Regulations 30 CFR 57.5060, 57.5065, 57.5066, 57.5070, 57.5071, and 57.5075(a) and (b)(3).

This information collection is subject to the PRA. A Federal agency generally cannot conduct or sponsor a collection of information, and the public is generally not required to respond to an information collection, unless it is approved by the OMB under the PRA and displays a currently valid OMB Control Number. In addition, notwithstanding any other provisions of law, no person shall generally be subject to penalty for failing to comply with a collection of information if the collection of information does not display a valid Control Number. *See* 5 CFR 1320.5(a) and 1320.6. The DOL obtains OMB approval for this information collection under Control Number 1219–0135. The current approval is scheduled to expire on September 30, 2012; however, it should be noted that existing information collection requirements submitted to the OMB receive a month-to-month extension while they undergo review. For additional information, see the related notice published in the **Federal Register** on June 4, 2012 (77 FR 33002).

Interested parties are encouraged to send comments to the OMB, Office of Information and Regulatory Affairs at the address shown in the **ADDRESSES** section within 30 days of publication of this notice in the **Federal Register**. In order to help ensure appropriate consideration, comments should mention OMB Control Number 1219–0135. The OMB is particularly interested in comments that:

- Evaluate whether the proposed collection of information is necessary for the proper performance of the functions of the agency, including whether the information will have practical utility;
- Evaluate the accuracy of the agency's estimate of the burden of the proposed collection of information, including the validity of the methodology and assumptions used;
- Enhance the quality, utility, and clarity of the information to be collected; and
- Minimize the burden of the collection of information on those who are to respond, including through the use of appropriate automated, electronic, mechanical, or other technological collection techniques or other forms of information technology, e.g., permitting electronic submission of responses.

Agency: DOL–MSHA.

Title of Collection: Health Standards for Diesel Particulate Matter Exposure (Underground Metal and Nonmetal Mines).

OMB Control Number: 1219–0135.

Affected Public: Private sector—businesses or other for-profits.

Total Estimated Number of Respondents: 173.

Total Estimated Number of Responses: 28,022.

Total Estimated Annual Burden Hours: 3,329.

Total Estimated Annual Other Costs Burden: $509,532.

Dated: August 22, 2012.

Michel Smyth,

Departmental Clearance Officer.

[FR Doc. 2012–21194 Filed 8–27–12; 8:45 a.m.]

BILLING CODE 4510–43–P

DEPARTMENT OF LABOR

Employee Benefits Security Administration

163rd Meeting of the Advisory Council on Employee Welfare and Pension Benefit Plans; Notice of Teleconference Meeting

Pursuant to the authority contained in Section 512 of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1142, the 163rd open meeting of the Advisory Council on Employee Welfare and Pension Benefit Plans (also known as the ERISA Advisory Council) will be held via teleconference on September 25, 2012.

The meeting will take place in C5521 Room 4, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210. Public access is available only in this room (i.e. not by telephone). The meeting will run from 10:00 a.m. to approximately 4:00 p.m. The purpose of the open meeting is to discuss reports/recommendations for the Secretary of Labor on the issues of (1) Managing Disability Risks in an Environment of Individual Responsibility; (2) Current Challenges and Best Practices Concerning Beneficiary Designations in Retirement and Life Insurance Plans; and (3) Examining Income Replacement During Retirement Years in a Defined Contribution Plan System. Descriptions of these topics are available on the Advisory Council page of the EBSA Web site at *http://www.dol.gov/ebsa/aboutebsa/erisa_advisory_council.html.*

Organizations or members of the public wishing to submit a written statement may do so by submitting 30 copies on or before September 18, 2012 to Larry Good, Executive Secretary, ERISA Advisory Council, U.S. Department of Labor, Suite N–5623, 200 Constitution Avenue NW., Washington, DC 20210. Statements also may be submitted as email attachments in text or pdf format transmitted to *good.larry@dol.gov.* It is requested that statements not be included in the body of an email. Statements deemed relevant by the Advisory Council and received on or before September 18 will be included in the record of the meeting and made available in the EBSA Public Disclosure Room, along with witness statements. Do not include any personally identifiable information (such as name, address, or other contact information) or confidential business information that you do not want publicly disclosed.

Individuals or representatives of organizations wishing to address the Advisory Council should forward their requests to the Executive Secretary or telephone (202) 693–8668. Oral presentations will be limited to ten minutes, time permitting, but an extended statement may be submitted for the record. Individuals with disabilities who need special accommodations should contact the Executive Secretary by September 18, 2012 at the address indicated.

