ADMINISTRATORS	$918.75	56	$134,812
GIANT	$1,138.75	2,536	8,600,598
LOCAL 400 STAFF TEMPS	$1,138.75	0	0
SAFEWAY[1]	$1,145.22	1,547	3,428,251
SAFEWAY DELAWARE[1]	$1,145.22	45	51,535
EMPLOYER CONTRIBUTION INCOME - RETIREE PLAN[2]			(3,944,050)
TOTAL		4,184	$8,271,146

[1]CREDIT APPLIED BASED ON THE REDUCTION TO A TWO-MONTH RESERVE AS NEGOTIATED 12/2020 - SAFEWAY - $1,334,181, SAFEWAY DELAWARE - $103,070

[2]PLAN I RETIREE RELATED INCOME THAT IS INCLUDED IN PLAN X MOB CALCULATION IS REPORTED ON THE PLAN INCOME PAGE, AS IT IS PLAN I RELATED INCOME.

PLAN X
FULL TIME
FIRST QUARTER 2021

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL	$4.95	$62,132	$4.95	4,182 PART
DENTAL FAMILY[1]	$57.97	$364,457		2,096 PART
DENTAL INDIVIDUAL[1]	$28.17	176,288		2,086 PART
TOTAL DENTAL		$540,745	$43.08	
DRUG	$.80/SCRIPT	$3,144,637	$250.53	27,417 SCRIPTS
HMO KAISER	$1,439.37	$112,271		26 PART
MEDICAL INDIVIDUAL		4,338,395		
MEDICAL FAMILY		5,256,463		
MEDICAL ADMINISTRATION	$14.58	181,667		4,153 PART
TOTAL MEDICAL		$9,888,796	$787.83	
BEHAVIORAL HEALTH	$2.59	$32,292	$2.57	4,156 PART
BEHAVIORAL HEALTH		$130,648	$10.41	
E.A.P.	$0.67	$8,354	$0.67	4,156 PART
UM/DM	$1.03/2.80	$98,052	$7.81	4,151 PART
PRESCRIPTION CARE MNGMT	$0.65	$15,522	$1.24	4,179 PART
P.P.O. CAREFIRST FLEXLINK[1]	$23.55	$73,666	$5.87	1,019 PART
P.P.O. CAREFIRST NETWORK[1]	$4.66	$44,377	$3.54	3,174 PART
HRGI/A&G CLAIM DISCOUNTER		$6,372	$0.51	
LIFE-AD&D	$.183/.018/1000	$18,402	$1.47	4,194 PART
A & S		$758,138	$60.40	
SUB TOTAL		**$14,822,133**	$1,180.88	

OPERATING EXPENSES

ADMINISTRATION	$14.23	$185,873	$14.81	4,343 PART
MISCELLANEOUS		$93,879	$7.48	
SUB TOTAL		$279,752	$22.29	
TOTAL		**$15,101,885**	**$1,203.17**	

[1]RATE CHANGE EFFECTIVE JANUARY 2021

PLAN X
FULL TIME
FIRST QUARTER 2021

QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$8,271,146				$8,271,146
MISC. INCOME - LOA	0				0
-COBRA	28,826				28,826
-HMO COPAY	73,649				73,649
TOTAL INCOME	$8,373,621	$0	$0	$0	$8,373,621
EXPENSES					
MEDICAL	$9,888,796				$9,888,796
A & S	758,138				758,138
DENTAL	540,745				540,745
DRUG	3,144,637				3,144,637
BEHAVIORAL HEALTH	162,940				162,940
OPTICAL	62,132				62,132
LIFE & AD & D	18,402				18,402
UM/DM	98,052				98,052
PRESCRIPTION CARE MNGMT	15,522				15,522
E.A.P.	8,354				8,354
P.P.O.	124,415				124,415
OPERATING EXPENSE	279,752				279,752
TOTAL EXPENSE	$15,101,885	$0	$0	$0	$15,101,885
SURPLUS (DEFICIT)	**($6,728,264)**	**$0**	**$0**	**$0**	**($6,728,264)**
AVERAGE INCOME	$667	$0	$0	$0	667
AVERAGE EXPENSE	$1,203	$0	$0	$0	1203
SURPLUS (DEFICIT)	($536)	$0	$0	$0	($536)
TOTAL PARTICIPANTS	4,184				4,184

PLAN X
FULL TIME
2020

QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTRIBUTIONS	$10,473,534	$10,420,388	$10,520,103	$7,590,170	$39,004,195
MISC. INCOME-LOA	0	0	0	0	0
-COBRA	35,750	29,053	31,444	40,741	136,988
-HMO COPAY	88,194	93,080	78,388	73,610	333,272
TOTAL INCOME	$10,597,478	$10,542,521	$10,629,935	$7,704,521	$39,474,455
EXPENSES					
MEDICAL	$8,826,263	$7,264,084	$8,873,849	$8,388,973	$33,353,169
A & S	843,094	803,809	698,523	797,897	3,143,323
DENTAL	590,163	582,628	501,610	569,317	2,243,718
DRUG	2,842,090	2,069,985	3,055,920	2,646,536	10,614,531
BEHAVIORAL HEALTH	138,751	149,761	164,481	139,597	592,590
OPTICAL	64,702	64,004	63,276	62,672	254,654
LIFE & AD & D	19,149	19,025	18,806	18,615	75,595
UM/DM	103,626	103,172	100,372	100,496	407,666
PRESCRIPTION CARE MNGMT	0	5,498	16,287	16,023	37,808
E.A.P.	8,685	8,602	8,493	8,424	34,204
P.P.O.	118,463	118,025	114,489	114,705	465,682
OPERATING EXPENSE	256,956	310,410	252,645	256,585	1,076,596
TOTAL EXPENSE	$13,811,942	$11,499,003	$13,868,751	$13,119,840	$52,299,536
SURPLUS (DEFICIT)	**($3,214,464)**	**($956,482)**	**($3,238,816)**	**($5,415,319)**	**($12,825,081)**
AVERAGE INCOME	$804	$815	$827	$599	$761
AVERAGE EXPENSE	$1,048	$889	$1,080	$1,020	$1,009
SURPLUS (DEFICIT)	($244)	($74)	($253)	($421)	($248)
TOTAL PARTICIPANTS	4,395	4,310	4,282	4,286	4,318

PLAN X
FULL TIME
2021

QUARTERLY RECAPS - ACTIVE

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$8,271,146				$8,271,146
MISC. INCOME-LOA	0				0
-COBRA	28,826				28,826
-HMO COPAY	73,649				73,649
TOTAL INCOME	$8,373,621	$0	$0	$0	$8,373,621
EXPENSES					
MEDICAL	$9,888,796				$9,888,796
A & S	758,138				758,138
DENTAL	540,745				540,745
DRUG	3,144,637				3,144,637
BEHAVIORAL HEALTH	162,940				162,940
OPTICAL	62,132				62,132
LIFE & AD & D	18,402				18,402
UM/DM	98,052				98,052
PRESCRIPTION CARE MNGMT	15,522				15,522
E.A.P.	8,354				8,354
P.P.O.	124,415				124,415
OPERATING EXPENSE	279,752				279,752
TOTAL EXPENSE	$15,101,885	$0	$0	$0	$15,101,885
SURPLUS (DEFICIT)	**($6,728,264)**	**$0**	**$0**	**$0**	**($6,728,264)**
AVERAGE INCOME	$667				667
AVERAGE EXPENSE	$1,203				1203
SURPLUS (DEFICIT)	($536)	$0	$0	$0	($536)
TOTAL PARTICIPANTS	4,184				4,184

PLAN X
PART TIME
FIRST QUARTER 2021

CONTRIBUTIONS
INDIVIDUAL

COMPANY	RATE	PARTICIPANTS	CONTRIBUTIONS
ASSOCIATED ADMINISTRATORS	$544.00	1	$1,632
GIANT	$764.00	1,720	3,942,240
SAFEWAY[1]	$770.47	651	999,300
SAFEWAY DELAWARE[1]	$770.47	32	49,310
LOCAL 400 STAFF TEMPS	$764.00	0	0
EMPLOYER CONTRIBUTION INCOME - RETIREE PLAN[2]			(515,787)
TOTAL		2,404	$4,476,695

[1]CREDIT APPLIED BASED ON THE REDUCTION TO A TWO-MONTH RESERVE AS NEGOTIATED 12/2020 - SAFEWAY - $504,657, SAFEWAY DELAWARE - $25,426

[2]PLAN I RETIREE RELATED INCOME THAT IS INCLUDED IN PLAN X MOB CALCULATION IS REPORTED ON THE PLAN INCOME PAGE, AS IT IS PLAN I RELATED INCOME.

