BENEFITS SUMMARY FOR TERMINATING EMPLOYEES

JANUARY 2014
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[Revised December 2013]
2014 BENEFITS SUMMARY
FOR TERMINATING EMPLOYEES

This booklet provides information regarding your benefit coverage when you terminate your employment with TVA. For more information regarding your benefits, please refer to the Benefits and Wellness website (http://orgs.tva.gov/ppmain/EBW/Pages/Home.aspx), the Retirees section of www.tva.com, or contact one of the resources shown on the Contact Information list on page 14.

MEDICAL PLAN

Active Employee Medical Coverage
If you currently have TVA medical coverage, it will stop at the end of the month in which your employment terminates.

NOTE: If you do not continue your TVA coverage as a retiree or otherwise, you will have "extended benefits" for six months following the termination of your active employee medical coverage. This extended benefits provision allows you to receive benefits only for any illness or injury which was diagnosed and treated before the termination of your coverage. Extended benefits are provided at no cost to you.

Extended benefits include coverage for prescription drugs. You must provide the TVA Service Center a letter from your doctor(s) to document medication(s) you are using for pre-existing conditions. You will also need to call the TVA Service Center at 888-275-8094 prior to obtaining any of these medications during these six months.

Retiree Medical Coverage

Eligibility
You are eligible to continue medical coverage for yourself and for your eligible dependents in one of the retiree medical plans, if you covered yourself and your dependents under a TVA medical plan on your last day of work, and you:

- are ACTUAL AGE 50 with at least 5 years service as a full-time annual TVA employee (if you were hired on or after January 1, 2005, you must be actual age 55 with 10 years of actual TVA service); or
- are at least ACTUAL AGE 60 with no service requirement; or
- are any age, with at least 5 years of service as a full-time annual TVA employee, who is terminated due to a reduction in force (voluntary or involuntary) or otherwise terminated for other than cause; or
- are any age and have been approved for a disability retirement benefit by the TVA Retirement System (TVARS) or terminate TVA employment because of a disability, as determined by the Senior Vice President, Human Resources and Communications, or
- retire with an immediate benefit from Federal Employees Retirement System (FERS) or Civil Service Retirement System (CSRS).

Note: Because it is important that your service dates are accurate, it is recommended that you review your service dates in the PLUS Portal before you terminate.
Enrollment
To enroll in retiree medical coverage, you must complete TVA form 17328 retiree medical application (included in this document) and submit it to the TVA Service Center (WT CP-K).
Retiree medical election forms must be received by the TVA Service Center within 30 days after termination in order to maintain eligibility for retiree medical coverage.

Individual or family coverage? If you currently have individual coverage as an active employee, you cannot elect family coverage at retirement. If you have eligible dependents at termination and do not elect coverage for the dependents when you leave TVA, you will not be allowed to cover those dependents in the future.

If you do not enroll in retiree medical coverage
If you are eligible for medical coverage as a retiree and you do not elect coverage at termination, you will not be given another opportunity to enroll in a TVA-sponsored medical plan. (See special provisions applicable to TVA couples if your spouse is also a TVA employee or retiree.)

If you terminate your retiree medical coverage
If you elect retiree medical coverage at the time you leave TVA and later elect to terminate that coverage, you will not be given another opportunity to re-enroll in a TVA-sponsored medical plan.

If your spouse or dependent loses eligibility for medical coverage
You must notify the TVA Service Center at 888-275-8094 within 30 days if a spouse or dependent child is no longer eligible for coverage and must respond to requests for information needed to confirm eligibility.

Coverage for a spouse ends on the date of legal separation or divorce. Coverage for a dependent child ends on the date the child becomes ineligible (e.g., date limiting age is reached).

Retiree Medical Plan Options
Retirees who are not eligible for Medicare may choose from two medical plans at retirement. You have a choice of the 80% PPO Plan or Consumer-Directed Health Plan. See the Retiree Medical Information and Forms section for a comparison of the medical plans.

Retirees not eligible for Medicare will have the opportunity each fall to select a medical plan option for the following year.

TVA reserves the right to amend, modify, suspend or terminate its retiree health plans, in whole or in part. Amendments, modifications, suspensions or terminations to the TVA retiree health plans may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction or elimination of benefits or other features of the plans to the extent permitted by law. TVA’s rights described above include the right, at any time, to (i) obtain coverage and/or administrative services from additional or different insurance carriers or third party administrators, (ii) revise the amount of the retirees' contributions toward the cost of coverage, and (iii) revise or eliminate TVA's contributions toward the cost of coverage.

[Revised December 2013]
Retiree Medical Plan Premiums

As of January 1, 2014, the full monthly premiums are:

<table>
<thead>
<tr>
<th>Blue Preferred Network P</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% PPO Plan</td>
<td>$592.00</td>
<td>$1,424.00</td>
</tr>
<tr>
<td>Consumer-Directed Health Plan (CDHP)</td>
<td>$336.00</td>
<td>$806.00</td>
</tr>
<tr>
<td>Medicare Supplement</td>
<td>$258.00</td>
<td>N/A</td>
</tr>
</tbody>
</table>

TVARS Supplemental Benefit for TVARS Members

Many retirees will receive a supplemental benefit from TVARS if they meet eligibility requirements.

You should contact TVARS to determine your eligibility for this benefit and, if eligible, the amount of the benefit in your case.

TVA Contributions for Retirees not Eligible for TVARS Supplemental Benefit

Retirees who are not members of TVARS but instead are members of FERS or CSRS (or who are disabled) and who meet the eligibility criteria below will receive a contribution toward the cost of retiree medical coverage directly from TVA as long as they remain eligible for and continue to be enrolled in a TVA-sponsored medical plan. Retirees who qualify for this TVA contribution are responsible for the full monthly amount of their premiums minus the amount of TVA’s monthly contribution.

Eligibility Criteria

To qualify for a TVA contribution, the retiree must be:

- A FERS/CSRS eligible retiree who ceases to be a TVA employee on or after January 1, 2009, and after reaching actual age 55 and having 5 years of actual full-time TVA service; or
- A FERS/CSRS eligible retiree upon reaching actual age 55 and who ceases to be a TVA employee on or after January 1, 2009, due to an involuntary reduction in force, after reaching actual age 50 and having performed 5 years of actual full-time TVA service; or
- A full-time annual TVA employee who retires on a disability retirement, or who is otherwise determined by TVA to be disabled at the time of separation from TVA employment, and who is not otherwise eligible for a contribution hereunder or for a supplemental benefit under TVARS Rules.

Effective January 1, 2014, the TVA contribution for eligible retirees is $9.73 per month for each year of actual combined Federal service (actual full-time TVA and Federal civilian service). The minimum contribution is for 5 years of actual combined Federal service. Effective January 1, 2014 individuals eligible for a TVA contribution will also receive an additional contribution of $79.18 per month under this plan.