Signed at Washington, DC this 22nd day of August, 2012.

Michael L. Davis,

Deputy Assistant Secretary, Employee Benefits Security Administration.

[FR Doc. 2012–21126 Filed 8–27–12; 8:45 am]

BILLING CODE 4510–29–P

DEPARTMENT OF LABOR

Employee Benefits Security Administration

[Application No. L–11688]

Notice of Proposed Exemption Involving Sharp HealthCare Located in San Diego, CA

AGENCY: Employee Benefits Security Administration, U.S. Department of Labor.

ACTION: Notice of proposed exemption.

SUMMARY: This document contains a notice of pendency (the Notice) before the Department of Labor (the Department) of a proposed individual exemption from certain prohibited transaction restrictions of the Employee Retirement Income Security Act of 1974 (the Act or ERISA). The transactions involve the Sharp HealthCare Health and Dental Plan (the Plan). The proposed exemption, if granted, would affect the Plan, its participants and beneficiaries, Sharp Healthcare (Sharp), and the Sharp Health Plan (the HMO).

DATES: *Effective Date:* The proposed exemption, if granted, will be effective as of August 1, 2006.

DATES: Written comments and requests for a public hearing on the proposed exemption should be submitted to the Department within 33 days from the date of publication of this **Federal Register** Notice.

ADDRESSES: Comments and requests for a hearing should state: (1) The name, address, and telephone number of the person making the comment or request, and (2) the nature of the person's interest in the proposed exemption and the manner in which the person would be adversely affected by the exemption, if granted. A request for a hearing must also state the issues to be addressed and include a general description of the evidence to be presented at the hearing. All written comments and requests for a public hearing concerning the proposed exemption should be sent to the Office of Exemption Determinations, Employee Benefits Security Administration, Room N–5700, U.S. Department of Labor, 200 Constitution Avenue NW., Washington, DC 20210, Attention: Application No. L–11688. Interested persons are also invited to submit comments and/or hearing requests to EBSA via email or FAX. Any such comments or requests should be sent either by email to: *moffitt.betty@dol.gov,* or by FAX to (202) 219–0204 by the end of the scheduled comment period. The application for exemption and the comments received will be available for public inspection in the Public Documents Room of the Employee Benefits Security Administration, U.S. Department of Labor, Room N–1513, 200 Constitution Avenue NW., Washington, DC 20210. Comments and hearing requests will also be available online at *www.regulations.gov* and *www.dol.gov/ebsa,* at no charge.

Warning: If you submit written comments or hearing requests, do not include any personally-identifiable or confidential business information that you do not want to be publicly-disclosed. All comments and hearing requests are posted on the Internet exactly as they are received, and they can be retrieved by most Internet search engines. The Department will make no deletions, modifications or redactions to the comments or hearing requests received, as they are public records.

FOR FURTHER INFORMATION CONTACT: Mr. Warren Blinder, Office of Exemption Determinations, Employee Benefits Security Administration, U.S. Department of Labor, telephone (202) 693–8553. (This is not a toll-free number.)

SUPPLEMENTARY INFORMATION: This document contains a notice of proposed exemption that, if granted, would provide exemptive relief from sections 406(a)(1)(A), 406(a)(1)(D), 406(b)(1), and 406(b)(2) of the Act, effective August 1, 2006, for the purchase of health insurance by the Plan from the HMO, a non-profit health maintenance organization wholly owned by the Plan's sponsor, Sharp, through a 100% non-profit membership interest.

Summary of Facts and Representations [1]

1. Background

Sharp is an integrated health care delivery system located in San Diego County. Sharp was created in 1946 as a non-profit association to raise funds to build a hospital and in 1955, based on a lead donation from Thomas E. Sharp, a hospital was built on 12.5 acres in Kearney Mesa, California. From that hospital, Sharp HealthCare has grown into a countywide system comprised of five hospitals, multiple clinics, and two pharmacies.