PLAN X
PART TIME
FIRST QUARTER 2021

BENEFIT EXPENSES
INDIVIDUAL

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL	$4.95	$32,917	$4.56	2,284 PART
DENTAL[1]	$28.17	$193,049	$26.77	2,284 PART
DRUG	$.80/SCRIPT	$1,324,898	$183.71	10,535 SCRIPTS
HMO KAISER	$1,036.71	$21,771		7 PART
MEDICAL		2,634,211		
MEDICAL ADMINISTRATION	$14.58	99,815		2,282 PART
TOTAL MEDICAL		$2,755,797	$382.11	
BEHAVIORAL HEALTH	$2.59	$17,669	$2.45	2,274 PART
BEHAVIORAL HEALTH		$48,054	$6.66	
E.A.P.	$0.67	$4,571	$0.63	2,274 PART
UM/DM	$1.03/2.80	$28,270	$3.92	2,281 PART
PRESCRIPTION CARE MNGMT	$0.65	$4,427	$0.61	2,276 PART
P.P.O. CAREFIRST FLEXLINK[1]	$23.55	$34,072	$4.72	471 PART
P.P.O. CAREFIRST NETWORK[1]	$4.66	$25,788	$3.58	1,845 PART
HRGI/A&G CLAIM DISCOUNTER		$3,660	$0.51	
LIFE-AD&D	$.183/.018/1000	$6,659	$0.92	2,312 PART
A & S		$197,775	$27.42	
SUB TOTAL		**$4,677,606**	$648.57	

OPERATING EXPENSES

ADMINISTRATION	$14.23	$107,137	$14.86	2,494 PART
MISCELLANEOUS		$53,941	$7.48	
SUB TOTAL		$161,078	$22.34	

TOTAL	**$4,838,684**	**$670.91**

[1]RATE CHANGE EFFECTIVE JANUARY 2021

PLAN X
PART TIME
FIRST QUARTER 2021

INDIVIDUAL
QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$4,476,695				$4,476,695
MISC. INCOME - LOA	0				0
-COBRA	39,198				39,198
-HMO COPAY	15,426				15,426
TOTAL INCOME	$4,531,319	$0	$0	$0	$4,531,319
EXPENSES					
MEDICAL	$2,755,797				$2,755,797
A & S	197,775				197,775
DENTAL	193,049				193,049
DRUG	1,324,898				1,324,898
BEHAVIORAL HEALTH	65,723				65,723
OPTICAL	32,917				32,917
LIFE & AD & D	6,659				6,659
UM/DM	28,270				28,270
PRESCRIPTION CARE MNGMT	4,427				4,427
E.A.P.	4,571				4,571
P.P.O.	63,520				63,520
OPERATING EXPENSES	161,078				161,078
TOTAL EXPENSE	$4,838,684	$0	$0	$0	$4,838,684
SURPLUS (DEFICIT)	**($307,365)**	**$0**	**$0**	**$0**	**($307,365)**
AVERAGE INCOME	$628	$0	$0	$0	628
AVERAGE EXPENSE	$671	$0	$0	$0	671
SURPLUS (DEFICIT)	($43)	$0	$0	$0	($43)
TOTAL PARTICIPANTS	2,404				2,404

PLAN X
PART TIME
2020

INDIVIDUAL
QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTRIBUTIONS	$5,742,567	$5,360,572	$5,259,183	$3,800,881	$20,163,203
MISC. INCOME-LOA	0	0	0	0	0
-COBRA	30,752	37,014	43,273	53,802	164,841
-HMO COPAY	13,309	12,704	12,776	9,907	48,696
TOTAL INCOME	$5,786,628	$5,410,290	$5,315,232	$3,864,590	$20,376,740
EXPENSES					
MEDICAL	$2,835,289	$3,057,858	$1,929,782	$3,233,193	$11,056,122
A & S	161,845	180,744	200,130	202,882	745,601
DENTAL	221,488	215,767	165,123	202,060	804,438
DRUG	961,376	720,375	1,024,183	1,173,467	3,879,401
BEHAVIORAL HEALTH	46,784	25,169	35,455	26,640	134,048
OPTICAL	37,769	36,793	35,200	34,458	144,220
LIFE & AD & D	7,428	7,265	6,975	6,775	28,443
UM/DM	30,806	30,377	28,811	28,635	118,629
PRESCRIPTION CARE MNGMT	0	1,563	4,613	4,527	10,703
E.A.P.	5,124	4,975	4,762	4,663	19,524
P.P.O.	65,755	64,102	59,805	58,386	248,048
OPERATING EXPENSES	159,341	186,866	148,719	150,465	645,391
TOTAL EXPENSE	$4,533,005	$4,531,854	$3,643,558	$5,126,151	$17,834,568
SURPLUS (DEFICIT)	**$1,253,623**	**$878,436**	**$1,671,674**	**($1,261,561)**	**$2,542,172**
AVERAGE INCOME	$715	$711	$704	$521	$663
AVERAGE EXPENSE	$560	$596	$482	$691	$582
SURPLUS (DEFICIT)	$155	$115	$222	($170)	$81
TOTAL PARTICIPANTS	2,699	2,535	2,518	2,474	2,557

PLAN X
PART TIME
2021

INDIVIDUAL
QUARTERLY RECAPS - ACTIVE

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$4,476,695				$4,476,695
MISC. INCOME-LOA	0				0
-COBRA	39,198				39,198
-HMO COPAY	15,426				15,426
TOTAL INCOME	$4,531,319	$0	$0	$0	$4,531,319
EXPENSES					
MEDICAL	$2,755,797				$2,755,797
A & S	197,775				197,775
DENTAL	193,049				193,049
DRUG	1,324,898				1,324,898
BEHAVIORAL HEALTH	65,723				65,723
OPTICAL	32,917				32,917
LIFE & AD & D	6,659				6,659
UM/DM	28,270				28,270
PRESCRIPTION CARE MNGMT	4,427				4,427
E.A.P.	4,571				4,571
P.P.O.	63,520				63,520
OPERATING EXPENSES	161,078				161,078
TOTAL EXPENSE	$4,838,684	$0	$0	$0	$4,838,684
SURPLUS (DEFICIT)	**($307,365)**	**$0**	**$0**	**$0**	**($307,365)**
AVERAGE INCOME	$628				628
AVERAGE EXPENSE	$671				671
SURPLUS (DEFICIT)	($43)	$0	$0	$0	($43)
TOTAL PARTICIPANTS	2,404				2,404

PLAN X
PART TIME
FIRST QUARTER 2021

CONTRIBUTIONS
DEPENDENT

COMPANY	RATE	PARTICIPANTS	CONTRIBUTIONS
ASSOCIATED ADMINISTRATORS	$1,316.00	0	$0
GIANT	$1,536.00	539	2,485,248
SAFEWAY[1]	$1,542.47	153	458,911
SAFEWAY DELAWARE[1]	$1,542.47	8	24,680
EMPLOYER CONTRIBUTION INCOME - RETIREE PLAN[2]			(150,188)
TOTAL		700	$2,818,651

[1]CREDIT APPLIED BASED ON THE REDUCTION TO A TWO-MONTH RESERVE AS NEGOTIATED 12/2020 - SAFEWAY - $237,540, SAFEWAY DELAWARE - $12,340

[1]PLAN I RETIREE RELATED INCOME THAT IS INCLUDED IN PLAN X MOB CALCULATION IS REPORTED ON THE PLAN INCOME PAGE, AS IT IS PLAN I RELATED INCOME.

PLAN X
PART TIME
FIRST QUARTER 2021

BENEFIT EXPENSES
DEPENDENT

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL	$4.95	$10,222	$4.87	714 PART
DENTAL[1]	$57.97	$124,055	$59.07	713 PART
DRUG	$.80/SCRIPT	$789,680	$376.04	7,286 SCRIPTS
HMO KAISER	$1,807.09	$32,528		6 PART
MEDICAL		1,974,152		
MEDICAL ADMINISTRATION	$14.58	31,012		709 PART
TOTAL MEDICAL		$2,037,692	$970.33	
BEHAVIORAL HEALTH	$2.59	$5,486	$2.61	706 PART
BEHAVIORAL HEALTH		$5,125	$2.44	
E.A.P.	$.67	$1,419	$0.68	706 PART
UM/DM	$1.03/2.80	$23,957	$11.41	708 PART
PRESCRIPTION CARE MNGMT	$0.65	$3,788	$1.80	714 PART
P.P.O. CAREFIRST FLEXLINK[1]	$23.55	$12,405	$5.91	172 PART
P.P.O. CAREFIRST NETWORK[1]	$4.66	$7,619	$3.63	545 PART
HRGI/A&G CLAIM DISCOUNTER		$1,066	$0.51	
LIFE-AD&D	$.183/.018/1000	$2,040	$0.97	708 PART
A & S		$74,565	$35.51	
SUB TOTAL		**$3,099,119**	$1,475.78	

OPERATING EXPENSES

ADMINISTRATION	$14.23	$31,562	$15.03	739 PART
MISCELLANEOUS		$15,707	$7.48	
SUB TOTAL		$47,269	$22.51	

TOTAL	**$3,146,388**	**$1,498.29**

[1]RATE CHANGE EFFECTIVE JANUARY 2021

PLAN X
PART TIME
FIRST QUARTER 2021

DEPENDENT
QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$2,818,651				$2,818,651
MISC. INCOME - LOA	0				0
-COBRA	0				0
-HMO COPAY	17,587				17,587
TOTAL INCOME	$2,836,238	$0	$0	$0	$2,836,238
EXPENSES					
MEDICAL	$2,037,692				$2,037,692
A & S	74,565				74,565
DENTAL	124,055				124,055
DRUG	789,680				789,680
BEHAVIORAL HEALTH	10,611				10,611
OPTICAL	10,222				10,222
LIFE & AD & D	2,040				2,040
UM/DM	23,957				23,957
PRESCRIPTION CARE MNGMT	3,788				3,788
E.A.P.	1,419				1,419
P.P.O.	21,090				21,090
OPERATING EXPENSE	47,269				47,269
TOTAL EXPENSE	$3,146,388	$0	$0	$0	$3,146,388
SURPLUS (DEFICIT)	**($310,150)**	**$0**	**$0**	**$0**	**($310,150)**
AVERAGE INCOME	$1,351	$0	$0	$0	1351
AVERAGE EXPENSE	$1,498	$0	$0	$0	1498
SURPLUS (DEFICIT)	($147)	$0	$0	$0	($147)
TOTAL PARTICIPANTS	700				700