Contributions made by TVA under this plan are subject to annual adjustments based on increases in the Consumer Price Index (CPI), not to exceed plan maximums. CPI adjustments
to these additional contributions will stop when these benefits reach $12.00 and $120.00, respectively.

**TVA Health-Care Credit for Retirees**
Under the TVA Health-Care Credit for Retirees, TVA will provide a credit based on years of TVA service and monthly base pension amount. Eligible retirees will receive the credit before their monthly payment is calculated, thus reducing the amount paid out-of-pocket each month.

The Health-Care credit is in addition to any supplemental benefit provided by TVARS or contributions from TVA for CSRS/FERS retirees. However, the credit will be reduced by the amount of the supplemental benefit or contributions. **TVA’s credit under this plan will not exceed $450 per month.**

**Eligibility**
To receive this credit, a retiree must be at least actual age 55, must have at least 20 years’ actual TVA service and must be receiving the original supplemental benefit from TVARS, not just the additional benefit (or a comparable credit from TVA for retirees who are not eligible for the TVARS supplemental benefit).

Eligible retirees who are under age 55 but meet the other criteria will receive this credit when they reach age 55. Qualifying survivors of deceased retirees and employees will receive the credit when the retiree or employee would have reached age 55. Upon reaching age 55, disabled retirees will receive the minimum Health-Care credit, based on 20 years of TVA service, or the contribution based on their years of TVA service, whichever is greater.

Retirees who have more than 20 years of TVA service but less than 25 years will receive a contribution based on 20 years of service. Retirees who have more than 25 years of service but less than 30 will receive a contribution based on 25 years of service. No additional credit will be given for TVA service over 30 years.

*Note: Because it is important that your service dates are accurate, it is recommended that you review your service dates in the PLUS Portal before you terminate.*
Determining the Health-Care Credit Amount

The plan is designed to place a limit on the out-of-pocket amount eligible retirees pay for medical coverage. The limit is based on the cost of the Medicare supplement if the retiree is eligible for Medicare or the cost of the 80% PPO medical plan if the retiree is not yet eligible for Medicare. Retirees not eligible for Medicare will still be able to choose from the CDHP or 80%, PPO options, but the TVA-provided credit calculation will be based on the 80% PPO plan premium.

If the retiree’s monthly base pension is less than $2,000 per month:

<table>
<thead>
<tr>
<th>Years of TVA Service</th>
<th>Retiree’s out-of-pocket cost, after applying the TVARS supplemental benefit, will not be more than 25 percent of the premium.* If the retiree’s health-care credit reaches the maximum of $450 per month, the retiree’s out-of-pocket cost may be greater than 25 percent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 years</td>
<td>Retiree’s out-of-pocket cost, after applying the TVARS supplemental benefit, will not be more than 25 percent of the premium.* If the retiree’s health-care credit reaches the maximum of $450 per month, the retiree’s out-of-pocket cost may be greater than 25 percent.</td>
</tr>
<tr>
<td>25 years</td>
<td>Retiree’s out-of-pocket cost, after applying the TVARS supplemental benefit, will not be more than 20 percent of the premium.* If the retiree’s health-care credit reaches the maximum of $450 per month, the retiree’s out-of-pocket cost may be greater than 20 percent.</td>
</tr>
<tr>
<td>30 years</td>
<td>Retiree’s out-of-pocket cost, after applying the TVARS supplemental benefit, will not be more than 15 percent of the premium.* If the retiree’s health-care credit reaches the maximum of $450 per month, the retiree’s out-of-pocket cost may be greater than 15 percent.</td>
</tr>
</tbody>
</table>

If the retiree’s monthly base pension is $2,000 or more per month:

<table>
<thead>
<tr>
<th>Years of TVA Service</th>
<th>Retiree’s out-of-pocket cost, after applying the TVARS supplemental benefit, will not be more than 30 percent of the premium.* If the retiree’s health-care credit reaches the maximum of $450 per month, the retiree’s out-of-pocket cost may be greater than 30 percent.</th>
</tr>
</thead>
<tbody>
<tr>
<td>20 years</td>
<td>Retiree’s out-of-pocket cost, after applying the TVARS supplemental benefit, will not be more than 30 percent of the premium.* If the retiree’s health-care credit reaches the maximum of $450 per month, the retiree’s out-of-pocket cost may be greater than 30 percent.</td>
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<td>25 years</td>
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<td>Retiree’s out-of-pocket cost, after applying the TVARS supplemental benefit, will not be more than 20 percent of the premium.* If the retiree’s health-care credit reaches the maximum of $450 per month, the retiree’s out-of-pocket cost may be greater than 20 percent.</td>
</tr>
</tbody>
</table>

*Premium is based on Medicare supplement cost or 80% PPO medical plan as applicable.

This TVA-provided healthcare credit is not a vested benefit, and TVA reserves the right to amend the plan or terminate this benefit at any time.

[Revised December 2013]
**Examples of TVA Health-Care Credit Calculation**

<table>
<thead>
<tr>
<th>25 Years of TVA Service</th>
<th></th>
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<tbody>
<tr>
<td>Base Pension At Least $2,000/month</td>
<td>Age 58</td>
<td>80% PPO Plan Premium, Family</td>
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<tr>
<td></td>
<td></td>
<td>25% of Premium*</td>
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<td>Difference to be covered by TVARS</td>
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<td></td>
<td></td>
<td>Supplemental Benefit and TVA Credit</td>
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<td></td>
<td></td>
<td>Less TVARS Supplemental Benefit and Additional Benefit</td>
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<td>TVA Health-Care Credit</td>
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<table>
<thead>
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<th>20 Years of TVA Service</th>
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<tbody>
<tr>
<td>Base Pension At Least $2,000/month</td>
<td>Age 58</td>
<td>80% PPO Plan, Individual, + One Medicare Supplement Plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td>30% of Premium*</td>
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<tr>
<td></td>
<td></td>
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<table>
<thead>
<tr>
<th>25 Years of TVA Service</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Pension Less Than $2,000/month</td>
<td>Age 66</td>
<td>2 Medicare Supplement Plans</td>
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<td></td>
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<tr>
<td></td>
<td></td>
<td>TVA Health-Care Credit</td>
</tr>
</tbody>
</table>

*Retiree out-of-pocket maximum per credit plan guidelines
**Maximum credit amount per credit plan guidelines

**Paying for Retiree Medical Coverage**

Your monthly cost for retiree medical coverage can be deducted from your monthly retirement pension. There will not be a deduction from your first pension check. This deduction will be
taken retroactively from your second or third pension check. Due to the final calculations of premiums due and any Health-Care credit, you may see varying deduction amounts over your first few pension checks until all calculations and adjustments are completed.

If the amount of your monthly pension does not allow for your full medical plan deduction, you must have your premium deducted from your bank account by completing a bank draft form TVA 17534 (included in this package). If premiums are not paid, coverage will be canceled for nonpayment and may not be reinstated.