In 1992, Sharp established its own licensed HMO through a subsidiary corporation called ''Sharp Health Plan.'' The HMO is a 501(c)(4) corporation and Sharp is its sole member, with appointment authority over 100% of the HMO's Board of Director positions. The HMO offers a provider network that consists of 5 Sharp-affiliated hospitals, 5 Sharp-affiliated urgent care clinics, 11 Sharp-affiliated pharmacies, and 347 Sharp-affiliated (or Sharp-contracted) physicians in 4 different medical groups. Additionally, the HMO offers access to 7 non-Sharp affiliated hospitals, 25 non-Sharp affiliated urgent care clinics, approximately 360 non-Sharp affiliated pharmacies, and 570 non-Sharp affiliated physicians comprised of 290 physicians in 4 different medical groups, and 280 independent physicians. The HMO is licensed by the California Department of Managed Health Care and is offered to San Diego employers and individuals. The Applicant notes that the HMO and Sharp's facilities have a good reputation in San Diego County and have received numerous awards for quality over the years. Additionally, Sharp states that it has more licensed hospital beds than any other health care provider in San Diego County.

Sharp provides health benefits to its employees under the Plan. As of March 2012, the Plan had 10,993 participants and provided benefits to approximately 24,339 individuals. In 1993, Sharp began providing its employees' medical and vision benefits under the HMO. As the HMO is the only available option under the Plan, all participants were covered under the HMO. Each year, Sharp establishes a flat employee contribution rate for different levels of coverage (e.g., employee-only, employee plus-one, employee plus-family) and Sharp pays any remaining premiums based on the rates that it negotiates with the HMO. Between 2006 and 2010 Sharp paid approximately 85% of the premium cost of such coverage and employees paid the remaining 15% through pre-tax salary deferral contributions. Employee contributions are collected by Sharp, put into its general account and used as part of the premium payment to the HMO. The Applicant represents that all such plan assets are spent on premiums almost immediately upon being withheld from employees' paychecks. Employees also make co-payments directly to the actual providers of the medical care they receive, including Sharp, if the services have been provided in one of its facilities.

The HMO sets premiums for Sharp employees based on the experience of the Sharp employee population, as is the case with its other employer clients. The Applicant notes that, as a non-profit, the HMO only retains sufficient earnings to maintain its legally required reserves. In addition, the Applicant states that the HMO reduces its claims administration costs and is able to get better capitated rates from providers by pooling all of the covered lives under the HMO, rather than negotiating separate claims administration and capitated rate negotiations for just the Sharp employee population. According to the Applicant, this reduces the overall cost of health benefits under the Plan, ultimately reducing the cost Sharp employees pay for their coverage.

Sharp is designated as the plan administrator of the Sharp HealthCare Group Health and Welfare Plan.[2] In the past, Sharp's Board of Directors had not appointed an administrative committee to act as the plan administrator on behalf of Sharp, but going forward, the Sharp Board of Directors will appoint a committee to act as the plan administrator for the Plan in place of

[1] The Summary of Facts and Representations is based on the Applicant's representations and does not reflect the views of the Department.

[2] The Applicant states that Sharp, its Board of Directors, Anne Stephenson, Ann Pumpian and Carlisle Lewis, III, Esq., are all fiduciaries within the meaning of section 3(21) of the Act.

Sharp, which will be comprised of the: (1) Senior Vice President, General Counsel, (2) Senior Vice President/Chief Financial Officer, and (3) Vice President/Compensation and Benefits. The Applicant states that although each of these employees receives a portion of their compensation based on factors that include ''target net revenue,'' [3] Sharp's use of the HMO for its employees has little, if any, impact on such compensation. The Applicant explains that the portion of target net revenue attributable to the Plan's use of the HMO for its employees is immaterial, and any premiums that are paid to the HMO are ultimately offset as a revenue item by fees the HMO pays to Sharp for medical and other services.

Sharp's Vice President of Compensation and Benefits conducts an annual review to determine the reasonableness of total premiums paid by Sharp employees for coverage under the HMO. Sharp's Vice President of Compensation and Benefits also reviews the ''employee share'' rates to make sure that they are competitive when compared to the rates their peer employers are charging. The Applicant notes that the Vice President of Compensation and Benefits has used the services of outside vendors, such as Keenan & Associates and SDH Consultants to assist her in this comparison, and based on these surveys, Sharp has concluded that the premiums paid, as well as the employees' share of such premiums, for coverage under the HMO were reasonable.

2. Request for Relief

The Applicant represents that for 18 years, Sharp has provided its employees with health insurance through the HMO, under the mistaken belief that this coverage was permissible under Prohibited Transaction Exemption (PTE) 79–41, 44 FR 46365 (August 7, 1979). The Applicant relates that, on April 5, 2011, the Los Angeles Regional Office of the Department of Labor (the Department) concluded an audit of the Plan and determined that the Plan's provision of coverage under the HMO did not meet the requirements of Section II(a)(1) of PTE 79–41, as described below.