PLAN X
PART TIME
2020

DEPENDENT
QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTRIBUTIONS	$3,319,396	$3,177,544	$3,273,083	$2,358,751	$12,128,774
MISC. INCOME -LOA	0	0	0	0	0
-COBRA	0	0	0	0	0
-HMO COPAY	20,349	24,933	21,934	18,908	86,124
TOTAL INCOME	$3,339,745	$3,202,477	$3,295,017	$2,377,659	$12,214,898
EXPENSES					
MEDICAL	$2,376,707	$2,041,273	$2,096,803	$1,961,902	$8,476,685
A & S	77,091	84,398	76,498	46,199	284,186
DENTAL	141,034	137,926	120,596	132,309	531,865
DRUG	926,002	533,021	716,695	623,457	2,799,175
BEHAVIORAL HEALTH	12,630	16,812	13,945	13,648	57,035
OPTICAL	11,682	11,424	11,043	10,979	45,128
LIFE & AD & D	2,272	2,208	2,130	2,091	8,701
UM/DM	26,073	25,735	24,775	24,770	101,353
PRESCRIPTION CARE MNGMT	0	1,353	4,011	3,966	9,330
E.A.P.	1,565	1,528	1,481	1,464	6,038
P.P.O.	21,680	20,921	19,763	19,753	82,117
OPERATING EXPENSE	46,594	55,335	43,872	44,135	189,936
TOTAL EXPENSE	$3,643,330	$2,931,934	$3,131,612	$2,884,673	$12,591,549
SURPLUS (DEFICIT)	**($303,585)**	**$270,543**	**$163,405**	**($507,014)**	**($376,651)**
AVERAGE INCOME	$1,393	$1,421	$1,478	$1,080	$1,343
AVERAGE EXPENSE	$1,520	$1,301	$1,405	$1,310	$1,384
SURPLUS (DEFICIT)	($127)	$120	$73	($230)	($41)
TOTAL PARTICIPANTS	799	751	743	734	757

PLAN X
PART TIME
2021

DEPENDENT
QUARTERLY RECAPS - ACTIVE

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$2,818,651				$2,818,651
MISC. INCOME -LOA	0				0
-COBRA	0				0
-HMO COPAY	17,587				17,587
TOTAL INCOME	$2,836,238	$0	$0	$0	$2,836,238
EXPENSES					
MEDICAL	$2,037,692				$2,037,692
A & S	74,565				74,565
DENTAL	124,055				124,055
DRUG	789,680				789,680
BEHAVIORAL HEALTH	10,611				10,611
OPTICAL	10,222				10,222
LIFE & AD & D	2,040				2,040
UM/DM	23,957				23,957
PRESCRIPTION CARE MNGMT	3,788				3,788
E.A.P.	1,419				1,419
P.P.O.	21,090				21,090
OPERATING EXPENSE	47,269				47,269
TOTAL EXPENSE	$3,146,388	$0	$0	$0	$3,146,388
SURPLUS (DEFICIT)	**($310,150)**	**$0**	**$0**	**$0**	**($310,150)**
AVERAGE INCOME	$1,351				1351
AVERAGE EXPENSE	$1,498				1498
SURPLUS (DEFICIT)	($147)	$0	$0	$0	($147)
TOTAL PARTICIPANTS	700				700

PLAN XX
FULL TIME
FIRST QUARTER 2021

CONTRIBUTIONS

COMPANY	RATE	PARTICIPANTS	CONTRIBUTIONS
ASSOCIATED ADMINISTRATORS	$334.00	80	$79,826
GIANT	$375.50	274	308,662
SAFEWAY[1]	$375.50	164	122,038
SAFEWAY DELAWARE[1]	$375.50	3	2,253
TOTAL		521	$512,779

[1]CREDIT APPLIED BASED ON THE REDUCTION TO A TWO-MONTH RESERVE AS NEGOTIATED 12/2020 - SAFEWAY - $62,709, SAFEWAY DELAWARE - $1,127

PLAN XX
FULL TIME
FIRST QUARTER 2021

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL	$4.95	$6,796	$4.35	458 PART
DENTAL FAMILY[1]	$34.17	$12,609		123 PART
DENTAL INDIVIDUAL[1]	$16.60	16,683		335 PART
TOTAL DENTAL		$29,292	$18.74	
DRUG	$.80/SCRIPT	$42,520	$27.20	1,322 SCRIPTS
HMO KAISER	$206.68	$2,480		4 PART
MEDICAL INDIVIDUAL		172,300		
MEDICAL FAMILY		88,608		
MEDICAL ADMINISTRATION	$14.58	19,946		456 PART
TOTAL MEDICAL		$283,334	$181.28	
BEHAVIORAL HEALTH	$2.59	$3,544	$2.27	456 PART
BEHAVIORAL HEALTH		$960	$0.61	
UM/DM	$1.03/2.80	$8,406	$5.38	457 PART
PRESCRIPTION CARE MNGMT	$0.65	$1,331	$0.85	460 PART
P.P.O CAREFIRST FLEXLINK[1]	$23.55	$8,183	$5.24	113 PART
P.P.O CAREFIRST NETWORK[1]	$4.66	$4,777	$3.06	342 PART
LIFE-AD&D	$.183/.018/1000	$1,363	$0.87	452 PART
A & S		$17,027	$10.89	
SUB TOTAL		**$407,533**	$260.74	

OPERATING EXPENSES

ADMINISTRATION	$14.23	$21,133	$13.52	493 PART
MISCELLANEOUS		$11,689	$7.48	
SUB TOTAL		$32,822	$21.00	
TOTAL		**$440,355**	**$281.74**	

[1]RATE CHANGE EFFECTIVE JANUARY 2021

PLAN XX
FULL TIME
FIRST QUARTER 2021

QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$512,779				$512,779
MISC. INCOME - LOA	0				0
-COBRA	1,359				1,359
-HMO COPAY	0				0
TOTAL INCOME	$514,138	$0	$0	$0	$514,138
EXPENSES					
MEDICAL	$283,334				$283,334
A & S	17,027				17,027
DENTAL	29,292				29,292
DRUG	42,520				42,520
BEHAVIORAL HEALTH	4,504				4,504
OPTICAL	6,796				6,796
LIFE & AD & D	1,363				1,363
UM/DM	8,406				8,406
PRESCRIPTION CARE MNGMT	1,331				1,331
P.P.O.	12,960				12,960
OPERATING EXPENSE	32,822				32,822
TOTAL EXPENSE	$440,355	$0	$0	$0	$440,355
SURPLUS (DEFICIT)	**$73,783**	**$0**	**$0**	**$0**	**$73,783**
AVERAGE INCOME	$329	$0	$0	$0	329
AVERAGE EXPENSE	$282	$0	$0	$0	282
SURPLUS (DEFICIT)	$47	$0	$0	$0	$47
TOTAL PARTICIPANTS	521				521

PLAN XX
FULL TIME
2020

QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTRIBUTIONS	$512,356	$548,065	$581,951	$450,676	$2,093,048
MISC. INCOME -LOA	0	0	0	0	0
-COBRA	684	684	1,367	656	3,391
-HMO COPAY	97	325	65	32	519
TOTAL INCOME	$513,137	$549,074	$583,383	$451,364	$2,096,958
EXPENSES					
MEDICAL	$499,900	$305,433	$242,934	$575,403	$1,623,670
A & S	31,839	17,626	24,376	44,033	117,874
DENTAL	29,205	29,781	21,947	29,646	110,579
DRUG	38,835	24,383	68,904	75,972	208,094
BEHAVIORAL HEALTH	4,179	4,472	4,786	4,748	18,185
OPTICAL	6,499	6,609	6,604	6,554	26,266
LIFE & AD & D	1,315	1,350	1,359	1,351	5,375
UM/DM	8,104	8,267	8,152	8,258	32,781
PRESCRIPTION CARE MNGMT	0	440	1,322	1,307	3,069
P.P.O.	11,383	11,972	12,128	12,328	47,811
OPERATING EXPENSE	29,976	36,470	30,638	30,732	127,816
TOTAL EXPENSE	$661,235	$446,803	$423,150	$790,332	$2,321,520
SURPLUS (DEFICIT)	**($148,098)**	**$102,271**	**$160,233**	**($338,968)**	**($224,562)**
AVERAGE INCOME	$335	$347	$370	$305	$339
AVERAGE EXPENSE	$431	$282	$269	$534	$379
SURPLUS (DEFICIT)	($96)	$65	$101	($229)	($40)
TOTAL PARTICIPANTS	511	528	525	493	514

PLAN XX
FULL TIME
2021

QUARTERLY RECAPS - ACTIVE

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$512,779				$512,779
MISC. INCOME -LOA	0				0
-HMO COPAY	1,359				1,359
-COBRA	0				0
TOTAL INCOME	$514,138	$0	$0	$0	$514,138
EXPENSES					
MEDICAL	$283,334				$283,334
A & S	17,027				17,027
DENTAL	29,292				29,292
DRUG	42,520				42,520
BEHAVIORAL HEALTH	4,504				4,504
OPTICAL	6,796				6,796
LIFE & AD & D	1,363				1,363
UM/DM	8,406				8,406
PRESCRIPTION CARE MNGMT	1,331				1,331
P.P.O.	12,960				12,960
OPERATING EXPENSE	32,822				32,822
TOTAL EXPENSE	$440,355	$0	$0	$0	$440,355
SURPLUS (DEFICIT)	**$73,783**	**$0**	**$0**	**$0**	**$73,783**
AVERAGE INCOME	$329				329
AVERAGE EXPENSE	$282				282
SURPLUS (DEFICIT)	$47	$0	$0	$0	$47
TOTAL PARTICIPANTS	521				521

PLAN XX
PART TIME
FIRST QUARTER 2021

CONTRIBUTIONS

COMPANY	RATE	PARTICIPANTS	CONTRIBUTIONS
ASSOCIATED ADMINISTRATORS	$128.00	2	$768
GIANT	$178.50	580	311,379
GIANT[1]	$310.03	10	9,301
GIANT[2]	$441.56	5	6,182
GIANT[3]	$573.09	0	0
SAFEWAY[4]	$178.50	279	97,997
SAFEWAY[1]	$310.03	0	0
SAFEWAY[2]	$441.56	0	0
SAFEWAY DELAWARE[4]	$178.50	6	2,142
TOTAL		882	$427,769

[1]PARTICIPANTS WITH ONE DEPENDENT CHILD
[2]PARTICIPANTS WITH TWO DEPENDENT CHILDREN
[3]PARTICIPANTS WITH THREE OR MORE DEPENDENT CHILDREN

