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Notice 2015-16

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AIR LINE PILOTS ASSOCIATION INTERNATIONAL

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May 15, 2015

VIA ELECTRONIC TRANSMISSION: Notice.comments@irscounsel.treas.gov

CC:PA:LPD:PR (Notice 2015-16)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Notice 2015-16
Section 4980I - Excise Tax on High Cost Employer-Sponsored Health Coverage

Ladies and Gentlemen:

On behalf of over 51,000 pilots who fly for 30 passenger and cargo airlines in the United States and Canada, the Air Line Pilots Association, International (ALPA) submits these comments in response to the invitation to comment on issues addressed in Notice 2015-16. We appreciate the opportunity to provide our views on potential approaches for calculating the excise tax on high cost employer-sponsored health coverage under the Patient Protection and Affordable Care Act of 2010 (ACA) described in the Notice before they are incorporated in future regulations.

Definition of Applicable Coverage

Health Savings Accounts (HSAs) as Applicable Employer-Sponsored Coverage

Internal Revenue Code (IRC) § 4980I provides that an HSA is applicable coverage to the extent of the employer's contribution to the HSA. The Notice states that Treasury and the Internal Revenue Service (IRS) anticipate that future guidance will provide that (1) employer contributions to HSAs, including salary reduction contributions to HSAs, are included in applicable coverage, and (2) employee after-tax contributions to HSAs are excluded from applicable coverage.

IRC § 4980I imposes an excise tax on any excess benefit provided under any "applicable employer-sponsored coverage." IRC § 4980I(d)(1) defines "applicable employer-sponsored coverage" as "coverage under any group health plan made available to the employee by an employer which is excludable from the employee's gross income under section 106, or would be so excludable if it were employer-provided coverage (within the meaning of such section 106)." The definition of

"applicable employer-sponsored coverage" includes two components. The coverage must be (1) provided under a group health plan, and then (2) must be excludable from income under IRC § 106 (or would be so excludable if it were employer-provided). As such, arrangements that are not group health plans are not subject to the excise tax.

By reference to IRC § 5000(b)(1), IRC § 4980I(f)(4) defines "group health plan" as "a plan...of, or contributed to by, an employer...to provide health care..." Based on guidance provided in Field Assistance Bulletin (FAB) 2004-1 and 2006-2, HSAs generally do not constitute group health plans provided employer involvement with the HSA is limited as described in the guidance. The fact that an employer makes contributions to the HSA or limits the forwarding of contributions through its payroll system to a single HSA provider does not, in itself, affect the conclusion that HSAs are not group health plans. As stated in FAB 2004-1, "HSAs are personal health care savings vehicles rather than a form of group health insurance." Further evidence that HSAs are not group health plans is the fact that the funds in an HSA may be used for both medical and non-medical expenses. Distributions for non-medical expenses are generally subject to tax and a penalty, but once the accountholder turns 65, becomes disabled, or dies, the penalty does not apply to distributions for non-medical expenses. If an HSA is not a group health plan, then it is not applicable employer-sponsored coverage to which IRC § 4980I applies.

To the extent that an HSA is determined to be applicable employer-sponsored coverage because it does not meet the conditions respecting employer involvement detailed in FAB 2204-1 and 2006-2, ALPA believes that the plain language of the statute does not support the inclusion of salary reduction contributions to an HSA as applicable coverage.

In the case of applicable coverage that consists of coverage under a health flexible spending account (FSA), IRC § 4980I(d)(2)(B)(i) specifically refers to "the amount of employer contributions under any salary reduction election under the arrangement." However, with respect to HSAs, IRC § 4980I(d)(2)(C) provides that "the cost of coverage shall be equal to the amount of employer contributions under the arrangement." ALPA believes that if Congress had intended to include salary reduction contributions to an HSA as employer contributions, and thereby as applicable coverage, it would have said so by using language consistent with the provision immediately before it relating to FSAs. Because the clause "under any salary reduction election" is contained only in the provision relating to FSAs, and not in the provision relating to HSAs, employer contributions under any salary reduction election should not be considered as applicable coverage with respect to HSAs.