PTE 79–41 provides that the restrictions of sections 406(a), 406(b)(1) and (2), and 407(a) of the Act and the taxes imposed by section 4975(a) and (b) of the Code, by reason of section 4975(c)(1)(A) through (E) of the Code, shall not apply to the sale, in any taxable year, by an insurance company which is a party in interest or disqualified person with respect to an employee benefit plan, of life insurance, health insurance, and annuities if certain conditions are met.

Section II(a) of PTE 79–41 provides that the insurance company making the sale must:

(1) [Be] a party in interest or disqualified person with respect to the plan by reason of a stock or partnership (including a joint venture) affiliation with the employer establishing or maintaining the plan that is described in section 3(14)(E) or (G) of the Act* * *,

(2) [Be] licensed to sell insurance in at least one of the United States or in the District of Columbia,

(3) [Have] obtained a Certificate of Compliance from the insurance commissioner of its domiciliary state within the 18 months prior to the date when the transaction is entered into or when such certificates were last made available by the domiciliary state, if earlier, and

(4)(i) [Have] undergone a financial examination (within the meaning of the law of its domiciliary state) by the insurance commissioner of such state within 5 years prior to the end of the year preceding the year in which the sale occurred, or

(ii) [Have] undergone an examination by an independent certified public accountant for its last completed taxable year.

The Applicant states that Section II(a)(1) has not been complied with because Sharp does not have a stock or partnership interest in the HMO, but instead is the sole member of the HMO, and as such, has the power to appoint 100% of the HMO's Board of Directors. Nevertheless, the Applicant contends that Sharp's control of the HMO is no less complete than it would be if Sharp's ownership interest was denominated in the form of stock or a partnership interest.[4]

The Applicant maintains that the general premise undergirding PTE 79–41 is no less applicable in the case of a non-profit health care system whose ownership is through membership rather than a shareholder interest. In this regard, the Applicant states that health systems that maintain their own HMO or insurance policies invariably use those policies to provide health insurance benefits to their own employees. Thus, according to the Applicant, it would be ''contrary to ordinary business practices, and unnecessarily restrictive, to require'' an employer who is in the business of selling health insurance to purchase such health insurance for its employees from a competitor.

Furthermore, Sharp contends that its control of the HMO via a non-profit membership interest presents a non-substantive, technical violation of the class exemption that has no bearing on the relief afforded to the Plan and its parties in interest, or the protection of the interests of the Plan and its participants and beneficiaries. The Applicant states that the relationship between Sharp and the HMO reflects the ''qualities'' behind PTE 79–41's affiliation requirement. In this regard, the Applicant observes that Sharp and the HMO are part of a closely connected system that have a common mission and integrated operations, and that Sharp could not find an independent carrier that would be as responsive to employer and participant needs as the HMO. According to the Applicant, the fact that Sharp and the HMO are non-profit corporations and do not have stock or partnership interests, and, therefore, exercise control through Sharp's Board of Directors' appointment authority, does not in any way diminish Sharp's control over and comprehensive integration with the HMO. Thus, the Applicant submits that Sharp's failure to meet the affiliation condition of PTE 79–41, as described herein, is merely technical in nature and not meaningful to the Department's granting of relief under PTE 79–41.

The Applicant is therefore requesting a retroactive exemption from sections 406(a)(1)(A), 406(a)(1)(D), 406(b)(1) and 406(b)(2) of the Act for the Plan's purchase of health care coverage from the HMO, which Sharp wholly-owns through a non-profit membership interest, effective August 1, 2006 through and until the date of publication of a final grant of exemption in the **Federal Register**. Furthermore, the Applicant is requesting a prospective exemption from sections 406(a)(1)(A), 406(a)(1)(D), 406(b)(1) and 406(b)(2) of the Act for the Plan's continued purchase of health care coverage from the HMO, which Sharp wholly-owns through a non-profit membership interest, effective as of the date of publication of a final grant of exemption in the **Federal Register**.[5]

[3] According to the Applicant, target net revenue is made up of all Sharp revenue, except ''Medi-Cal'' hospital fee program receipts, reduced by bad debt.

[4] The Applicant maintains that the DOL and the IRS are of the view that, in the context of a non-profit corporation, control may be exercised through appointment power over the Board of Directors rather than stock or partnership interests. See ERISA Opinion Letter 82–48A (September 16, 1982), and Treasury Regulation 1.414(c)–5(b). The Department expresses no opinion herein as to the applicability of the aforementioned authorities to the covered transactions.