[4]CREDIT APPLIED BASED ON THE REDUCTION TO A TWO-MONTH RESERVE AS NEGOTIATED 12/2020 - SAFEWAY - $51,587, SAFEWAY DELAWARE - $1,071

PLAN XX
PART TIME
FIRST QUARTER 2021

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL	$4.95	$7,801	$2.95	572 PART
DENTAL FAMILY[1]	$34.17	$2,187		21 PART
DENTAL INDIVIDUAL[1]	$16.60	27,440		551 PART
DENTAL		$29,627	$11.20	
DRUG	$.80/SCRIPT	$115,786	$43.76	1,647 SCRIPTS
HMO KAISER	$206.68	$2,480		4 PART
MEDICAL		312,166		
MEDICAL ADMINISTRATION	$14.58	24,843		568 PART
TOTAL MEDICAL		$339,489	$128.30	
BEHAVIORAL HEALTH	$2.59	$4,418	$1.67	569 PART
BEHAVIORAL HEALTH		$696	$0.26	
UM/DM	$1.03/2.80	$7,368	$2.78	568 PART
PRESCRIPTION CARE MNGMT	$0.65	$1,162	$0.44	570 PART
P P O CAREFIRST FLEXLINK[1]	$23.55	$7,206	$2.72	100 PART
P P O CAREFIRST NETWORK[1]	$4.66	$6,650	$2.51	476 PART
LIFE-AD&D	$.183/.018/1000	$871	$0.33	579 PART
A & S		$12,136	$4.59	
SUB TOTAL		**$533,210**	$201.51	

OPERATING EXPENSES

ADMINISTRATION	$14.23	$40,128	$15.17	937 PART
MISCELLANEOUS		$19,790	$7.48	
SUB TOTAL		$59,918	$22.65	
TOTAL		**$593,128**	**$224.16**	

[1]RATE CHANGE EFFECTIVE JANUARY 2021

PLAN XX
PART TIME
FIRST QUARTER 2021

QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$427,769				$427,769
MISC. INCOME - LOA	0				0
-COBRA	1,300				1,300
-HMO COPAY	1,668				1,668
TOTAL INCOME	$430,737	$0	$0	$0	$430,737
EXPENSES					
MEDICAL	$339,489				$339,489
A & S	12,136				12,136
DENTAL	29,627				29,627
DRUG	115,786				115,786
BEHAVIORAL HEALTH	5,114				5,114
OPTICAL	7,801				7,801
LIFE & AD & D	871				871
UM/DM	7,368				7,368
PRESCRIPTION CARE MNGMT	1,162				1,162
P.P.O.	13,856				13,856
OPERATING EXPENSE	59,918				59,918
TOTAL EXPENSE	$593,128	$0	$0	$0	$593,128
SURPLUS (DEFICIT)	**($162,391)**	**$0**	**$0**	**$0**	**($162,391)**
AVERAGE INCOME	$163	$0	$0	$0	163
AVERAGE EXPENSE	$224	$0	$0	$0	224
SURPLUS (DEFICIT)	($61)	$0	$0	$0	($61)
TOTAL PARTICIPANTS	882				882

PLAN XX
PART TIME
2020

QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTRIBUTIONS	$409,218	$431,683	$523,393	$396,984	$1,761,278
MISC. INCOME -LOA	0	0	0	0	0
-COBRA	1,124	562	1,641	1,915	5,242
-HMO COPAY	1,394	1,498	821	1,514	5,227
TOTAL INCOME	$411,736	$433,743	$525,855	$400,413	$1,771,747
EXPENSES					
MEDICAL	$246,578	$348,736	$394,415	$358,741	$1,348,470
A & S	4,796	15,036	4,648	12,045	36,525
DENTAL	34,683	33,520	21,308	30,674	120,185
DRUG	165,551	147,068	141,023	117,865	571,507
BEHAVIORAL HEALTH	5,541	6,782	5,672	5,350	23,345
OPTICAL	9,585	9,241	8,723	8,529	36,078
LIFE & AD & D	977	951	912	873	3,713
UM/DM	8,227	8,065	7,508	7,415	31,215
PRESCRIPTION CARE MNGMT	0	409	1,210	1,178	2,797
P.P.O.	14,841	14,639	13,832	13,398	56,710
OPERATING EXPENSE	61,985	73,898	55,818	56,588	248,289
TOTAL EXPENSE	$552,764	$658,345	$655,069	$612,656	$2,478,834
SURPLUS (DEFICIT)	**($141,028)**	**($224,602)**	**($129,214)**	**($212,243)**	**($707,087)**
AVERAGE INCOME	$132	$150	$183	$142	$152
AVERAGE EXPENSE	$178	$228	$228	$217	$213
SURPLUS (DEFICIT)	($46)	($78)	($45)	($75)	($61)
TOTAL PARTICIPANTS	1,038	963	956	939	974

PLAN XX
PART TIME
2021

QUARTERLY RECAPS - ACTIVE

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$427,769				$427,769
MISC. INCOME -LOA	0				0
-HMO COPAY	1,300				1,300
-COBRA	1,668				1,668
TOTAL INCOME	$430,737	$0	$0	$0	$430,737
EXPENSES					
MEDICAL	$339,489				$339,489
A & S	12,136				12,136
DENTAL	29,627				29,627
DRUG	115,786				115,786
BEHAVIORAL HEALTH	5,114				5,114
OPTICAL	7,801				7,801
LIFE & AD & D	871				871
UM/DM	7,368				7,368
PRESCRIPTION CARE MNGMT	1,162				1,162
P.P.O.	13,856				13,856
OPERATING EXPENSE	59,918				59,918
TOTAL EXPENSE	$593,128	$0	$0	$0	$593,128
SURPLUS (DEFICIT)	**($162,391)**	**$0**	**$0**	**$0**	**($162,391)**
AVERAGE INCOME	$163				163
AVERAGE EXPENSE	$224				224
SURPLUS (DEFICIT)	($61)	$0	$0	$0	($61)
TOTAL PARTICIPANTS	882				882

PLAN XXX
FULL TIME
FIRST QUARTER 2021

CONTRIBUTIONS

COMPANY	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	$275.25	709	$585,457
LOCAL 400 STAFF TEMPS	$275.25	0	0
SAFEWAY[1]	$275.25	344	191,299
SAFEWAY DELAWARE[1]	$275.25	13	7,432
TOTAL		1,066	$784,188

[1]CREDIT APPLIED BASED ON THE REDUCTION TO A TWO-MONTH RESERVE AS NEGOTIATED 12/2020 - SAFEWAY - $93,035, SAFEWAY DELAWARE - $3,578

PLAN XXX
FULL TIME
FIRST QUARTER 2021

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL	$4.95	$9,326	$2.92	628 PART
DENTAL FAMILY[1]	$34.17	$20,673		202 PART
DENTAL INDIVIDUAL[1]	$16.60	21,182		425 PART
TOTAL DENTAL		$41,855	$13.09	
DRUG	$.80/SCRIPT	$238,279	$74.51	2,145 SCRIPTS
HMO KAISER	$330.14	$660		13 PART
MEDICAL INDIVIDUAL		428,843		
MEDICAL FAMILY		111,793		
MEDICAL ADMINISTRATION	$14.58	28,679		656 PART
TOTAL MEDICAL		$569,975	$178.23	
BEHAVIORAL HEALTH	$2.59	$5,034	$1.57	648 PART
BEHAVIORAL HEALTH		$3,548	$1.11	
UM/DM	$1.03/2.80	$12,848	$4.02	656 PART
PRESCRIPTION CARE MNGMT	$0.65	$2,040	$0.64	661 PART
P.P.O. CAREFIRST FLEXLINK[1]	$23.55	$11,519	$3.60	159 PART
P.P.O. CAREFIRST NETWORK[1]	$4.66	$6,431	$2.01	460 PART
LIFE-AD&D	$.183/.018/1000	$1,832	$0.57	608 PART
A & S		$35,135	$10.99	
SUB TOTAL		**$937,822**	$293.26	

OPERATING EXPENSES

ADMINISTRATION	$14.23	$42,745	$13.37	981 PART
MISCELLANEOUS		$23,919	$7.48	
SUB TOTAL		$66,664	$20.85	

TOTAL	**$1,004,486**	**$314.11**

[1]RATE CHANGE EFFECTIVE JANUARY 2021

PLAN XXX
FULL TIME
FIRST QUARTER 2021

QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$784,188				$784,188
MISC. INCOME - LOA	0				0
-COBRA	401				401
-HMO COPAY	2,020				2,020
TOTAL INCOME	$786,609	$0	$0		$786,609
EXPENSES					
MEDICAL	$569,975				$569,975
A & S	35,135				35,135
DENTAL	41,855				41,855
DRUG	238,279				238,279
BEHAVIORAL HEALTH	8,582				8,582
OPTICAL	9,326				9,326
LIFE & AD & D	1,832				1,832
UM/DM	12,848				12,848
PRESCRIPTION CARE MNGMT	2,040				2,040
P.P.O.	17,950				17,950
OPERATING EXPENSE	66,664				66,664
TOTAL EXPENSE	$1,004,486	$0	$0	$0	$1,004,486
SURPLUS (DEFICIT)	**($217,877)**	**$0**	**$0**	**$0**	**($217,877)**
AVERAGE INCOME	$246	$0	$0	$0	246
AVERAGE EXPENSE	$314	$0	$0	$0	314
SURPLUS (DEFICIT)	($68)	$0	$0	$0	($68)
TOTAL PARTICIPANTS	1,066				1,066