**Medicare Eligible Retirees or Dependents**
A retiree, or covered dependent, eligible for Medicare cannot be covered by the 80%, or Consumer-Directed Health Plan. Such retiree, or covered dependent, will instead be covered under a TVA-sponsored Medicare supplement plan.

Most individuals will become eligible for Medicare upon reaching age 65. The TVA Service Center will notify you, or your dependent, before reaching age 65 about coverage under the Medicare supplement plan. Any covered family members not yet eligible for Medicare will remain in the plan you have selected for that year.

Some individuals, however, will become eligible for Medicare before age 65. If you, or your dependent, become eligible for Medicare before age 65, you must notify the TVA Service Center within 30 days so that your enrollment and premiums can be adjusted accordingly. Failure to provide such information could result in your having to repay the amount of any claims that were paid incorrectly.

See the *Retiree Medical Information and Forms* section for a description of the Supplement to Medicare plan.

**TVA Retiree Couples**
Retirees cannot be both a subscriber and dependent in a TVA-sponsored medical plan. If a TVA retiree’s spouse is a TVA employee, the retiree covered at retirement, either as a subscriber or as a dependent in a TVA-sponsored medical plan, may choose either family or individual coverage within 30 days of:
- death of the spouse
- divorce or legal separation from the spouse
- spouse’s termination from TVA, or
- last covered dependent other than spouse becoming ineligible provided that he/she met the eligibility criteria for retiree medical at the time he/she terminated employment from TVA.

Example: You and your spouse both worked for TVA. Your spouse retired, dropped insurance and has been covered on your active employee medical plan. You are now retiring. If your spouse qualified for retiree medical upon leaving TVA, your spouse has the option to come back into the retiree medical plan. You and your spouse can each have individual policies, or one of you can have family coverage.

TVA retiree couples should consider any Health-Care credit each may be eligible for when determining the manner in which they plan to continue their medical coverage in retirement. The

[Revised December 2013]
Health-Care credit reduces the amount you pay out of pocket each month for medical coverage. See the TVA Health-Care Credit For Retirees section for more information.

**Continuation of Medical Coverage if Ineligible for Retiree Medical**

If you are not eligible to continue medical coverage through the retiree medical plan, you can continue your medical plan coverage for up to 3 months after termination.

To continue your coverage, you must send your payments to:

TVA Treasury  
WT 4C, 400 West Summit Hill Drive  
Knoxville, Tennessee 37902

You will not be billed by TVA. Checks must be made payable to TVA and include the employee’s EIN. Include a notation on the check indicating the payment is for “Medical for (insert appropriate month).”

The first payment is due by the first of the month following termination. After that, payments are due by the 15th of the month preceding the month for which payment is being made. For example, if you leave September 30, your payment for October is due October 1. November’s payment is due by October 15. December’s payment is due by November 15.

If you have questions regarding the rates for coverage you may call the TVA Service Center at 888-275-8094. **If you do not make the payment, your medical coverage will be canceled.**

**Medical Plan Premiums**

Premiums payable to continue medical coverage under this provision are the same premiums applicable to TVA retirees. As of January 1, 2014, the full monthly premiums are:

<table>
<thead>
<tr>
<th>Blue Preferred Network P</th>
<th>Individual</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% PPO Plan</td>
<td>$592.00</td>
<td>$1424.00</td>
</tr>
<tr>
<td>Consumer-Directed Health Plan (CDHP)</td>
<td>$336.00</td>
<td>$806.00</td>
</tr>
</tbody>
</table>

**HealthCheck Benefit Credit**

If you are currently receiving a benefit credit earned from your participation in HealthCheck, the last benefit credit will appear on your final regular payroll. You will no longer be eligible for this credit.
DENTAL PLAN

Active Employee Dental Coverage
Dental coverage under TVA’s plan for employees stops at the end of the month in which your employment terminates and cannot be continued after you leave TVA.

NOTE: Certain limited circumstances exist in which benefits can be provided for services that are concluded after your employee plan coverage ends:

- Charges for dentures will be payable if the impression was taken prior to termination of coverage and the dentures are installed within two months following termination of coverage.
- Charges for fixed bridgework, crowns, and gold restorations will be payable if the tooth was prepared prior to termination of coverage and the bridge, crown, or gold restoration is placed within two months following termination of coverage.
- Charges for endodontics, including root canal therapy, will be payable if the tooth was opened prior to termination of coverage and the expenses in connection with the endodontic treatment are incurred within two months following such termination.

Dental Coverage in Retirement
A retiree who receives a monthly pension benefit has the option to purchase dental coverage from Delta Dental Plan of Tennessee (DDP). A retiree must enroll within 30 days of their date of retirement or they will not be given another opportunity to elect retiree dental coverage unless one of the following applies:

- an open enrollment period is designated in the future, or
- the retiree has deferred his/her pension benefit to a future date. The retiree will become eligible when he/she begins receiving a benefit check.

To enroll, retirees should complete the TVA Retiree Dental Enrollment form. The form explains the options for payment of premiums after the first three-month period. A form authorizing bank-draft payment of monthly premiums is included if needed. All retiree dental forms must be mailed to Delta Dental at the address shown on the forms.

Delta Dental Plan Premiums
As of July 1, 2013, the monthly premiums are:
Employee Only: $34.26  Family: $80.85

For more detailed information see the Delta Dental Information and Forms section for a description of the Retiree Dental Plan.

Supplemental Life Insurance Plan
Supplemental life insurance coverage stops at the end of the month in which your employment terminates. To be eligible to convert your life insurance to an individual policy, you must:
- apply within 31 days of termination and have been insured under the TVA group plan for at least 5 consecutive years.

Conversion rates are different from current rates and are established by the insurance company. Conversion applications are available from the TVA Service Center at 888-275-8094. For additional information regarding conversion, call Aetna at 800-523-5065.

[Revised December 2013]
**Accidental Death and Dismemberment Plan**
Accidental death and dismemberment coverage stops at the end of the month in which your employment terminates. You can convert your coverage if you apply within 31 days after coverage terminates.

Conversion rates are different from current rates and are established by the insurance company. Conversion applications are available from the TVA Service Center at 888-275-8094. For additional information regarding conversion, call the Selman Group at The Hartford at 877-320-0484.

**Optional Long-Term Disability**
Optional long-term disability coverage stops on the date your employment terminates. To be eligible to convert your long-term disability coverage to an individual policy, you must:
- apply within 31 days of termination, and
- have been insured under the TVA group plan for at least 12 months, and
- your TVA employment must have been terminated for reasons other than retirement, disability, or gross misconduct

Conversion rates are different from current rates and are established by the insurance company. Conversion applications are available from the TVA Service Center at 888-275-8094.