Furthermore, it is reasonable and appropriate to exclude salary reductions contributions to an HSA from applicable coverage since an eligible employee who makes after-tax contributions to an HSA may take an "above the line" tax deduction for the contribution, achieving the same income tax result - i.e., exclusion of the amount of such contributions - as the employee would have achieved by making the

contributions as salary reduction contributions in the first place. We don't believe an employee should have to achieve this result in a roundabout way by making after-tax contributions to the HSA and claiming the above-the-line deduction, rather than simply making salary reduction contributions to the HSA with the same income tax result.

Another issue with respect to HSAs which is not addressed in the Notice involves HSA catch-up contributions. As discussed above, ALPA strongly believes that no salary reduction contributions to an HSA should be applicable coverage, including any catch-up contributions made to an HSA via salary reduction. However, if final regulations provide otherwise, then any HSA salary reduction contributions which constitute catch-up contributions by employees age 55 and older should certainly be excluded from applicable coverage. Excluding HSA catch-up contributions for purposes of determining applicable coverage would result in treatment similar to the way in which 401(k) plan catch-up contributions are excluded for purposes of applying the IRC § 415(c) limitation.

Limited Scope Dental and Vision Benefits as Applicable Employer-Sponsored Coverage

IRC § 4980I(d)(1)(B)(ii) excludes from applicable coverage "any coverage under a separate policy, certificate, or contract of insurance which provides benefits substantially all of which are for treatment of the mouth (including any organ or structure within the mouth) or for treatment of the eye." We support the proposed approach under which self-insured limited scope dental and vision coverage that qualify as excepted benefits pursuant to the recently issued regulations under IRC § 9831, would be excluded from applicable coverage for purposes of IRC § 4980I as well.

Employee Assistance Programs (EAPs) as Applicable Coverage

With regard to employee assistance programs (EAPs), ALPA sees no reason not to apply the same rule. Therefore, ALPA agrees with the proposal that EAPs which qualify as excepted benefits under § 9831 should also be excluded from applicable coverage for purposes of IRC § 4980I.

Determining Cost of Applicable Coverage

Similarly Situated Individuals

Similar to COBRA, in determining the cost of applicable coverage, ALPA believes "similarly situated individuals" for purposes of IRC § 4980I should be determined by aggregating employees by the benefit package in which they are enrolled, and then disaggregating the employees within the benefit package according to the employee's self-only or other-than-self-only level of coverage. ALPA supports permissive aggregation within other-than-self-only coverage so that all employees who are enrolled in the same benefit package, who receive coverage for any number of

individuals in addition to the employee, would be treated as similarly situated for purposes of determining the cost of coverage for that benefit package.

ALPA supports permissive disaggregation based on factors that bear some logical relationship to the purpose and structure of the tax. For example, the rules should permit disaggregation of active and retired employees even if both groups are enrolled in the same benefit package.

Methods for Self-Insured Plans to Determine Cost of Coverage

COBRA rules prescribe two methods for self-insured plans to determine the COBRA applicable premium - the actuarial basis method and the past cost method. A plan must use the actuarial basis method unless the plan administrator elects to use the past cost method and the plan is eligible to do so. For purposes of the excise tax, allowing both methods would give taxpayers more flexibility. It may smooth anomalous plan experience and taxes due from year to year, providing some predictability for employers and unions, instead of having greatly fluctuating yearly costs and taxes. Therefore, ALPA supports the option for a plan to (1) choose which method it uses, (2) switch between methods as frequently as annually (subject to the existing restrictions for using the past cost method), and (3) to use a different method for purposes of COBRA from the method used for purposes of the excise tax, in a given determination period.

Actuarial Basis Method. For the actuarial basis method, Treasury and IRS are considering whether to propose "a broad standard under which the cost of applicable coverage for a group of similarly situated individuals would be equal to a reasonable estimate of the cost of providing coverage under the plan for individuals in that group for a determination period, using reasonable actuarial principles and practices." Proposed regulations should include a specific list of costs that may be taken into account in the actuarial analysis/projections, and factors that must be satisfied to make an actuarial determination of the cost, including a requirement that individuals making actuarial estimates must be accredited.

ALPA strongly supports standards under which an estimate of the cost under the actuarial basis method would be an estimate of the actual cost the plan is expected to incur for a determination period, not the minimum (or maximum) exposure that the plan could have for that period. However, the rules should not prevent a plan from adopting reasonable actuarial methods for evaluating costs including methods designed to reduce or smooth volatility such as disregarding or discounting catastrophic claims that are not expected to be indicative of future plan cost or claims.