PLAN XXX
FULL TIME
2020

QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTRIBUTIONS	$1,333,657	$1,150,871	$723,633	$626,471	$3,834,632
MISC. INCOME -LOA	0	0	0	0	0
-COBRA	3,171	668	995	2,213	7,047
-HMO COPAY	1,384	0	0	2,497	3,881
TOTAL INCOME	$1,338,212	$1,151,539	$724,628	$631,181	$3,845,560
EXPENSES					
MEDICAL	$290,155	$218,245	$352,841	$419,642	$1,280,883
A & S	13,702	32,725	17,417	27,723	91,567
DENTAL	30,769	32,396	26,021	37,204	126,390
DRUG	113,983	111,459	135,353	169,799	530,594
BEHAVIORAL HEALTH	4,549	4,799	9,298	4,856	23,502
OPTICAL	6,638	7,010	7,436	7,975	29,059
LIFE & AD & D	1,306	1,427	1,530	1,601	5,864
UM/DM	9,077	9,522	10,196	10,876	39,671
PRESCRIPTION CARE MNGMT	0	511	1,606	1,712	3,829
P.P.O.	11,902	13,195	13,941	14,636	53,674
OPERATING EXPENSE	42,023	54,776	48,215	54,792	199,806
TOTAL EXPENSE	$524,104	$486,065	$623,854	$750,816	$2,384,839
SURPLUS (DEFICIT)	**$814,108**	**$665,474**	**$100,774**	**($119,635)**	**$1,460,721**
AVERAGE INCOME	$596	$484	$275	$214	$392
AVERAGE EXPENSE	$233	$204	$237	$255	$232
SURPLUS (DEFICIT)	$363	$280	$38	($41)	$160
TOTAL PARTICIPANTS	749	793	877	981	850

PLAN XXX
FULL TIME
2021

QUARTERLY RECAPS - ACTIVE

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$784,188				$784,188
MISC. INCOME -LOA	0				0
-COBRA	401				401
-HMO COPAY	2,020				2,020
TOTAL INCOME	$786,609	$0	$0	$0	$786,609
EXPENSES					
MEDICAL	$569,975				$569,975
A & S	35,135				35,135
DENTAL	41,855				41,855
DRUG	238,279				238,279
BEHAVIORAL HEALTH	8,582				8,582
OPTICAL	9,326				9,326
LIFE & AD & D	1,832				1,832
UM/DM	12,848				12,848
PRESCRIPTION CARE MNGMT	2,040				2,040
P.P.O.	17,950				17,950
OPERATING EXPENSE	66,664				66,664
TOTAL EXPENSE	$1,004,486	$0	$0	$0	$1,004,486
SURPLUS (DEFICIT)	**($217,877)**	**$0**	**$0**	**$0**	**($217,877)**
AVERAGE INCOME	$246				246
AVERAGE EXPENSE	$314				314
SURPLUS (DEFICIT)	($68)	$0	$0	$0	($68)
TOTAL PARTICIPANTS	1,066				1,066

PLAN XXX
PART TIME
FIRST QUARTER 2021

CONTRIBUTIONS

COMPANY	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	$101.75	1,924	$587,301
GIANT[1]	$240.47	21	15,150
GIANT[2]	$379.19	7	8,342
GIANT[3]	$517.91	1	1,554
SAFEWAY[4]	$101.75	1,199	245,320
SAFEWAY[1,4]	$240.47	8	4,088
SAFEWAY[2,4]	$379.19	5	3,792
SAFEWAY[3]	$517.91	0	0
SAFEWAY DELAWARE[4]	$101.75	33	6,818
TOTAL		3,198	$872,365

[1]PARTICIPANTS WITH ONE DEPENDENT CHILD
[2]PARTICIPANTS WITH TWO DEPENDENT CHILDREN
[3]PARTICIPANTS WITH THREE OR MORE DEPENDENT CHILDREN

[4]CREDIT APPLIED BASED ON THE REDUCTION TO A TWO-MONTH RESERVE AS NEGOTIATED 12/2020 - SAFEWAY - $124,495, SAFEWAY DELAWARE - $3,358

PLAN XXX
PART TIME
FIRST QUARTER 2021

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL	$4.95	$11,736	$1.22	790 PART
DENTAL FAMILY[1]	$34.17	$3,554		35 PART
DENTAL INDIVIDUAL[1]	$16.60	37,616		755 PART
DENTAL		$41,170	$4.29	
DRUG	$.80/SCRIPT	$199,035	$20.75	2,605 SCRIPTS
HMO KAISER	$206.25	$619		1 PART
MEDICAL INDIVIDUAL		547,758		
MEDICAL FAMILY		12,816		
MEDICAL ADMINISTRATION	$14.58	48,435		1,107 PART
TOTAL MEDICAL		$609,628	$63.54	
BEHAVIORAL HEALTH	$2.59	$8,529	$0.89	1,098 PART
BEHAVIORAL HEALTH		$4,725	$0.49	
UM/DM	$1.03/2.80	$14,475	$1.51	1,106 PART
PRESCRIPTION CARE MNGMT	$0.65	$2,294	$0.24	1,117 PART
P.P.O. CAREFIRST FLEXLINK[1]	$23.55	$17,496	$1.82	242 PART
P.P.O. CAREFIRST NETWORK[1]	$4.66	$11,338	$1.18	811 PART
LIFE-AD&D	$.183/.018/1000	$1,447	$0.15	959 PART
A & S		$7,951	$0.83	
SUB TOTAL		**$929,824**	$96.91	

OPERATING EXPENSES

ADMINISTRATION	$14.23	$125,708	$13.10	2,878 PART
MISCELLANEOUS		$71,755	$7.48	
SUB TOTAL		$197,463	$20.58	

TOTAL	**$1,127,287**	**$117.49**

[1]RATE CHANGE EFFECTIVE JANUARY 2021

PLAN XXX
PART TIME
FIRST QUARTER 2021

QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$872,365				$872,365
MISC. INCOME - LOA	0				0
-COBRA	13,330				13,330
-HMO COPAY	3,291				3,291
TOTAL INCOME	$888,986	$0	$0	$0	$888,986
EXPENSES					
MEDICAL	$609,628				$609,628
A & S	7,951				7,951
DENTAL	41,170				41,170
DRUG	199,035				199,035
BEHAVIORAL HEALTH	13,254				13,254
OPTICAL	11,736				11,736
LIFE & AD & D	1,447				1,447
UM/DM	14,475				14,475
PRESCRIPTION CARE MNGMT	2,294				2,294
P.P.O.	28,834				28,834
OPERATING EXPENSE	197,463				197,463
TOTAL EXPENSE	$1,127,287	$0	$0	$0	$1,127,287
SURPLUS (DEFICIT)	**($238,301)**	**$0**	**$0**	**$0**	**($238,301)**
AVERAGE INCOME	$93	$0	$0	$0	93
AVERAGE EXPENSE	$117	$0	$0	$0	117
SURPLUS (DEFICIT)	($24)	$0	$0	$0	($24)
TOTAL PARTICIPANTS	3,198				3,198

PLAN XXX
PART TIME
2020

QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTRIBUTIONS	$1,162,541	$984,186	$863,933	$711,272	$3,721,932
MISC. INCOME -LOA	0	0	0	0	0
-COBRA	7,263	8,803	8,997	11,569	36,632
-HMO COPAY	0	570	1,302	1,120	2,992
TOTAL INCOME	$1,169,804	$993,559	$874,232	$723,961	$3,761,556
EXPENSES					
MEDICAL	$316,754	$616,808	$1,192,298	$918,040	$3,043,900
A & S	4,896	15,779	14,984	17,727	53,386
DENTAL	36,527	37,712	26,276	39,028	139,543
DRUG	99,997	104,102	162,617	205,430	572,146
BEHAVIORAL HEALTH	11,183	11,699	8,916	19,097	50,895
OPTICAL	10,033	10,355	10,662	10,780	41,830
LIFE & AD & D	1,247	1,330	1,295	1,301	5,173
UM/DM	12,088	12,109	11,996	12,428	48,621
PRESCRIPTION CARE MNGMT	0	622	1,924	1,960	4,506
P.P.O.	24,283	25,313	24,939	25,287	99,822
OPERATING EXPENSE	141,132	198,481	156,057	167,256	662,926
TOTAL EXPENSE	$658,140	$1,034,310	$1,611,964	$1,418,334	$4,722,748
SURPLUS (DEFICIT)	**$511,664**	**($40,751)**	**($737,732)**	**($694,373)**	**($961,192)**
AVERAGE INCOME	$132	$126	$106	$84	$112
AVERAGE EXPENSE	$74	$131	$196	$164	$141
SURPLUS (DEFICIT)	$58	($5)	($90)	($80)	($29)
TOTAL PARTICIPANTS	2,964	2,629	2,741	2,878	2,803

PLAN XXX
PART TIME
2021

QUARTERLY RECAPS - ACTIVE

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$872,365				$872,365
MISC. INCOME -LOA	0				0
-COBRA	13,330				13,330
-HMO COPAY	3,291				3,291
TOTAL INCOME	$888,986	$0	$0	$0	$888,986
EXPENSES					
MEDICAL	$609,628				$609,628
A & S	7,951				7,951
DENTAL	41,170				41,170
DRUG	199,035				199,035
BEHAVIORAL HEALTH	13,254				13,254
OPTICAL	11,736				11,736
LIFE & AD & D	1,447				1,447
UM/DM	14,475				14,475
PRESCRIPTION CARE MNGMT	2,294				2,294
P.P.O.	28,834				28,834
OPERATING EXPENSE	197,463				197,463
TOTAL EXPENSE	$1,127,287	$0	$0	$0	$1,127,287
SURPLUS (DEFICIT)	**($238,301)**	**$0**	**$0**	**$0**	**($238,301)**
AVERAGE INCOME	$93				93
AVERAGE EXPENSE	$117				117
SURPLUS (DEFICIT)	($24)	$0	$0	$0	($24)
TOTAL PARTICIPANTS	3,198				3,198

PLAN XL
PART TIME
FIRST QUARTER 2021

CONTRIBUTIONS

COMPANY	RATE	PARTICIPANTS	CONTRIBUTIONS
GIANT	$22.75	1,503	$102,581
SAFEWAY[1]	$22.75	755	34,603
SAFEWAY DELAWARE[1]	$22.75	22	1,024
TOTAL		2,280	$138,208