**Flexible Spending Accounts**
Contributions to the flexible spending accounts and participation in the accounts stop when you leave TVA. You can receive reimbursement for eligible expenses that were incurred prior to the date of your termination. Expenses incurred after your termination are not reimbursable. You will forfeit any money left in your accounts at termination after all claims have been paid.

Employees participating in the flexible spending accounts must file for reimbursement for eligible expenses incurred in 2013, prior to date of termination, by April 15, 2014. All claims are filed with ADP, formerly SHPS HR Solutions, P.O. Box 34700, Louisville, Kentucky 40232-4700.

**Federal Employees Group Life Insurance (FEGLI)**
When you terminate employment and your FEGLI coverage stops, except by waiver or cancellation, your coverage automatically continues for an additional 31 days after the termination date. There is no extension of coverage during the following situations:

- When you waive or cancel your insurance.
- When your annuity or compensation is terminated and your FEGLI stops.
- When a family member loses his/her eligibility.
- There is no extension beyond 31 days.

If you have had FEGLI coverage for at least five years (or as long as you have been eligible if you have not been eligible for at least five years), you may continue FEGLI if you qualify for an immediate retirement benefit. TVARS will provide information on continuing FEGLI as a retiree.
If you are not eligible for a retirement benefit, you may convert FEGLI coverage to a direct-pay policy. The FEGLI conversion form may be obtained by calling the TVA Service Center at 888-275-8094 or from the FEGLI website at www.opm.gov/forms/pdf_fill/sf2819.pdf. You must apply for conversion within 31 days of termination. FEGLI information may also be found at the FEGLI website at www.opm.gov/insure/life.
## CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Vendor/Customer Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>TVA Service Center</td>
<td>888-275-8094</td>
</tr>
<tr>
<td></td>
<td>888-633-0372 Fax</td>
</tr>
<tr>
<td></td>
<td>e-mail <a href="mailto:esc@tva.gov">esc@tva.gov</a></td>
</tr>
<tr>
<td>Aetna (Supplemental life insurance conversion)</td>
<td>800-523-5065</td>
</tr>
<tr>
<td>BlueCross BlueShield of Tennessee (Medical)</td>
<td>800-245-7942</td>
</tr>
<tr>
<td>BlueCross BlueShield of Tennessee (Vision)</td>
<td>877-342-0737</td>
</tr>
<tr>
<td>Catamaran (Prescription Drugs)</td>
<td>855-234-3511</td>
</tr>
<tr>
<td></td>
<td>855-207-5871 (Medicare Supplement plan members only)</td>
</tr>
<tr>
<td>Delta Dental</td>
<td>800-223-3104</td>
</tr>
<tr>
<td>Federal Employees’ Group Life Insurance Program (FEGLI)</td>
<td>Contact the TVA Service Center</td>
</tr>
<tr>
<td>HSA Bank (Health Savings Account)</td>
<td>800-357-6246</td>
</tr>
<tr>
<td>ADP, formerly SHPS HR Solutions (Flexible Spending Accounts)</td>
<td>800-678-6684</td>
</tr>
<tr>
<td>The Hartford (The Selman Group) (Accidental Death &amp; Dismemberment conversion)</td>
<td>800-523-2233</td>
</tr>
<tr>
<td>Unum (Long-term disability conversion)</td>
<td>800-635-5597</td>
</tr>
</tbody>
</table>

Be sure to notify TVARS and the TVA Service Center if you have a change in address.
BENEFITS CHECKLIST FOR RETIREES

To enroll in retiree medical coverage:
□ Complete TVA form 17328 Retiree Medical Application
□ Complete TVA form 17534 Retiree Medical Bank Draft if necessary
□ Return forms to TVA Service Center within 30 days of retirement
□ If enrolling in the CDHP and do not currently have a Health Savings Account (HSA), follow the instructions on page 2 of the Retiree Medical Application

To enroll in retiree dental coverage:
□ Complete Delta Dental enrollment form and direct debit form
□ Return forms to Delta Dental within 30 days of retirement

To convert life insurance coverage:
□ Complete conversion application from TVA Service Center
□ Submit application within 31 days of termination

To convert accidental death & dismemberment coverage:
□ Complete conversion application from TVA Service Center
□ Submit application within 31 days of termination

Flexible spending accounts
□ Determine if any money is left in flexible spending accounts.
□ File for reimbursement by deadlines for eligible expenses incurred prior to termination

FEGLI
□ Check with TVARS regarding retiree FEGLI coverage
   To convert FEGLI coverage, if not eligible for retiree coverage:
   □ Complete conversion application from TVA Service Center
   □ Submit application within 31 days of termination

Remember to keep copies of all the forms submitted.

Reminders
• Review your service dates in the PLUS Portal before you terminate.
• Notify the TVA Service Center if you or any of your dependents become eligible for Medicare before age 65.
• Notify TVARS and the TVA Service Center if you have a change in address.
• Notify the TVA Service Center if a spouse or dependent child is no longer eligible for coverage.
To continue medical coverage for up to 3 months:
  □ Send payments to TVA Treasury
    □ First payment due by the first of the month following termination
    □ Following payments due by the 15th of the month preceding the month for which payment is being made.

To use the medical plan’s extended benefits coverage
  □ Send a signed letter to the TVA Service Center from your doctor to confirm any pre-existing medication(s)
  □ Call the TVA Service Center prior to obtaining any of these medications during the six months extended benefits period

To convert life insurance coverage:
  □ Complete conversion application from TVA Service Center
  □ Submit application within 31 days of termination

To convert accidental death & dismemberment coverage:
  □ Complete conversion application from TVA Service Center
  □ Submit application within 31 days of termination

To convert long-term disability coverage:
  □ Complete conversion application from TVA Service Center
  □ Submit application within 60 days of termination

Flexible spending accounts
  □ Determine if any money is left in flexible spending accounts.
  □ File for reimbursement by deadlines for eligible expenses incurred prior to termination

FEGLI
  □ Check with TVARS regarding retiree FEGLI coverage
    □ To convert FEGLI coverage, if not eligible for retiree coverage:
      □ Complete conversion application from TVA Service Center
      □ Submit application within 31 days of termination

Remember to keep copies of all the forms submitted.
RETIREE MEDICAL INFORMATION AND FORMS

- Application
- Bank Draft Authorization
- Medical Plan Information
TVA Medical Coverage Application for Non-Employees
TVA Service Center, 400 West Summit Hill Drive, WT CP-K, Knoxville, TN 37902
Telephone - 888-275-8094

Last Name  First  Middle  Social Security Number
Street Address  Apt. No.  City  State  Zip
Telephone Number  Marital Status  Date of Birth (mm/dd/yyyy)  Male  Female

Eligible for coverage as:  □ Retiree  □ RIF-Voluntary  □ RIF-Involuntary  □ No-fault Separation
                                    □ Survivor of deceased active employee  □ Other
                                    (Please specify)

Termination Date (mm/dd/yyyy): ____________________________
Previous federal civilian service:  □ Yes  □ No
(See note on page 2.)
I am a:  □ TVA Disability Retiree  □ FERS  □ CSRS
I am eligible for Medicare:  □ Yes  □ No  If Yes, attach copy of the Medicare card(s).
I have Medicare eligible dependents/spouse:  □ Yes  □ No  If Yes, attach copy of the Medicare card(s).