[5] The Applicant represents that Sharp provides certain services to the HMO in connection with the operation of its integrated health care delivery system. The Applicant states that Sharp is of the view that these services are within the scope of

Continued

After considering the Applicant's request, the Department has determined to propose an individual prohibited transaction exemption. The proposed exemption has been requested in an application filed by Sharp pursuant to section 408(a) of ERISA and in accordance with the procedures set forth in 29 CFR 2570, Subpart B (55 FR 32836, August 10, 1990).

3. Compliance With Conditions of PTE 79–41

The Applicant urges the Department to propose exemptive relief, because, according to the Applicant, all of the conditions of relief required under PTE 79–41 have been satisfied with respect to the Sharp arrangement described herein, except the condition in Section II(a)(1), requiring that Sharp control the HMO via a stock or partnership ownership interest. In this regard, the Applicant represents that the HMO: Is licensed as an HMO in California by the Department of Managed Healthcare; has been certified by the California Department of Managed Healthcare as being in compliance with the requirements for a licensed HMO within the last 18 months; and has undergone a financial examination by the California Department of Managed Healthcare within the last five years and is audited by an independent certified public accountant each year, including its last completed taxable year. Therefore, the Applicant maintains that Sharp has satisfied the conditions set forth in Sections II(a)(2), (3), and (4) of PTE 79–41. The Applicant also represents that the amount the Plan pays to Sharp for HMO coverage is reasonable and does not exceed the amount that would be paid for similar services in an arm's length transaction between unrelated parties, thereby satisfying Section II(b) of PTE 79–41. The Applicant also represents that no commissions are paid by the Plan for the insurance coverage purchased from the HMO, thereby satisfying Section II(c) of PTE 79–41. Finally, the Applicant states that the total HMO premiums collected for participants in the Plan (including employee and employer payments) have always, during the period covered by this application, been less than 50% of total premiums collected by the HMO. Therefore, the Applicant maintains that the condition contained in Section II(d) of PTE 79–41 is satisfied.

4. Additional Protections

According to the Applicant, the HMO, as a licensed HMO in California, employs an underwriter and contracts with an actuary to calculate the appropriate premiums that it charges to employers who purchase group HMO contracts from the HMO. According to the Applicant, this analysis involves a study of industry trends and also the particular demographics of the employer's workforce and, for a continuing employer, such as Sharp, a review of the historic experience that the HMO has had with the employer's population. Based on this underwriting analysis, premiums are set for a contract year.[6]

In addition, the Applicant states that it also conducts its own survey of premiums that are being paid for HMO coverage by other San Diego area hospitals, using the services of third-party benefit consultants to conduct these surveys.[7] The Applicant explains that, under these third party surveys, each of the large hospitals in San Diego County are anonymously surveyed as to the COBRA rates they are charging.[8] The Applicant maintains that the premiums that have been paid by Sharp to the HMO are within the market price paid by similarly situated employers in San Diego County. Based on these two separate methodologies, Sharp and its individual fiduciaries have concluded that the amount the Plan pays to Sharp for HMO coverage is reasonable and does not exceed the amount that would be paid for similar services in an arm's length transaction between unrelated parties.

The Applicant notes that Sharp will continue with these efforts, going forward, and will commit to hiring an independent third-party consultant each year to issue a formal report. According to the Applicant, the consultant will determine whether the amount employees and/or their dependents pay for coverage is reasonable and does not exceed the amount that would have been paid for similar services in an arm's length transaction between unrelated parties. This amount will include the cost of co-payments and other out-of-pocket expenses for such coverage borne by participants and/or their dependents, and copies of the certification will be distributed to Plan participants along with summaries of health care costs for similar, competing health care providers.

The Applicant states that if the proposed exemption is granted, the Board of Directors of Sharp will appoint a committee (the Plan Committee) consisting of the Senior Vice President and General Counsel, the Senior Vice President and Chief Financial Officer, and the Vice President, Compensation and Benefits, and such other representatives as the Board may deem appropriate, which will annually ascertain and certify in writing that the above requirements of this proposed exemption, if granted, continue to be met.