[1]CREDIT APPLIED BASED ON THE REDUCTION TO A TWO-MONTH RESERVE AS NEGOTIATED 12/2020 - SAFEWAY - $16,881, SAFEWAY DELAWARE - $501

PLAN XL
PART TIME
FIRST QUARTER 2021

BENEFIT EXPENSES

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL	$4.95	$5,054	$0.74	340 PART
DENTAL[1]	$16.60	$16,882	$2.47	339 PART
LIFE-AD&D	$.183/.018/1000	$676	$0.10	448 PART
A & S		$2,427	$0.35	
SUB TOTAL		**$25,039**	$3.66	

OPERATING EXPENSES

ADMINISTRATION	$14.23	$99,254	$14.51	2,305 PART
MISCELLANEOUS		$51,159	$7.48	
SUB TOTAL		$150,413	$21.99	

TOTAL	**$175,452**	**$25.65**

[1]RATE CHANGE EFFECTIVE JANUARY 2021

PLAN XL
PART TIME
FIRST QUARTER 2021

QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$138,208				$138,208
MISC. INCOME - LOA	0				0
-COBRA	69				69
TOTAL INCOME	$138,277	$0	$0	$0	$138,277
EXPENSES					
A & S	$2,427				$2,427
DENTAL	16,882				16,882
OPTICAL	5,054				5,054
LIFE & AD & D	676				676
OPERATING EXPENSE	150,413				150,413
TOTAL EXPENSE	$175,452	$0	$0	$0	$175,452
SURPLUS (DEFICIT)	**($37,175)**	**$0**	**$0**	**$0**	**($37,175)**
AVERAGE INCOME	$20	$0	$0	$0	20
AVERAGE EXPENSE	$26	$0	$0	$0	26
SURPLUS (DEFICIT)	($6)	$0	$0	$0	($6)
TOTAL PARTICIPANTS	2,280				2,280

PLAN XL
PART TIME
2020

QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTRIBUTIONS	$129,984	$143,635	$149,393	$122,670	$545,682
MISC. INCOME -LOA	0	0	0	0	0
-COBRA	0	0	99	69	168
TOTAL INCOME	$129,984	$143,635	$149,492	$122,739	$545,850
EXPENSES					
A & S	$2,673	$2,360	889	2,457	$8,379
DENTAL	18,223	18,410	11,958	18,085	66,676
OPTICAL	5,256	5,326	5,242	5,247	21,071
LIFE & AD & D	667	702	703	675	2,747
OPERATING EXPENSE	122,973	133,558	120,499	132,330	509,360
TOTAL EXPENSE	$149,792	$160,356	$139,291	$158,794	$608,233
SURPLUS (DEFICIT)	**($19,808)**	**($16,721)**	**$10,201**	**($36,055)**	**($62,383)**
AVERAGE INCOME	$24	$24	$23	$18	$22
AVERAGE EXPENSE	$28	$26	$21	$23	$25
SURPLUS (DEFICIT)	($4)	($2)	$2	($5)	($3)
TOTAL PARTICIPANTS	1,804	2,029	2,189	2,306	2,082

PLAN XL
PART TIME
2021

QUARTERLY RECAPS - ACTIVE

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$138,208				$138,208
MISC. INCOME -LOA	0				0
-COBRA	69				69
TOTAL INCOME	$138,277	$0	$0	$0	$138,277
EXPENSES					
A & S	$2,427				$2,427
DENTAL	16,882				16,882
OPTICAL	5,054				5,054
LIFE & AD & D	676				676
OPERATING EXPENSE	150,413				150,413
TOTAL EXPENSE	$175,452	$0	$0	$0	$175,452
SURPLUS (DEFICIT)	**($37,175)**	**$0**	**$0**	**$0**	**($37,175)**
AVERAGE INCOME	$20				20
AVERAGE EXPENSE	$26				26
SURPLUS (DEFICIT)	($6)	$0	$0	$0	($6)
TOTAL PARTICIPANTS	2,280				2,280

ACTIVE PLANS
2021

QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTR - ACTIVE	$19,633,330	$0	$0	$0	$19,633,330
EMPLOYEE CONTRIBUTIONS	209,517	0	0	0	209,517
INTEREST & DIVIDENDS - ACTIVE	121,845	0	0	0	121,845
MISCELLANEOUS	0	0	0	0	0
TOTAL INCOME	$19,964,692	$0	$0	$0	$19,964,692
EXPENSES					
MEDICAL	$18,102,244	$0	$0	$0	$18,102,244
A & S	1,254,481	0	0	0	1,254,481
DENTAL	1,095,002	0	0	0	1,095,002
DRUG	6,392,369	0	0	0	6,392,369
BEHAVIORAL HEALTH	362,760	0	0	0	362,760
OPTICAL	156,738	0	0	0	156,738
LIFE & AD & D	38,929	0	0	0	38,929
UM/DM	206,325	0	0	0	206,325
PRESCRIPTION CARE MNGMT	32,603	0	0	0	32,603
E.A.P.	15,588	0	0	0	15,588
P.P.O.	302,074	0	0	0	302,074
OPERATING EXPENSE	1,037,577	0	0	0	1,037,577
TOTAL EXPENSE	$28,996,690	$0	$0	$0	$28,996,690
SURPLUS (DEFICIT)	**($9,031,998)**	**$0**	**$0**	**$0**	**($9,031,998)**
TOTAL PARTICIPANTS	15,858	0	0	0	15,858

FUND RESERVE	$21,431,191			

FELRA & UFCW

RETIREE HEALTH PLAN

FIRST QUARTER 2021

ADMINISTRATIVE MANAGER'S REPORT

FULL TIME RETIREES
FIRST QUARTER 2021

INCOME

EMPLOYER CONTRIBUTIONS[1]	$3,438,589
RETIREE COPAYMENTS	$862,085
INTEREST AND DIVIDENDS	$21,591
TOTAL INCOME	**$4,322,264**

EXPENSES

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL	$4.95	$40,041	$4.75	2,697 RET
DENTAL	$28.80	$226,034		2,697 RET
TOTAL DENTAL		$226,034	$26.81	
DRUG	$.80/1.25/SCRIPT	$693,314		16,538 SCRIPTS
DRUG CLAIMS		0		
DRUG FEES	$0.21/CLAIM	1,785		
TOTAL DRUG		$695,099	$82.46	
HMO KAISER[2]	$243.17	$1,335,940		1,380 RET
HOSPITAL		344,555		
SURGICAL		232,660		
DIAGNOSTIC		70,782		
MAJOR MEDICAL		218,140		
MEDICAL ADMINISTRATION	$14.58	58,932		1,347 RET
TOTAL MEDICAL		$2,261,009	$268.21	
BEHAVIORAL HEALTH	$2.59	$10,446	$1.24	1,344 RET
BEHAVIORAL HEALTH/EAP		($1,109)	($0.13)	
P.P.O. CAREFIRST FLEXLINK	$22.86	$0	$0.00	0 RET
P.P.O. CAREFIRST NETWORK	$4.52	$79	$0.01	6 RET
HRGI/A&G CLAIM DISCOUNTER		$4,279	$0.51	
ADMINISTRATION	$6.80	$57,317	$6.80	2,810 RET
TOTAL EXPENSES		**$3,293,195**	**$390.65**	
SURPLUS (DEFICIT)		**$1,029,069**		

[1]INCLUDES INCOME FROM PLAN I AND PLAN X MOB CONTRIBUTION, LESS THE STIPEND RELATED INCOME
[2]RATE CHANGE EFFECTIVE JANUARY 2021

PART TIME RETIREES
FIRST QUARTER 2021

INCOME

EMPLOYER CONTRIBUTIONS[1]	$543,587
RETIREE COPAYMENTS	$183,461
INTEREST AND DIVIDENDS	$4,595
TOTAL INCOME	**$731,643**

EXPENSES

BENEFIT	RATE	EXPENSE	AVG. COST	COMMENT
OPTICAL	$4.95	$8,885	$4.95	598 RET
DENTAL	$28.80	$50,124	$27.94	598 RET
DRUG	$.80/1.25/SCRIPT	$56,338		2,271 SCRIPTS
DRUG CLAIMS		0		
DRUG FEES	$0.21/CLAIM	154		
DRUG		$56,492	$31.49	
HMO KAISER[2]	$243.17	$285,051		372 RET
HOSPITAL		47,180		
SURGICAL		47,401		
DIAGNOSTIC		13,982		
MAJOR MEDICAL		57,090		
MEDICAL ADMINISTRATION	$14.58	11,212		256 RET
TOTAL MEDICAL		$461,916	$257.48	
BEHAVIORAL HEALTH	$2.59	$1,987	$1.11	256 RET
BEHAVIORAL HEALTH/EAP		$0	$0.00	
P.P.O. CAREFIRST FLEXLINK	$22.86	$0	$0.00	0 RET
P.P.O. CAREFIRST NETWORK	$4.52	$28	$0.02	2 RET
HRGI/A&G CLAIM DISCOUNTER		$910	$0.51	
ADMINISTRATION	$6.80	$12,206	$6.80	598 RET
TOTAL EXPENSES		**$592,548**	**$330.29**	
SURPLUS (DEFICIT)		**$139,095**		

[1]INCLUDES INCOME FROM PLAN I AND PLAN X MOB CONTRIBUTION, LESS THE STIPEND RELATED INCOME
[2]RATE CHANGE EFFECTIVE JANUARY 2021

FIRST QUARTER 2021
STIPEND
INCOME & EXPENSES

INCOME[1]

GIANT	$842,610
SAFEWAY	179,317
TOTAL INCOME	**$1,021,927**

BENEFIT EXPENSES

CATEGORY	AMOUNT
STIPEND BENEFITS	$1,013,550
SUBTOTAL	$1,013,550

OPERATING EXPENSES

CATEGORY	AMOUNT
ADMINISTRATION	$7,612
PNC FEES	699
POSTAGE	66
SUBTOTAL	$8,377
TOTAL EXPENSES	**$1,021,927**

SURPLUS (DEFICIT)	**$0**

PARTICIPANTS 926

2021
RETIREES
QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTRIBUTIONS	$3,982,176				$3,982,176
RETIREE COPAYMENTS	1,045,546				1,045,546
STIPEND INCOME	1,021,927				1,021,927
INTEREST & DIVIDENDS	26,185				26,185
TOTAL INCOME	$6,075,834	$0	$0	$0	$6,075,834