Please Mark All Appropriate Elections

Medical Plan
A.  □ Self  □ Spouse  □ Dependents

Medicare Supplement Plan
B.  Options:
     □ 80% PPO
     □ Consumer-Directed Health Plan*
     *You must complete a separate election to open a
       Health Savings Account (HSA). See page 2 for details.

Attach copy of Medicare card for each person
eligible for Medicare.

Dependent’s Information (Including Spouse): (See page 2 for definition of eligible dependents)

1.  Last Name  First  Middle  Social Security No.  Date of Birth  Relationship
2.  ____________________________  ____________________________  ____________________________
3.  ____________________________  ____________________________  ____________________________
4.  ____________________________  ____________________________  ____________________________

Method of Payment:
If your monthly pension does not allow for medical plan deduction, you may have your premium deducted from
your bank account. If premiums are not paid, coverage will be canceled for nonpayment and you may not be reinstated.

□ PENSION PAYROLL DEDUCTION AUTHORIZATION. By checking this block, you authorize TVA to deduct your medical plan
premiums from your TVARS check.

□ BANK DRAFT DEDUCTION. You may have your premiums automatically deducted from your bank account. If you choose this
option, complete form TVA 17534, available electronically or from the TVA Service Center.

I certify that the statements and answers provided on this form are complete and true to the best of my knowledge. I understand that
any false answers or misstatements could result in criminal prosecution leading to a fine, imprisonment, or both under 18 USC
SEC. 1001. I also understand that a false answer or misstatement could result in coverage being declared null and void as of its
effective date. I understand the following:

TVA reserves the right to amend, modify, suspend or terminate its retiree health plans, in whole or in part. Amendments,
modifications, suspensions or terminations to the TVA retiree health plans may be made for any reason, and at any time, and may,
in certain circumstances, result in the reduction or elimination of benefits or other features of the plans to the extent permitted by
law. TVA’s rights described above include the right, at any time, to (i) obtain coverage and/or administrative services from
additional or different insurance carriers or third party administrators, (ii) revise the amount of the retirees’ contributions toward the
cost of coverage, and (iii) revise or eliminate TVA’s contributions toward the cost of coverage.

Sign and date:  ____________________________  ____________________________
TVA 17328 [01-08-2014] Page 1 of 2
Service Dates

Before you terminate, review your service dates through the PLUS Portal (go to Personal Information Summary and then scroll to the bottom). These dates could affect your benefits at retirement. Contact the TVA Service Center at 888-275-8094 if you have questions about your service dates.

Consumer-Directed Health Plan (CDHP) enrollees

If you will be enrolled in the CDHP, you must also complete an election to open your Health Savings Account (HSA). In order to contribute to or receive TVA’s contributions to an HSA, you must be eligible for and open an HSA. If you already have a HSA Bank HSA account, you do not need to open another account.

You must meet the following requirements to be eligible for an HSA:

• Must be covered by an HSA-qualified high-deductible health plan. This means you must be enrolled in the CDHP medical option to be eligible for the HSA.
• Cannot be enrolled in Medicare
• Cannot be claimed as a dependent on someone else’s tax return
• Cannot be covered by another health plan that is not HSA-qualified (with some exceptions, including vision coverage, dental coverage, accident and disability coverage, and employee assistance programs)

To open your HSA go to https://secure.hsabank.com/tvaenroll and complete the online enrollment process online. Alternatively, you may complete a paper application form, available from the web site, and fax the form to HSA Bank at 877-851-7041 or mail it to the address on the front page of the form. It is critical that you follow this process to open up your account, using the TVA specific link provided above, otherwise, your account will not be linked to TVA and you will not receive any TVA contributions.

For more information, call HSA Bank at 1-800-357-6246 or visit www.hsabank.com/tva.

Dependent Eligibility Requirements for Participation in TVA-Sponsored Medical Plans

Dependent is the subscriber’s:

a. spouse
b. natural child or adopted child, foster child, stepchild, or child for whom the subscriber is legal guardian or for whom the subscriber has legal custody, under the age of 26

A child is considered a foster child if:

a. TVA received the application to cover the child within 30 days prior to the placement or date the child established residency, whichever is earlier;

b. the placement is for a minimum of 25 days per month and expected to exceed one year; and

c. the medical expenses of the child are not covered by any other group coverage, or by the agency through which the child was placed.

Notarized statements of custody, guardianship, adoption, foster care, or legitimacy are not acceptable documentations. Copies of the actual legal papers as issued with the final decree from the respective court or legal placement papers issued by the authorized agency are required.

Coverage for dependent children may be continued past the age limit if they are unable to support themselves because of physical handicap or mental retardation which began before age 26. The disability must be certifiable by a physician. TVA must receive this certification within 31 days prior to the date coverage would otherwise end. TVA may also require continued proof of the disability from time to time.

Please note: It is the employee’s responsibility to report to TVA any changes in your dependent eligibility. (For example: divorce or dependent child’s loss of eligibility.)
TVA Retiree Medical Plan Bank Draft Authorization Form

I hereby authorize the Tennessee Valley Authority to initiate monthly drafts from the account indicated at the financial institution named below responsible for my TVA medical plan contributions. I understand the debit amount cannot exceed the contributions. I further understand I have the right to revoke this authorization by notifying TVA Employee Service Center in writing at least ten (10) days prior to the time my account is charged. And by doing so, loss of medical coverage will occur unless my net pension amount is sufficient to support payroll deduction of the responsible amount. If funds are insufficient at the time my account is charged, two (2) months’ contribution will be drafted the next month. Should funds be insufficient a second time, I realize my insurance coverage will be canceled unless payment is made to bring my account current by the last workday of the month. Payment to bring the account current must be made by cashier’s check or money order.

Name on Bank Account

Social Security Number

Signature

Date

Retiree Name (if different than above)

Retiree Social Security Number

Financial Institution Information

Financial Institution Name:

Street Address:

City/State:

Routing Number

Account Number:

Check Digit

☐ Checking Account ☐ Savings Account

Signature of Representative:

Telephone Number: Date:

Privacy Act Statement

The information requested in this form you complete and return to the human resources department becomes part of the TVA Personnel Files Privacy Act System of Records (TVA-2). Authority for maintenance of this system of records is provided by the Tennessee Valley Authority Act of 1933 (16 U.S.C. 831-831ee).