Past Cost Method. With respect to costs to be taken into account under the past cost method, the Notice suggests that the costs could include (1) claims, (2) premiums for stop-loss or reinsurance policies, (3) administrative expenses, and (4) reasonable

overhead expenses (to be defined). Regulations should provide that costs may include the actual claims, reasonable administrative expenses (to include third-party administrator fees), and premiums for stop-loss or reinsurance (provided claims exceeding the stop-loss threshold are excluded from the cost).

ALPA agrees that a presumption should be adopted that, for self-insured plans with a third-party administrator, overhead expenses are reflected in the third-party administrator fee and should therefore not be included for purposes of determining the cost of coverage for the excise tax. The employer should not be required or permitted to include overhead expenses related to its administration of a self-insured plan for purposes of determining the cost of coverage for the excise tax.

Excise Tax Not Included in Determination of Cost. IRC § 4980I(d)(2)(A) provides that the cost of applicable employer-sponsored coverage shall be determined under rules similar to COBRA except that "any portion of the cost of such coverage which is attributable to the tax imposed under this section shall not be taken into account..." The Notice states that Treasury and the IRS anticipate that the costs taken into account under the past cost method under the proposed regulations would not take into account, among other things, "any portion of the cost of coverage which is attributable to the excise tax." ALPA believes this exclusion should also apply to the actuarial basis method for calculating the cost. The Notice invites comments on whether a similar standard should apply for purposes of determining the COBRA applicable premium. If proposed regulations provide that the excise tax is excluded for purposes of IRC § 4980I only, and not for purposes of the COBRA applicable premium, guidance is requested on how the excise tax is to be taken into account for COBRA, and thereby passed along to the plan participants. It should be noted that allowing for the inclusion of the excise tax in the cost of coverage in any fashion would mean that the explicitly nondeductible excise tax may become deductible as part of an employer's deduction for health benefits provided to its employees.

Health Reimbursement Arrangements (HRAs)

Integrated vs. Stand-alone HRAs. The Notice does not distinguish between HRAs which are integrated with major medical coverage (a requirement, under the ACA for plans covering active employees), and stand-alone, retiree-only HRAs. Based on a review of the HRAs currently available to ALPA members, these two types of HRAs could have very different characteristics, and may require different rules with regard to determining the cost of coverage. For example, integrated HRAs generally provide an amount of employer contributions based on the tier of coverage elected, designed to offset the employee's out-of-pocket expenses such as the deductible, coinsurance, and copayments. An example would be a PPO plan accompanied by an HRA with an annual company contribution of $1,000/employee-only coverage, $1,500/employee+1 coverage, and $2,000/employee+2 or more coverage. These HRA contributions are notional, and unused amounts carry over from year to year but are generally forfeited

upon termination or retirement, or even upon the employee's switching out of the plan with which the HRA is integrated.

The stand-alone, retiree-only HRAs negotiated by ALPA are not notional amounts, but are actual dollars held in a VEBA trust. The HRA balances at retirement may or may not be integrated with a post-retirement plan that would be applicable coverage. Funds may be used to purchase individual coverage such as Medicare supplements.

Methods for Determining Cost of Applicable Coverage. Of the various methods suggested in the Notice for determining the cost of applicable coverage under an HRA, ALPA believes that determining the cost based on the amounts made newly available to a participant each year, **excluding carry-over amounts or amounts contributed or otherwise made newly available before 2018**, would be simple to administer and appropriate. ALPA requests that regulations confirm the following with regard to this approach:

- The exclusion for amounts made newly available before 2018 includes amounts that were credited or contributed to the HRA ***before*** 2018, even if not available to the participant until ***2018 or after***, including any investment earnings on such contributions.
- The exclusion for carry-overs includes amounts made newly available in one determination period which go unused, but remain available to the participant in subsequent years.
- No investment earnings on HRA account balances, regardless of the date contributed (i.e. whether before 2018 or in 2018 or after), are included in the cost of coverage.
- Any amounts that may be used only during retirement, even if contributed or credited while the employee is actively employed, is disregarded in determining the cost of the employee's coverage during active employment.