EXPENSES					
MEDICAL	$2,722,925				$2,722,925
DENTAL	276,158				276,158
DRUG	751,591				751,591
BEHAVIORAL HEALTH	11,324				11,324
OPTICAL	48,926				48,926
P.P.O.	5,296				5,296
ADMINISTRATION	69,523				69,523
STIPEND	1,021,927				1,021,927
TOTAL EXPENSES	$4,907,670	$0	$0	$0	$4,907,670
SURPLUS (DEFICIT)	$1,168,164	$0	$0	$0	$1,168,164
TOTAL PARTICIPANTS	3,408				3,408
FUND RESERVE	$5,048,838				

2020
RETIREES
QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTRIBUTIONS	$4,225,791	$4,061,678	$4,059,554	$4,065,620	$16,412,643
RETIREE COPAYMENTS	1,085,279	1,060,581	1,059,148	1,050,165	4,255,173
STIPEND INCOME	1,200,856	1,163,185	1,119,766	1,084,602	4,568,409
INTEREST & DIVIDENDS	28,371	43,859	29,759	29,015	131,004
TOTAL INCOME	$6,540,297	$6,329,303	$6,268,227	$6,229,402	$25,367,229

EXPENSES					
MEDICAL	$3,087,811	$2,618,131	$2,567,108	$2,593,875	$10,866,925
DENTAL	295,142	293,126	233,061	289,123	1,110,452
DRUG	1,217,946	551,628	1,531,050	838,050	4,138,674
BEHAVIORAL HEALTH	14,438	12,825	12,904	12,848	53,015
OPTICAL	50,726	50,381	50,167	49,689	200,963
P.P.O.	2,955	2,086	679	316	6,036
ADMINISTRATION	69,808	71,367	71,122	70,591	282,888
STIPEND	1,200,856	1,163,185	1,119,766	1,084,602	4,568,409
TOTAL EXPENSES	$5,939,682	$4,762,729	$5,585,857	$4,939,094	$21,227,362
SURPLUS (DEFICIT)	$600,615	$1,566,574	$682,370	$1,290,308	$4,139,867
TOTAL PARTICIPANTS	3,526	3,498	3,487	3,460	3,493
FUND RESERVE	$5,765,638	$5,521,879	$5,339,723	$5,306,841	

COMBINED FUND
FIRST QUARTER 2021

QUARTERLY RECAPS

	FIRST 2021	SECOND 2021	THIRD 2021	FOURTH 2021	TOTAL
EMPLOYER CONTR - ACTIVE	$19,633,330	$0	$0	$0	$19,633,330
EMPLOYER CONTR - RETIREE	3,982,176	0	0	0	3,982,176
EMPLOYEE CONTRIBUTIONS	1,255,063	0	0	0	1,255,063
INTEREST & DIVIDENDS - ACTIVE	121,845	0	0	0	121,845
INTEREST & DIVIDENDS - RETIREE	26,185	0	0	0	26,185
STIPEND	1,200,856	0	0	0	1,200,856
MISCELLANEOUS	0	0	0	0	0
TOTAL INCOME	$26,219,455	$0	$0	$0	$26,219,455
EXPENSES					
MEDICAL	$18,102,244	$0	$0	$0	$18,102,244
RETIREES	3,885,743	0	0	0	3,885,743
STIPEND	1,200,856	0	0	0	1,200,856
A & S	1,254,481	0	0	0	1,254,481
DENTAL	1,095,002	0	0	0	1,095,002
DRUG	6,392,369	0	0	0	6,392,369
BEHAVIORAL HEALTH	362,760	0	0	0	362,760
OPTICAL	156,738	0	0	0	156,738
LIFE & AD & D	38,929	0	0	0	38,929
UM/DM	206,325	0	0	0	206,325
PRESCRIPTION CARE MNGMT	32,603	0	0	0	32,603
E.A.P.	15,588	0	0	0	15,588
P.P.O.	302,074	0	0	0	302,074
OPERATING EXPENSE	1,037,577	0	0	0	1,037,577
TOTAL EXPENSE	$34,083,289	$0	$0	$0	$34,083,289
SURPLUS (DEFICIT)	**($7,863,834)**	**$0**	**$0**	**$0**	**($7,863,834)**
TOTAL PARTICIPANTS	15,858	0	0	0	15,858

FUND RESERVE	$26,480,029			

COMBINED FUND
2020

QUARTERLY RECAPS

	FIRST 2020	SECOND 2020	THIRD 2020	FOURTH 2020	TOTAL
EMPLOYER CONTR - ACTIVE	$26,032,469	$25,127,978	$24,821,555	$18,329,108	$94,311,110
EMPLOYER CONTR - RETIREE	4,225,791	4,061,678	4,059,554	4,065,620	16,412,643
EMPLOYEE CONTRIBUTIONS	1,304,292	1,292,702	1,277,982	1,281,981	5,156,957
INTEREST & DIVIDENDS - ACTIVE	125,883	190,608	132,076	131,986	580,553
INTEREST & DIVIDENDS - RETIREE	28,371	43,859	29,759	29,015	131,004
STIPEND	1,200,856	1,163,185	1,119,766	1,084,602	4,568,409
MISCELLANEOUS[1]	147	2,486	0	102,077	104,710
TOTAL INCOME	$32,917,809	$31,882,496	$31,440,692	$25,024,389	$121,265,386
EXPENSES					
MEDICAL	$16,963,827	$15,327,533	$16,392,178	$18,015,704	$66,699,242
RETIREES	4,738,826	3,599,544	4,466,091	3,854,492	16,658,953
STIPEND	1,200,856	1,163,185	1,119,766	1,084,602	4,568,409
A & S	1,364,185	1,321,909	1,166,696	1,310,825	5,163,615
DENTAL	1,192,099	1,176,786	968,974	1,141,594	4,479,453
DRUG	5,943,419	4,219,960	5,893,336	5,495,819	21,552,534
BEHAVIORAL HEALTH	259,725	299,566	288,450	285,717	1,133,458
OPTICAL	164,072	162,531	159,550	158,276	644,429
LIFE & AD & D	40,512	40,349	39,670	39,044	159,575
UM/DM	212,560	211,609	205,387	206,291	835,847
PRESCRIPTION CARE MNGMT	0	11,145	33,173	32,804	77,122
E.A.P.	16,747	16,459	16,045	15,826	65,077
P.P.O.	288,002	287,526	277,458	276,687	1,129,673
OPERATING EXPENSE	901,611	1,098,094	895,211	931,711	3,826,627
TOTAL EXPENSE	$33,286,441	$28,936,196	$31,921,985	$32,849,392	$126,994,014
SURPLUS (DEFICIT)	**($368,632)**	**$2,946,300**	**($481,293)**	**($7,825,003)**	**($5,728,628)**
TOTAL PARTICIPANTS	15,645	15,202	15,476	15,739	15,516
FUND RESERVE	$33,501,442	$32,398,796	$41,245,219	$39,737,569	

[1]LITIGATION SETTLEMENTS 4TH QTR:

$101,990	MADOFF FUND
87	VISIUM FAIR FUND
$102,077	

COMBINED FUND
FIRST QUARTER 2021

MISCELLANEOUS

ACCOUNTING	$117,653
ACTUARIAL & CONSULTING	79,483
EDUCATION FEES FOR RETIREE ASSISTANCE	8,910
INVESTMENT MANAGEMENT	7,347
INVESTMENT PERFORMANCE SERVICES	10,000
LEGAL	95,495
POSTAGE	20,566
PRINTING	15,024
TELEPHONE	1,340
TOTAL	$355,818

DELINQUENCIES

NONE

COMBINED FUND
FELRA & UFCW VEBA FUND
INCLUDING LEGAL, SEVERANCE AND SCHOLARSHIP
FIRST QUARTER 2021

QUARTERLY RECAPS

INCOME	1Q2021	2Q2021	3Q2021	4Q2021	Total
Health	$26,219,455				$26,219,455
Legal	768,086				768,086
Severance	2,274,324				2,274,324
Scholarship	0				0
Total Income	$29,261,865	$0	$0	$0	$29,261,865

EXPENSES	1Q2021	2Q2021	3Q2021	4Q2021	Total
Health	$34,083,289				$34,083,289
Legal	768,027				768,027
Severance	1,028,529				1,028,529
Scholarship	4,004				4,004
Total Expenses	$35,883,849	$0	$0	$0	$35,883,849

Surplus/(Deficit)	1Q2021	2Q2021	3Q2021	4Q2021	Total
Health	($7,863,834)	$0	$0	$0	($7,863,834)
Legal	59	0	0	0	59
Severance	1,245,795	0	0	0	1,245,795
Scholarship	(4,004)	0	0	0	(4,004)
Total Surplus/(Deficit)	($6,621,984)	$0	$0	$0	($6,621,984)

Fund Reserve	$31,005,835			

COMBINED FUND
FELRA & UFCW VEBA FUND
INCLUDING LEGAL, SEVERANCE AND SCHOLARSHIP
2020

QUARTERLY RECAPS

INCOME	1Q2020	2Q2020	3Q2020	4Q2020	Total
Health	$32,917,809	$31,882,496	$31,440,692	$25,024,389	$121,265,386
Legal	803,742	771,450	771,416	771,141	3,117,749
Severance	18,427	1,474,569	2,475,793	7,738	3,976,527
Scholarship	421	257	166	125	969
Total Income	$33,740,399	$34,128,772	$34,688,067	$25,803,393	$128,360,631