In order for TVA to enroll you in the benefit plans and administer your benefits, you are asked to provide all of the requested information and any supporting documentation. Compliance is voluntary, but failure to provide the requested information may result in delay in plan enrollment or claims processing and may even result in your being foreclosed from certain benefit programs.

TVA uses the requested information to provide and administer its employee benefit program. Information may be provided to TVA consultants, contractors, and subcontractors who are engaged in providing services or supporting TVA in these areas. Information may also be used in studies and evaluation of TVA’s benefit programs, to the extent necessary to the performance of such studies and evaluation, should a dispute arise or congressional inquiry be made concerning TVA’s employee benefit programs; for oversight or similar purposes; and for corrective action, litigation, or law enforcement, or in response to process issued by a court of competent jurisdiction. Information provided, including information that you provide for claims reimbursement, may also be used in and verified through a computer match. Additional disclosures may be made as required or permitted by the Freedom of Information Act.

PLEASE ATTACH A VOIDED DEPOSIT SLIP OR CHECK
AND RETURN WITH THIS FORM
## 2014 Comparison of Medical Benefit Plans

<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>80% COINSURANCE PPO</th>
<th>CONSUMER-DIRECTED HEALTH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td>$300 Individual/$600 Family</td>
<td>In-network: $1,250 Individual Contract/ $2,500 Family Contract</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Out-of-network: $2,000 Individual Contract/ $4,000 Family Contract</td>
</tr>
<tr>
<td><strong>Health Savings Account (HSA)</strong></td>
<td>N/A</td>
<td>TVA contribution: $600 Individual Contract/ $1,200 Family Contract</td>
</tr>
<tr>
<td><strong>Preventive Care –</strong></td>
<td><strong>In-network covered 100%</strong></td>
<td>In-network covered 100%</td>
</tr>
<tr>
<td>Age 6 and above</td>
<td>with no dollar limit</td>
<td>with no dollar limit</td>
</tr>
<tr>
<td><strong>Preventive Care –</strong></td>
<td>Birth to age 1 - 5 exams</td>
<td>Birth to age 1 - 5 exams</td>
</tr>
<tr>
<td>Children under age 6</td>
<td>Age 1 up to 2 - 3 exams</td>
<td>Age 1 up to 2 - 3 exams</td>
</tr>
<tr>
<td></td>
<td>Age 2 up to 3 - 2 exams</td>
<td>Age 2 up to 3 - 2 exams</td>
</tr>
<tr>
<td></td>
<td>Age 3 up to 6 - 1 exam per year</td>
<td>Age 3 up to 6 - 1 exam per year</td>
</tr>
<tr>
<td><strong>Physician Services in Physician’s Office</strong></td>
<td>In-network covered 80% after deductible</td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td>Specialist referral required</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>Allergy Services</strong></td>
<td>In-network covered 80% after deductible – allergy serum 80% after deductible</td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td>In-network covered 80% after deductible</td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td>Physician services</td>
<td></td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td>Prenatal, delivery, postnatal care</td>
<td></td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td>Neonatal care</td>
<td></td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td>Well care for newborn in hospital</td>
<td></td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td>Inpatient hospitalization Maternity hospitalization</td>
<td>In-network covered 80% after deductible</td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td><strong>Approved Hospital Inpatient Services</strong></td>
<td>In-network covered 80% after deductible</td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td>Semi-private room</td>
<td></td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td><strong>Approved Outpatient Services</strong></td>
<td>In-network covered 80% after deductible</td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td>Diagnostic services</td>
<td></td>
<td>In-network covered 80% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room Services</strong></td>
<td>In-network covered 80% after deductible</td>
<td>In-network covered 80% after deductible</td>
</tr>
</tbody>
</table>

NOTE: This is a summary of benefits and explains the plans in general terms. Different benefits apply for out-of-network services. For a free copy of the Summary of Benefits and Coverage (see page 3), or for more information on the plan documents, please contact the TVA Service Center.
<table>
<thead>
<tr>
<th>BENEFITS</th>
<th>80% COINSURANCE PPO</th>
<th>CONSUMER-DIRECTED HEALTH PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Ambulance Services</td>
<td>Covered 80% after deductible</td>
<td>Covered 80% after deductible</td>
</tr>
<tr>
<td>Vision Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exam</td>
<td>$10 copay every 12 months</td>
<td>$10 copay every 12 months</td>
</tr>
<tr>
<td>Lenses</td>
<td>$10 copay every 12 months</td>
<td>$10 copay every 12 months</td>
</tr>
<tr>
<td>Frames (Every 2 years)*</td>
<td>$10 up to $100</td>
<td>$10 up to $100</td>
</tr>
<tr>
<td></td>
<td>80% amount over $100</td>
<td>80% amount over $100</td>
</tr>
<tr>
<td>Contacts*</td>
<td>$10 up to $115</td>
<td>$10 up to $115</td>
</tr>
<tr>
<td></td>
<td>* Children under 19 have a selection of frames and contacts to choose from. The allowance does not apply.</td>
<td></td>
</tr>
<tr>
<td>Approved Durable Medical Equipment</td>
<td>Covered 80% after deductible</td>
<td>Covered 80% after deductible</td>
</tr>
<tr>
<td>Approved Prosthetic Devices</td>
<td>Covered 80% after deductible</td>
<td>Covered 80% after deductible</td>
</tr>
<tr>
<td>Mental Health/Substance Abuse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>Covered the same as other medical conditions</td>
<td>Covered the same as other medical conditions</td>
</tr>
<tr>
<td>Outpatient</td>
<td>Covered the same as other medical conditions</td>
<td>Covered the same as other medical conditions</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>$1,500 every three years</td>
<td>$1,500 every three years</td>
</tr>
<tr>
<td>Covered Prescription Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>$10 copayment</td>
<td>Covered 80% after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered 80% after deductible Minimum of $10</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Covered 80% after deductible Maximum of $100</td>
<td></td>
</tr>
<tr>
<td>Preferred Brand</td>
<td>$28 copayment</td>
<td>Covered 80% after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered 80% after deductible Minimum of $24</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Covered 80% after deductible Maximum of $100</td>
<td></td>
</tr>
<tr>
<td>Nonpreferred Brand</td>
<td>$43 copayment</td>
<td>Covered 80% after deductible</td>
</tr>
<tr>
<td></td>
<td>Covered 80% after deductible Minimum of $39</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Covered 80% after deductible Maximum of $100</td>
<td></td>
</tr>
<tr>
<td>Mail-Order Pharmacy</td>
<td>2x retail copayment for up to a 90-day supply</td>
<td>Covered 80% after deductible 2x retail minimums and maximums for up to 90-day supply</td>
</tr>
<tr>
<td>Out-of-pocket maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-network</td>
<td>$2,500 Individual</td>
<td>$4,500 Individual</td>
</tr>
<tr>
<td></td>
<td>$5,000 Family</td>
<td>$9,000 Family</td>
</tr>
<tr>
<td>Out-of-Network</td>
<td>$5,000 Individual</td>
<td>$9,000 Individual</td>
</tr>
<tr>
<td></td>
<td>$10,000 Family</td>
<td>$18,000 Family</td>
</tr>
</tbody>
</table>

NOTE: This is a summary of benefits and explains the plans in general terms. Different benefits apply for out-of-network services. For a free copy of the Summary of Benefits and Coverage (see page 3), or for more information on the plan documents, please contact the TVA Service Center.
Almost anyone age 65, and almost anyone under age 65 who receives a Social Security
disability benefit, will become eligible for Medicare.