The following illustrative examples are provided:

> Example 1. A retiree HRA established in 2012 provides that the employer will make ongoing contributions to a VEBA trust on behalf of all employees during active employment. Upon retirement, each employee becomes eligible to use the balance in his/her HRA account, including investment earnings, to reimburse the eligible medical expenses of the retired employee and any eligible dependents.
>
> - Employee A retires on February 28, 2017, with an HRA balance of $75,000, including investment earnings on company contributions. No further contributions are made to the employee's HRA after retirement. As of January 1, 2018, the balance in this retired employee's HRA is $71,000 after reimbursement of eligible post-retirement medical expenses. Employee A's HRA balance, including investment earnings

credited after December 31, 2017, is not applicable coverage in 2018 or in any year thereafter.

- Employee B is an active employee. The balance in Employee B's retiree HRA on December 31, 2017, is $50,000, including investment earnings to date. The company continues to make contributions to Employee B's retiree HRA in 2018 and beyond, until Employee B retires on October 31, 2019. Employee B's HRA balance that becomes available to him at retirement is $75,000, including investment earnings to date. The retiree HRA is not applicable coverage in 2018 as Employee B is still actively employed and does not have access to the retiree HRA. The retiree HRA is not applicable coverage through October 2019 for the same reason. As of November 1, 2019, the retiree HRA is applicable coverage to the extent the account exceeds $50,000 (the balance in the HRA on December 31, 2017), not including any of the excess that is attributable to any investment earnings.

Example 2. A retiree HRA in the amount of $25,000 is established in 2008 on behalf of each employee satisfying certain age and service-related eligibility criteria pursuant to collective bargaining. The HRA does not become available to the employee until retirement. The HRA is not applicable coverage in any year with respect to any retiree, whether retirement occurs before or after January 1, 2018.

ALPA supports the additional methods described in the Notice as optional alternatives to the "amounts made newly available" method for determining the cost of coverage available, provided all methods exclude amounts contributed to the HRA before 2018, and all investment earnings. An approach that would permit adding together all claims and administrative expenses attributable to the HRA for a determination period and dividing that sum by the number of employees covered (subject to the aggregation/disaggregation rules) may be a preferred method for some stand-alone, retiree HRAs. The actuarial basis method should also be available to provide maximum flexibility in determining the cost of coverage, although guidance is needed on how the actuarial basis method would apply with respect to HRAs. Furthermore, ALPA supports the ability to switch between the available methods as frequently as annually, and to use different methods with respect to HRAs for active employees and retiree-only HRAs.

Avoid Double-Counting of Cost. HRAs which can only be used to fund employee contributions toward other applicable coverage should be excluded from applicable coverage to avoid double-counting.

Similarly, if the amount of an employer's contribution to an HRA is already being taken into account in determining the cost of the plan with which the HRA is integrated, adding the cost of the HRA to the aggregate cost of applicable coverage would result in double-counting. Therefore, the amount of an employer's contribution

to an HRA should not be added to the cost of the plan with which it is integrated if the cost of the plan already takes the HRA contribution into account.

HRAs Used for Excepted Benefits or Coverage Which is Not Applicable Coverage. Most HRAs allow reimbursement for a range of benefits, including some benefits which are not applicable coverage. Many, if not most, HRAs cover reimbursements for all medical care pursuant to IRC § 213(d),including excepted benefits such as dental and vision, and health insurance premiums, including premiums for individual coverage which is not applicable coverage. Determining the cost of an HRA based on amounts used only for applicable coverage may be administratively cumbersome, unpredictable and will simply add unnecessary cost to the plan.

ALPA urges the development of a safe harbor to discount the cost of HRAs based on what benefits are reimbursable by the HRA (pursuant to the HRA's plan design). Assuming the cost of an HRA is equal to the amount made newly available in the determination period (subject to the exclusions previously described for this approach), the following discount factors are suggested:

- 25% discount factor (cost equals 75% of the amount made newly available) for an HRA that may only be used for medical, dental and vision expenses, but not for other expenses (including other excepted benefits) otherwise considered medical care under IRC § 213(d). The 25% discount recognizes that the HRA may be used to reimburse dental and vision expenses, which are excepted benefits.
- 50% discount factor (cost equals 50% of the amount made newly available) for an HRA that may be used for *all* medical care pursuant to IRC § 213(d). The 50% discount recognizes that the HRA may be used to reimburse expenses for excepted benefits such dental, vision, long-term care, coverage for specified disease or illness, and coverage which is not applicable coverage, such as individual health insurance coverage.
- 100% discount factor (no cost) for an HRA that may only be used to fund employee contributions toward applicable coverage (to avoid double-counting), or for an HRA that reimburses excepted benefits only (HSA-compatible, limited-purpose HRA that reimburses dental and vision expenses only).