EXPENSES	1Q2020	2Q2020	3Q2020	4Q2020	Total
Health	$33,286,441	$28,936,196	$31,921,985	$32,849,392	$126,994,014
Legal	812,977	799,841	780,340	777,167	3,170,325
Severance	1,250,054	920,257	994,698	1,186,685	4,351,694
Scholarship	11,496	18,838	14,147	6,377	50,858
Total Expenses	$35,360,968	$30,675,132	$33,711,170	$34,819,621	$134,566,891

Surplus/(Deficit)	1Q2020	2Q2020	3Q2020	4Q2020	Total
Health	($368,632)	$2,946,300	($481,293)	($7,825,003)	($5,728,628)
Legal	(9,235)	(28,391)	(8,924)	(6,026)	(52,576)
Severance	(1,231,627)	554,312	1,481,095	(1,178,947)	(375,167)
Scholarship	(11,075)	(18,581)	(13,981)	(6,252)	(49,889)
Total Surplus/(Deficit)	($1,620,569)	$3,453,640	$976,897	($9,016,228)	($6,206,260)

Fund Reserve	$36,286,031	$35,341,640	$45,768,124	$43,071,868

CONTRACT INFORMATION
FIRST QUARTER 2021

COMPANY	PLAN	RATES	EFF. DATE	CONTRACT EXP.
ASSOCIATED ADMINISTRATORS	X	918.75	11-01-20	10-29-24
	X	544.00	11-01-20	
	X	1,316.00	11-01-20	
	XX	334.00	11-01-20	
	XX	128.00	11-01-20	
GIANT 27	I	1,834.50	06-01-20	10-28-23
	I	1,022.25	06-01-20	
	X	1,138.75	06-01-20	
	X	764.00	06-01-20	
	X	1,536.00	06-01-20	
	XX	375.50	06-01-20	
	XX	178.50	06-01-20	
	XXX	275.25	06-01-20	
	XXX	101.75	06-01-20	
	XL	22.75	06-01-20	
GIANT 400	I	1,834.50	06-01-20	10-28-23
	I	1,022.25	06-01-20	
	X	1,138.75	06-01-20	
	X	764.00	06-01-20	
	X	1,536.00	06-01-20	
	XX	375.50	06-01-20	
	XX	178.50	06-01-20	
	XXX	275.25	06-01-20	
	XXX	101.75	06-01-20	
	XL	22.75	06-01-20	
GIANT DELAWARE	X	1,138.75	06-01-20	10-28-23
	X	764.00	06-01-20	
	X	1,536.00	06-01-20	
	XX	375.50	06-01-20	
	XX	178.50	06-01-20	
	XXX	275.25	06-01-20	
	XXX	101.75	06-01-20	
	XL	22.75	06-01-20	
GIANT LEXINGTON PARK 400	X	1,138.75	06-01-20	10-28-23
	X	764.00	06-01-20	
	X	1,536.00	06-01-20	
	XX	375.50	06-01-20	
	XX	178.50	06-01-20	
	XXX	275.25	06-01-20	
	XXX	101.75	06-01-20	
	XL	22.75	06-01-20	
GIANT VALLEY 400	I	1,834.50	06-01-20	10-28-23
	I	1,022.25	06-01-20	
	X	1,138.75	06-01-20	
	X	764.00	06-01-20	
	X	1,536.00	06-01-20	
	XX	375.50	06-01-20	
	XX	178.50	06-01-20	
	XXX	275.25	06-01-20	
	XXX	101.75	06-01-20	
	XL	22.75	06-01-20	

CONTRACT INFORMATION
FIRST QUARTER 2021

COMPANY	PLAN	RATES	EFF. DATE	CONTRACT EXP.
SAFEWAY 27	I	1,840.97	06-01-20	10-28-23
	I	1,028.72	06-01-20	
	X	1,145.22	06-01-20	
	X	770.47	06-01-20	
	X	1,542.47	06-01-20	
	XX	375.50	06-01-20	
	XX	178.50	06-01-20	
	XXX	275.25	06-01-20	
	XXX	101.75	06-01-20	
	XL	22.75	06-01-20	
SAFEWAY 400	I	1,840.97	06-01-20	10-28-23
	I	1,028.72	06-01-20	
	X	1,145.22	06-01-20	
	X	770.47	06-01-20	
	X	1,542.47	06-01-20	
	XX	375.50	06-01-20	
	XX	178.50	06-01-20	
	XXX	275.25	06-01-20	
	XXX	101.75	06-01-20	
	XL	22.75	06-01-20	
SAFEWAY CULPEPER	I	1,840.97	06-01-20	10-28-23
	I	1,028.72	06-01-20	
	X	1,145.22	06-01-20	
	X	770.47	06-01-20	
	X	1,542.47	06-01-20	
	XX	375.50	06-01-20	
	XX	178.50	06-01-20	
	XXX	275.25	06-01-20	
	XXX	101.75	06-01-20	
	XL	22.75	06-01-20	
SAFEWAY DELAWARE	X	1,145.22	06-01-20	10-28-23
	X	770.47	06-01-20	
	X	1,542.47	06-01-20	
	XX	375.50	06-01-20	
	XX	178.50	06-01-20	
	XXX	275.25	06-01-20	
	XXX	101.75	06-01-20	
	XL	22.75	06-01-20	
SAFEWAY DOVER	X	1,145.22	06-01-20	10-28-23
	X	770.47	06-01-20	
	X	1,542.47	06-01-20	
	XX	375.50	06-01-20	
	XX	178.50	06-01-20	
	XXX	275.25	06-01-20	
	XXX	101.75	06-01-20	
	XL	22.75	06-01-20	
STAFF 400	X	1,114.00	11-01-18	

Work Snapshot 2021 FELRA					
Function	***1st Quarter***	***2nd Quarter***	***3rd Quarter***	***4th Quarter***	***YTD***
Accident & Sickness Claims	374				**374**
Appeals	132				**132**
Participant Services Calls	32,616				**32,616**
COBRA Notices Mailed	412				**412**
Pension Apps Received	267				**267**
Pension Estimates Received	99				**99**
Medical Claims Processed	85,421				**85,421**
Communications Mailings Sent to Participants	68,097				**68,097**

SPECIAL PROJECTS IN 1Q:

1. PBGC project - Professional's Meetings and AA internal activities
2. Dependent Eligibility Audit
3. Open enrollment
4. COVID Experience and Tracking project
5. Dentegra implementation

INVOICES

FELRA & UFCW
VEBA FUND
INVOICES

JUNE 22, 2021

1. **Calibre**

03/17/21	For services rendered in connection with the Safeway payroll audit for the period 01/01/2014 - 12/31/2017	$ 2,152.50

2. **Chartwell Investment Partners**

04/24/21	Investment Consultant Services rendered – 1Q2021	$ 3,087.25

3. **Cheiron**

03/25/21	Retainer Services - 02/2021	$ 3,725.00
04/22/21	Retainer Services - 03/2021	3,725.00
05/27/21	Retainer Services - 04/2021	3,725.00

4. **Confidio**

03/08/21	Retainer Services - 02/2021	$ 3,620.00

5. **Groom Law Group, Chartered**

02/28/21	Professional Services rendered - 01/2021	$ 8,127.00
04/01/21	Professional Services rendered - 02/2021	2,581.20
04/26/21	Professional Services rendered - 03/2021	5,767.20

6. **Investment Performance Services**

06/07/21	For Investment Consultant Services - 2Q2021	$ 10,000.00

7. **Segal Select**

06/01/21	Renewal of Fiduciary Insurance through Chubb for the period 05/29/2021 – 05/29/2022	$ 67,090.00

8. **Segall Bryant & Hamill**

04/22/21	Investment Management Services rendered - 1Q2021	$ 2,895.04
04/22/21	Investment Management Services (Illiquid) rendered - 1Q2021	24.20

9. **Slevin & Hart P.C.**

02/28/21	Professional Services rendered - 01/2021	$ 5,312.13
03/31/21	Professional Services rendered - 02/2021	13,782.00
04/15/21	Subrogation Services rendered - 1Q2021	8,780.00
04/28/21	Professional Services rendered - 03/2021	15,943.00
05/28/21	Professional Services rendered - 04/2021	29,342.38

FELRA & UFCW
HEALTH AND WELFARE FUND – RETIREE PLAN
INVOICES

JUNE 22, 2021

1.	**Segal Select**			
	06/01/21	Renewal of Fidelity Bond through Chubb for the period 06/01/2021 – 06/01/2024	$	3,747.00
2.	**Slevin & Hart, P.C.**			
	04/28/21	Professional Services rendered 01/2021 – 03/2021	$	1,635.00
3.	**Woodard Insurance Agency**			
	04/02/21	Ongoing FELRA Healthcare customer service and Orphan Enrollment	$	8,748.00

ASSOCIATED ADMINISTRATORS

To: Board of Trustees
FELRA VEBA Fund

From: Linda DuVall, CEBS
Associated Administrators, LLC

Date: June 22, 2021

Re: Invoice for Implementation of New Vendor – Dentegra Dental

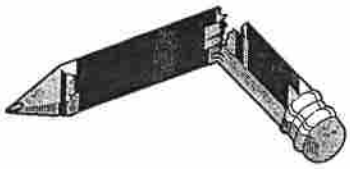
This invoice is presented to the Board of Trustees in accordance with Associated Administrators' administrative services agreement with the FELRA VEBA Fund. The hours and fees below reflect work performed by Associated in changing dental providers from Group Dental Service to Dentegra Dental.

	Hours	Amount
Information Technology	62 hours @ $100/hour	$6,200
Account Management	49 hours @ $100/hour	$4,900
Eligibility, Participant Services, Communications	12 hours @ $60/hour	$720
Accounting	4 hours @ $60/hour	$1,800
	Total	$13,620

Please let us know if you have any questions.

Thank you for your consideration.

911 Ridgebrook Road, Sparks, MD 21152-9451 (410) 683-6500
8400 Corporate Drive, Suite 430, Landover, MD 20785-2361 (301) 459-3020



MEETING NOTES