The TVA Supplement to Medicare provides some benefits that are not paid by Medicare. It
supplements and extends your insurance coverage. To determine if you are eligible for this
coverage, see the next page.

Following is a comparative summary of Medicare benefits through this Supplement.

### Hospital Insurance (Part A)

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Supplement</th>
</tr>
</thead>
<tbody>
<tr>
<td>For the first 60 days in a hospital, Part A pays for all the covered services, except for the first $1,216.</td>
<td>Pays the first $1,216.</td>
</tr>
<tr>
<td>For the 61st through the 90th day in a hospital, Part A pays for all covered services except for $304 per day.</td>
<td>Pays the $304 per day for 61st through 90th day.</td>
</tr>
<tr>
<td>For 60 additional “lifetime reserve” days, Part A pays for all covered services in a hospital, except for $608 a day.</td>
<td>Pays the $608 a day of hospital charges for 60 lifetime reserve days.</td>
</tr>
<tr>
<td>Does not pay for additional days.</td>
<td>Pays for 215 additional days of hospital charges per benefit period.</td>
</tr>
<tr>
<td>Does not cover private-duty nurses.</td>
<td>Pays 80 percent of the charge for 480 hours of an in-hospital private-duty licensed nurse per benefit period, if required and nurse is not related to subscriber.</td>
</tr>
<tr>
<td>Pays for all covered services in a participating skilled nursing facility for the first 20 days in each benefit period. (See your Medicare Handbook for requirements.)</td>
<td>None</td>
</tr>
<tr>
<td>Pays for 80 additional days in the skilled nursing facility per benefit period except for $152 a day.</td>
<td>Pays the $152 a day of skilled nursing facility charges from 21st through 100th day of each benefit period.</td>
</tr>
<tr>
<td>Does not pay for additional days.</td>
<td>Pays charges not exceeding $152 a day for 100 additional days in the skilled nursing facility after all days provided by Medicare have been used.</td>
</tr>
<tr>
<td>For blood transfusions for inpatients, Medicare pays for all but the first three units each calendar year.</td>
<td>Pays for the first three pints of unreplaced blood or blood plasma not paid by Medicare.</td>
</tr>
</tbody>
</table>

Coverage for a stay in a skilled nursing facility could total as much as 200 days in a calendar year.
Medical Insurance (Part B)

1. After you meet a $147.00 deductible each year (see your Medicare Handbook), Medicare pays 80 percent of usual, customary, and reasonable charges for many medical services and supplies, including:
   - Physicians’ charges
   - Outpatient hospital services
   - Use of durable medical equipment
   - Oxygen
   - Home health services
   - Outpatient physical therapy service
   - Ambulance.

2. The Supplement pays 20 percent of Medicare-approved charges submitted for any Part B medical services and supplies. The Supplement will not pay if Part B does not pay.

The above expenses are not covered when billed for, by and payable to a hospital inside the United States that is not a Blue Cross member or a Medicare-approved hospital, or to a hospital that is, other than incidentally, a place for the treatment of mental disorders.

In a Blue Cross participating hospital not approved for Medicare, the benefits regularly provided by Medicare will be deducted before these services and supplies become covered expenses.

Benefits under Medicare and this Supplement:

1. Who is eligible?
   Any TVA retiree, spouse or dependent currently covered under TVA’s medical plan who becomes eligible for Medicare may receive coverage under this insurance plan that supplements Medicare.
   **Note:** A subscriber who elects to drop this Supplement plan will not be able to re-enroll at a later date.

2. How to enroll
   If you are currently enrolled in a TVA retiree medical plan, you will automatically be enrolled in the Supplement to Medicare plan when you reach age 65.

Medicare Part D (prescription drug) coverage is part of the Supplement Plan. You do not need to enroll in a separate Medicare Part D plan. Your enrollment in the Supplement Plan will be reported to Medicare.

Be sure to notify the TVA Service Center if you, or a covered dependent, become eligible for Medicare before reaching age 65 so that your enrollment and premiums can be adjusted.

3. What it costs
   The monthly premium is $258.00 per person. This does not reflect any pension supplement or contribution you may receive to help offset the cost of your medical coverage.

   A retiree or dependent who does not have the premium deducted from a TVA pension check must have payment drafted from a bank account. Call the TVA Service Center for an autopay form.

4. How to claim benefits
   BlueCross BlueShield of Tennessee (BCBST) receives Medicare claims through a Coordination of Benefits Agreement (COBA) with Group Health Inc. (GHI). As a result of this agreement, BCBST will automatically receive your Medicare claim regardless of where services are rendered within the U.S.

   **What you need to do**
   Always show your Medicare and TVA Medicare Supplement identification card to your provider at the time of service. If the provider accepts Medicare assignment for payment, he or she will file a claim for you.

   Upon enrolling in the TVA Medicare Supplement plan, be sure to provide BCBST with your Medicare ID (HICN) number. BCBST will send this number to GHI to identify the claims that need to be processed for secondary payment.

   If your claims are not being crossed over from Medicare, call BCBST at 800-245-7942 and verify that your Medicare ID number is on file.

5. Limitations and exclusions
   - Claims filed after the limit for filing Medicare claims has expired
   - Injuries or diseases covered by Workers’ Compensation
   - Services provided by an employer-sponsored program
• Services covered under federal, state or local laws, or by a foreign government
• Disease contracted or injury sustained as a result of war
• Services or supplies not ordered by the attending physician or not for the treatment of disease or injury
• Services of blood donors, blood and blood plasma, and packed cells, except as stated as a benefit
• Services provided to a subscriber during a confinement in a hospital or skilled nursing facility that began prior to the subscriber’s effective date
• Services covered, or that could have been covered, under Medicare
• Benefits provided or services covered under any other policy, plan, or program of health insurance that duplicates the benefits of this program, except when payment by Blue Cross is limited to 20 percent
• Charges not approved by Medicare.

The prescription drug coverage under the Supplement Plan meets Medicare Part D requirements and may provide greater coverage than that offered by other Medicare Part D plans.

Key features of the plan include electronic claims filing for all in-network drug purchases, copayments for the purchase of generic and brand-name drugs and continued coverage across the Medicare Part D coverage stages.

Medicare Part D drugs are organized into four categories, or tiers, of different drug types. Your copayment depends on which tier your drug is in.