Similar Issues Also Apply to FSAs and HSAs. The Notice raises the issue of how the cost should be determined for HRAs that reimburse expenses for excepted benefits or for coverage which is or is not applicable coverage. However, the same issue arises with respect to health FSAs and HSAs as well.

IRC § 4980I explicitly provides that FSAs are applicable coverage, and § 4980I(d)(2)(B) provides that the cost of applicable coverage under an FSA is equal to the sum of salary reduction contributions plus the amount determined under the general calculation rule with respect to any reimbursement under the arrangement in excess of the salary reduction contributions (identified in the Notice as employer flex contributions used for the health FSA). However, health FSAs, like HRAs, are available to reimburse all IRC § 213(d) medical expenses (with the exception of

premiums). In fact, limited-purpose FSAs, designed to complement HSA-eligible high-deductible health plans, usually limit reimbursements to dental and vision expenses.

With regard to HSAs, the Notice anticipates that future regulations will provide that employer contributions to HSAs are included in applicable coverage. Here again, consideration should be given to the fact that an HSA is generally available to reimburse all IRC § 213(d) medical expenses (with the exception of most premiums). Furthermore, any catch-up contributions made by employees age 55 and older should be excluded from applicable coverage similar to the way in which catch-up contributions in 401(k) plans are excluded for purposes of the IRC § 415(c) limits.

For these reasons, ALPA urges that any rules promulgated with respect to HRAs in this regard should also apply to FSAs and to the portion of HSA contributions considered to be applicable coverage.

Determining the Cost on a Monthly Basis. IRC § 4980(d)(2)(D) provides that allocation of the cost of applicable coverage will be on a monthly basis, and gives the Secretary authority to prescribe rules for allocating the cost if determined on other than a monthly basis. Determining the cost on a monthly basis for major medical coverage is typical and reasonable, but guidance is needed on how to determine the cost on a monthly basis with respect to FSAs, HRAs, and HSAs (to the extent the HSA is applicable coverage).

For an FSA, it would be reasonable to provide that the monthly cost is $1/12^{th}$ of the annual salary deferral election plus any additional company contribution in the form of flex credits or otherwise (subject to any adjustment that may be considered for the FSAs availability to reimburse excepted benefits, as discussed above).

HRAs and HSAs get more complicated. The employer may make contributions for active employees on a monthly, quarterly, or annual basis, but sometimes contributions consist of wellness credits, which employees have to qualify for, and which may never be made. Retiree-only HRAs may provide that the entire HRA balance is made available at retirement, but only a small portion may actually be used to reimburse expenses in any year. Salary reduction elections for HSA contributions are not subject to the rules under IRC § 125, so changes can be made throughout the year to either increase or reduce the amount of the reduction, and front-loading is often permitted. The regulations will need to provide a method for calculating the cost on other than a monthly basis for these types of applicable coverage.

Application to COBRA. Regardless which approaches are adopted to determine the cost of applicable coverage under an HRA, it is unclear how they could be applied in the context of COBRA. Prior guidance relating to HRAs provides that HRAs are subject to COBRA, but under the COBRA rules, the qualified beneficiary is responsible for payment of the COBRA applicable premium. The rules governing HRAs require that

contributions to the HRA be made by the employer only, so it is unclear how HRA coverage could be continued under COBRA if the qualified beneficiary is responsible for the full COBRA cost.

Determination Period

ALPA believes it would be beneficial, particularly in the collective bargaining environment, for any liability under § 4980I to be known well in advance of a taxable year. Advance knowledge of the potential liability will provide parties to a collective bargaining agreement the opportunity to negotiate changes that may be necessary to reduce the cost of the plan to avoid the excise tax. Therefore, ALPA strongly supports a rule similar to the COBRA rule, whereby the determination of the cost of applicable coverage would be made in advance for a 12-month period.