5. Merits of the Covered Transactions

The Applicant states that the covered transactions are in the interest of the Plan and its participants and beneficiaries. The Applicant maintains that the covered transactions allow the Plan to provide quality medical coverage to its participants at a lower price and in a manner that harmonizes with the business practices of employers who are in the insurance and health care industry. Sharp maintains that participants in the Plan pay for less than half of the Plan's cost for coverage under the HMO and by electing coverage under the HMO, participants have access to a wide range of high quality Sharp and non-Sharp affiliated health care providers.[9] Furthermore, if the exemption is denied, the Applicant maintains that the Plan and its participants and beneficiaries will lose their coverage under the HMO and will no longer be able to use Sharp providers, creating a hardship for the many Sharp employees who have demonstrated a preference for being treated in Sharp's health care system.

The Applicant represents that the savings garnered from the HMO's efficiencies of scale, and the lack of need for commissions, redounds to the benefit of Plan participants. In this regard, the Applicant explains that there

exemptive relief provided by section 408(b)(2) of ERISA. The Department is expressing no opinion herein regarding whether the provision of a service by Sharp to the HMO in connection with the operation of its integrated health care delivery system is within the scope of relief provided by that statutory exemption.

[6] The Applicant also notes that Sharp has historically paid a majority of the Plan's premiums that are paid to the HMO and employee contributions have always constituted less than half of the cost of coverage.

[7] As stated above, Sharp has previously employed the firms of Keenan and Associates and SDH Consultants to conduct these surveys.

[8] Sharp officials believe that surveying COBRA premiums charged by other large hospitals in the San Diego County area will give an ''apples-to-apples'' comparison of premiums that are actually being paid by employers with similar demographics to Sharp, since, under COBRA, the ''applicable premium'' is the cost or 102% of the cost actually paid by the employer for such coverage.

[9] The Applicant notes that Plan participants in the HMO are able to select any health care provider in the HMO's network, regardless of whether they are affiliated with Sharp, but in an HMO (rather than a Preferred Provider Organization) participants are not allowed to select health care providers outside the HMO's network, except in case of emergency.

is no need to retain a broker and pay a commission for the retention of the Plan's HMO coverage. Additionally, since the HMO also covers the health plans of other employers, Sharp is able to achieve economies of scale on its risk, claims processing, administration and health care provider capitation costs that further drive down the overall cost of Plan medical benefits for employees under the Plan.

Moreover, the Applicant represents that an exemption, if granted, would be administratively feasible because the covered transactions are standard for employers who are in the insurance and health care industry. The Applicant also observes that, because the HMO is a fully licensed HMO carrier whose claims processing activities are subject to regulation and periodic review by the California Department of Managed Health Care, no third party audit of its claims processing is necessary.[10] Finally, the Applicant states that Sharp has complied with, and will continue to comply with the conditions of PTE 79–41 (with the exception of the affiliation requirement).

Notice to Interested Persons

Notice of the proposed exemption will be provided to all interested persons in the manner agreed upon by the Applicant and the Department within 3 days of the date of publication in the **Federal Register**. Such notice will contain a copy of the notice of proposed exemption, as published in the **Federal Register**, and a supplemental statement, as required pursuant to 29 CFR 2570.43(b)(2). The supplemental statement will inform interested persons of their right to comment on and to request a hearing with respect to the pending exemption. Written comments and hearing requests are due within 33 days of the publication of the notice of proposed exemption in the **Federal Register**.

General Information

The attention of interested persons is directed to the following:

(1) The fact that a transaction is the subject of an exemption under section 408(a) of ERISA does not relieve a fiduciary or other party in interest from certain other provisions of ERISA, including any prohibited transaction provisions to which the exemption does not apply and the general fiduciary responsibility provisions of section 404 of ERISA, which, among other things, require a fiduciary to discharge his duties respecting the plan solely in the interest of the participants and beneficiaries of the plan and in a prudent fashion in accordance with section 404(a)(1)(b) of ERISA;

(2) Before an exemption may be granted under section 408(a) of ERISA, the Department must find that the exemption is administratively feasible, in the interests of the plan and of its participants and beneficiaries, and protective of the rights of participants and beneficiaries of the plan;

(3) The proposed exemption, if granted, will be supplemental to, and not in derogation of, any other provisions of ERISA, including statutory or administrative exemptions and transitional rules. Furthermore, the fact that a transaction is subject to an administrative or statutory exemption is not dispositive of whether the transaction is in fact a prohibited transaction; and

(4) The proposed exemption, if granted, will be subject to the express condition that the material facts and representations contained in the application are true and complete, and that the application accurately describes all material terms of the transaction which is the subject of the proposed exemption.