Special rules would need to be included, however, with respect to determining the applicable cost of FSAs in advance, as employees generally do not make their FSA salary deferral elections as far in advance as the cost of major medical coverage is typically calculated. Also, to the extent salary deferral contributions to HSAs are applicable coverage, it would also be difficult to determine the cost in advance as the IRC § 125 rules respecting the timing of salary deferral elections and changes do not apply to HSA contributions. Finally, many HRAs, HSAs, and even FSAs, are sometimes funded by wellness credits which the employees must earn, and therefore the cost is not known in advance. This uncertainty creates a need for special timing rules for determining the cost of these types of applicable coverage.

Applicable Dollar Limit

Employees with Both Self-Only and Other-Than-Self-Only Applicable Coverage

The Notice recognizes that an employee may simultaneously have coverage to which the self-only dollar limit applies and coverage to which the other-than-self-only dollar limit applies. Two potential approaches for application of the dollar limit to employees with both self-only and other-than-self-only coverage are described - the primary coverage approach and the composite approach. ALPA generally supports the availability of both methods, applied consistently to all the employees of the employer (subject to the permissive aggregation/disaggregation rules). However, if only one approach is permissible, ALPA supports the primary coverage approach, wherein an employee's primary coverage is the type of coverage that accounts for the majority of the aggregate cost of applicable coverage. The applicable dollar limit for an employee should be determined based on whether the employee's primary coverage is self-only or other-than-self-only coverage.

Applicable Dollar Limit as Applied to HRAs. In applying either of these methods, further guidance is needed with respect to determining whether HRA coverage is self-only or other-than-self-only. Unlike a major medical plan, which requires employees

to "enroll" in self-only or other-than-self-only coverage, actual "enrollment" in an HRA is not typically required. If an employee enrolls in a major medical plan which is integrated with an HRA, the employee is automatically enrolled in the HRA, which may or may not pay the eligible expenses of the employee's dependents depending on the terms of the plan. The following are examples for consideration:

1. An HRA is integrated with a major medical plan and reimbursements from the HRA are only available for the eligible expenses of the individuals actually enrolled in the primary major medical plan. If the employee enrolls in self-only coverage under the major medical plan, the HRA automatically reimburses only the eligible out-of-pocket medical expenses of the employee. The HRA only reimburses the eligible medical expenses of an employee's dependents if the dependents are enrolled in the major medical plan. The regulations should confirm that the HRA is considered self-only coverage with respect to an employee enrolled as self-only in the major medical plan, and other-than-self-only coverage with respect to an employee who is enrolled as other-than-self-only in the major medical plan.
2. An HRA is integrated with a major medical plan, but the reimbursement of eligible out-of-pocket medical expenses is not automatic. The HRA will reimburse the eligible medical expenses of the employee and any eligible dependents irrespective of whether the employee is enrolled as self-only or other-than-self-only under the major medical plan. ALPA understands that under the primary coverage approach, the applicable dollar limit will be based on the employee's enrollment in the major medical plan as either self-only or other-than-self-only. Under the composite approach, the other-than-self-only limit should apply with respect to the portion of the aggregate cost attributable to an HRA that is available to reimburse the eligible expenses of the employee and all eligible dependents.
3. A stand-alone HRA is made available to each employee upon retirement. No "enrollment" is required, and the HRA is available for the reimbursement of the eligible medical expenses of the retiree and any eligible dependents. The other-than-self-only dollar limit should apply with respect to a stand-alone HRA that is available to reimburse the eligible expenses of the employee and all eligible dependents, whether or not a particular retired employee has any eligible dependents.

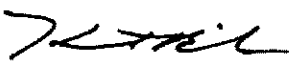
Age and Gender Adjustments

IRC § 4980I(b)(3)(C)(iii) provides for age and gender adjustment to the applicable dollar limits if the age and gender characteristics of an employer's workforce are different from those of the national workforce. ALPA welcomes the availability of such adjustments to the dollar limits and requests further guidance on the characteristics that that are to be taken into consideration, and the extent to which they need to be different from those of the national workforce. To simplify the

process, ALPA fully supports the development of safe harbors that appropriately adjust the dollar limits to take differing age and gender characteristics into account.

ALPA appreciates the opportunity to participate in the process of developing regulatory guidance regarding the excise tax by submitting these comments. Any questions relating to these comments may be directed to Marian Tashjian at (703) 689-4129, or via email to marian.tashjian@alpa.org.

Sincerely,



F/O Kenneth Binder
Chairman, National Retirement & Insurance Committee
Air Line Pilots Association, International