Proposed Exemption

Based on the facts and representations set forth in the application, the Department is considering granting the requested exemption under the authority of section 408(a) of the Act and in accordance with the procedures set forth in 29 CFR Part 2570, Subpart B (55 FR 32836, 32847, August 10, 1990), as follows:

Section I. Covered Transactions

A. If the proposed exemption is granted, the restrictions of sections 406(a)(1)(A), 406(a)(1)(D), 406(b)(1), and 406(b)(2) of the Act shall not apply, effective August 1, 2006 through and until the date of publication in the **Federal Register** of a final grant of exemption, to the purchase of health insurance by the Sharp HealthCare Health and Dental Plan (the Plan) from the Sharp Health Plan (the HMO), provided that the conditions of Section II have been met.

B. If the proposed exemption is granted, the restrictions of sections 406(a)(1)(A), 406(a)(1)(D), 406(b)(1), and 406(b)(2) of the Act shall not apply, effective as of the date of publication in the **Federal Register** of a final grant of exemption, to the purchase of health insurance by the Plan from the HMO, provided that the conditions of Section II and Section III are met.

Section II. General Conditions

(a) Sharp is the sole member of the HMO, and more than 50% of the appointment power for the HMO's Board of Directors is held by Sharp.

(b) Sharp is licensed to sell HMO coverage in the State of California.

(c) The HMO is certified by the California Department of Managed Health Care as being in compliance with the requirements for a licensed HMO within the last 18 months.

(d) The HMO has undergone a financial examination by the California Department of Managed Health Care within the past 5 years and will continue to undergo such financial examinations at least once every five years.

(e) The HMO has been, and will continue to be, examined by an independent certified public accountant annually.

(f) The amount the Plan pays to Sharp for HMO coverage is reasonable and does not exceed the amount the Plan would have paid for similar services in an arm's length transaction between unrelated parties.

(g) All HMO-offered health care providers meet all applicable licensure requirements and certifications.

(h) The HMO offers a sufficient number of non-Sharp affiliated health care providers to effectively allow Plan participants the opportunity to receive health care services from either Sharp or non-Sharp affiliated health care providers.

(i) No commissions are paid by the Plan with respect to the sale of HMO coverage.

(j)(i) With respect to the relief provided in section I. A., for each taxable year of the HMO, the gross premiums received in that taxable year by the HMO from the Plan did not exceed 50% of the gross premiums received by the HMO for all HMO coverage issued in that taxable year; or (ii) with respect to the relief provided in section I. B., for each taxable year of the HMO, the gross premiums received in that taxable year by the HMO from the Plan will not exceed 50% of the gross premiums received by the HMO for all HMO coverage issued in that taxable year.

(k) Sharp maintains or causes to be maintained for a period of six years from the date of any covered transaction hereunder such records as are necessary to enable the persons described in paragraph (l)(i) below to determine whether the conditions of this proposed exemption, if granted, have been met, provided that (i) a separate prohibited transaction will not be considered to

[10] The Applicant notes that the Department of Managed Health Care also reviews and approves all HMO provisions for compliance with its rules and regulations.

have occurred if, due to circumstances beyond the control of Sharp, the records are lost or destroyed prior to the end of the six-year period, and (ii) no party in interest other than Sharp shall be subject to a civil penalty that may be assessed under section 502(i) of the Act, if such records are not maintained, or are not available for examination as required by paragraph (l)(i) below.

(l)(i) Except as provided below in paragraph (l)(ii), and notwithstanding any provisions of subsections (a)(2) and (b) of section 504 of the Act, the records referred to above in paragraph (k) are unconditionally available at their customary location for examination during normal business hours by:

(A) Any duly authorized employee or representative of the Department,

(B) Any duly authorized representative of the California Department of Managed Health Care or any State or Federal governmental body responsible for regulatory oversight of Sharp or the HMO, and

(C) Any fiduciary of the Plan or the Plan's authorized representative; and

(ii) None of the persons described above in paragraph (l)(i)(C) shall be authorized to examine trade secrets of Sharp, or commercial or financial information which is privileged or confidential, and should Sharp refuse to disclose information on the basis that such information is exempt from disclosure, Sharp shall, by the close of the thirtieth (30th) day following the request, provide a written notice advising that person of the reasons for the refusal and that the Department may request such information.

Section III. Prospective Conditions

(a) Sharp retains annually the services of an independent third-party consultant to determine whether the amount employees and/or their dependents pay for coverage is reasonable and does not exceed the amount that would be paid for similar services in an arm's length transaction between unrelated parties, which amount includes the cost of co-payments and other out-of-pocket expenses for such coverage borne by participants and/or their dependents, and written copies of such determination are distributed to Plan participants along with summaries of health care costs for similar, competing health care providers.

(b) The Board of Directors of Sharp appoints a committee (the Plan Committee) consisting of the Senior Vice President and General Counsel, the Senior Vice President and Chief Financial Officer, the Vice President, Compensation and Benefits, and such other representatives as the Board of Directors may deem appropriate. The Plan Committee will annually ascertain and certify in writing that the above requirements of this proposed exemption, if granted, continue to be met.

Signed at Washington, DC, this 17th day of August, 2012.

Lyssa E. Hall,

Director of Exemption Determinations, Employee Benefits Security Administration, U.S. Department of Labor.

[FR Doc. 2012–21158 Filed 8–27–12; 8:45 am]

BILLING CODE 4510–29–P

LEGAL SERVICES CORPORATION

Sunshine Act Meeting

DATE AND TIME: The Legal Services Corporation's Board of Directors will meet telephonically on August 31, 2012. The meeting will commence at 11 a.m., Eastern Daylight Time, and will continue until the conclusion of the Board's agenda.

LOCATION: F. William McCalpin Conference Room, Legal Services Corporation Headquarters, 3333 K Street NW., Washington DC 20007.

PUBLIC OBSERVATION: Members of the public who are unable to attend in person but wish to listen to the public proceedings may do so by following the telephone call-in directions provided below but are asked to keep their telephones muted to eliminate background noises. To avoid disrupting the meeting, please refrain from placing the call on hold. From time to time, the presiding Chair may solicit comments from the public.

CALL–IN DIRECTIONS FOR OPEN SESSIONS:

- Call toll-free number: 1–866–451–4981;
- When prompted, enter the following numeric pass code: 5907707348;
- When connected to the call, please immediately ''MUTE'' your telephone.

STATUS OF MEETING: Open, except that, upon a vote of the Board of Directors, a portion of the meeting may be closed to the public to discuss a candidate for the position of Vice President for Grants Management. A verbatim written transcript will be made of the closed session of the Board of Directors meeting. The transcript of any portion of the closed session falling within the relevant provisions of the Government in the Sunshine Act, 5 U.S.C. 552b(c)(6), and the corresponding provision of the Legal Service's Corporation's implementing regulations, 45 CFR 1622.5(e), will not be available for public inspection. A copy of the General Counsel's Certification that in his opinion the closing is authorized by law will be available upon request.

Matters To Be Considered

Open Session

1. Approval of agenda
2. Approval of minutes of the Board's meeting of July 27, 2012
3. Consider and act on the Finance Committee's recommendation to the Board on the appropriations request for FY 2014 (Resolution 2012–XXX)
4. Consider and act on the Strategic Plan
5. Consider and act on a resolution abolishing the Office of Vice President for Programs and Performance and establishing the Office of Vice President for Grants Management (Resolution 2012–XXX)
6. Consider and act on whether to authorize an executive session of the Board

Closed Session

7. Discussion of candidate for the Office of Vice President for Grants Management

Open Session

8. Consider and act on a resolution on the appointment of a Vice President for Grants Management (Resolution 2012–XXX)
9. Public comment
10. Consider and act on other business
11. Consider and act on motion to adjourn the meeting

CONTACT PERSON FOR INFORMATION: Katherine Ward, Executive Assistant to the Vice President & General Counsel, at (202) 295–1500. Questions may be sent by electronic mail to *FR_NOTICE_QUESTIONS@lsc.gov.*

NON–CONFIDENTIAL MEETING MATERIALS: Non-confidential meeting materials will be made available in electronic format at least 24 hours in advance of the meeting on the LSC Web site, at *http://www.lsc.gov/board-directors/meetings/board-meeting-notices/non-confidential-materials-be-considered-open-session.*

ACCESSIBILITY: LSC complies with the American's with Disabilities Act and Section 504 of the 1973 Rehabilitation Act. Upon request, meeting notices and materials will be made available in alternative formats to accommodate individuals with disabilities. Individuals who need other accommodations due to disability in order to attend the meeting in person or telephonically should contact Katherine Ward, at (202) 295–1500 or *FR_NOTICE_QUESTIONS@lsc.gov*, at least 2 business days in advance of the