**Deductible and Copayments**
You must satisfy a deductible of $200 per person per calendar year for prescriptions purchased at a retail pharmacy. For retail purchases, after the deductible has been satisfied, the copayments shown below must be made by you.

There is not a deductible for prescriptions purchased through mail order service (i.e., home delivery). You pay the copayments shown below.

<table>
<thead>
<tr>
<th></th>
<th>Retail (30-day supply)</th>
<th>Mail Service (90-day supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic (Tier 1)</td>
<td>$10*</td>
<td>$20</td>
</tr>
<tr>
<td>Preferred brand name (Tier 2)</td>
<td>$40*</td>
<td>$80</td>
</tr>
<tr>
<td>Nonpreferred brand name (Tier 3)</td>
<td>$80*</td>
<td>$120</td>
</tr>
<tr>
<td>Specialty (Tier 4)</td>
<td>$80*</td>
<td>$120</td>
</tr>
</tbody>
</table>

*After you meet your deductible

**Retail Purchases**
Retail pharmacies are used for short-term medications. You can purchase a 31-day supply at a retail pharmacy for one copayment after you have met your deductible.

**Home Delivery (Mail Service) for Maintenance Medications**
The home delivery (mail-order service) is administered by
Catamaran Home Delivery. This service is for maintenance-type prescriptions. Maintenance medications are those you use on an ongoing basis to treat chronic medical conditions like high blood pressure, allergies, and high cholesterol. To use home delivery, contact your physician for prescriptions for your maintenance medications. The prescription should be written to prescribe up to a 90-day supply with refills as appropriate for up to one year. You must mail the first home-delivery order for a medication to Catamaran Home Delivery. Catamaran mail-order forms are available at www.mycatamaranrx.com or by calling Catamaran Member Services at 855-207-5871. Because it could take up to two weeks to receive your first home-delivery order, be sure you have enough medication on hand to last until it is received.

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**Definitions**

**Formulary** — lists all drugs covered by your prescription drug plan. It is among the most powerful tools available to make sure you receive safe, effective and affordable prescription drugs. You are encouraged to discuss with your physician the drugs that are covered under your plan.

**Noncovered drugs** — drugs that are not covered at all by Medicare Part D plans, meaning that the plan pays nothing and the patient pays the full cost for those noncovered drugs.

**Nonpreferred brand name drugs** — brand name drugs that are covered by the formulary but may not be as cost-effective as similar preferred brand name drugs.

**Preferred brand name drugs** — brand name drugs that are medically sound, cost-effective alternatives to higher-priced drugs.

**Specialty drugs** — include a category of expensive, generally biotechnological medications that are used to treat patients with serious and complex conditions and may require special administration and handling.

You may be taking drugs that are not covered on the formulary, or that are subject to certain restrictions. You should review your formulary that you receive with your ID card, or contact Catamaran Member Services at 855-207-5871 to verify if your current medications are covered, and then discuss with your physician which drugs are appropriate for you under this drug plan. More information is available in the Prescription Drug Formulary and Evidence of Coverage booklets that are mailed by Catamaran to plan participants each fall.

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**Numbers to Know**

<table>
<thead>
<tr>
<th>BlueCross BlueShield of Tennessee</th>
<th>1 Cameron Hill Circle</th>
<th>800-245-7942</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chattanooga, TN 37402</td>
<td></td>
</tr>
<tr>
<td>Catamaran</td>
<td>Attn: Medicare Part D</td>
<td>855-207-5871</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 3410</td>
<td>TTY 711</td>
</tr>
<tr>
<td></td>
<td>Lisle, IL 60532-8410</td>
<td></td>
</tr>
<tr>
<td>TVA Service Center</td>
<td>400 W. Summit Hill Drive</td>
<td>888-275-8094</td>
</tr>
<tr>
<td></td>
<td>WT CP, Knoxville, TN 37902</td>
<td></td>
</tr>
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</table>
DELTA DENTAL
INFORMATION AND FORMS

- Enrollment Form

- Bank Draft Authorization

- Information Sheet
Delta Dental of Tennessee  Attn: TVA Administrator
240 Venture Circle
Nashville, TN  37228-1699
Telephone 800-223-3104

**TVA RETIREES ENROLLMENT**
GROUP 1500

**STREET ADDRESS**

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>M I</th>
<th>LAST NAME</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
<th>ZIP</th>
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**SOCIAL SECURITY NUMBER**

<table>
<thead>
<tr>
<th>DATE OF BIRTH</th>
<th>M</th>
<th>F</th>
<th>PHONE NUMBER</th>
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</table>

<table>
<thead>
<tr>
<th>SOCIAL SECURITY NUMBER</th>
<th>DATE OF BIRTH</th>
<th>M</th>
<th>F</th>
<th>PHONE NUMBER</th>
</tr>
</thead>
</table>

Please list the dependents that you wish to be covered below.

<table>
<thead>
<tr>
<th>FIRST NAME &amp; M.I. (LAST NAME IF DIFFERENT)</th>
<th>SEX</th>
<th>BIRTH DATE</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th></th>
<th>M</th>
<th>F</th>
</tr>
</thead>
</table>

**PAYMENT OPTIONS**

<table>
<thead>
<tr>
<th>CHECK ONE</th>
<th>SPECIAL INSTRUCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TVARS Deduction- monthly</td>
<td>*Monthly bank draft and credit card deductions are made on the 24th of each month</td>
</tr>
<tr>
<td>Single - $34.26 Family - $80.85</td>
<td>Must include a check or money order in the amount of $102.78 for single or $242.55 for family for 3 months of premium</td>
</tr>
<tr>
<td>Bank Draft- monthly ($1.00 per transaction)</td>
<td>Complete Direct Debit Application</td>
</tr>
<tr>
<td>Credit Card- monthly ($1.00 per transaction)</td>
<td>Account Number Exp Date</td>
</tr>
<tr>
<td>Circle One VISA Master Card</td>
<td></td>
</tr>
<tr>
<td>Annual Premium</td>
<td>Send check with enrollment form</td>
</tr>
<tr>
<td>Single- $411.12 Family- $970.20</td>
<td>Make payable to Delta Dental of Tennessee</td>
</tr>
</tbody>
</table>

**IF YOU DROP COVERAGE, YOU MAY NEVER RE-ENROLL**

I agree to make the required contribution. I certify that the information contained in this form is true and correct to the best of my ability.

Signature: ______________________ Date: ______________________

For Delta Use Only E.D.  

DDTN SS 3 EF-TVA (Rev 6/09)
AUTHORIZATION AGREEMENT FOR DIRECT DEBIT (ACH DEBITS)

Name ____________________________________  Social Security Number ____________________________

I (we) hereby authorize Delta Dental Plan of Tennessee, herein called COMPANY, to initiate debit entries and to initiate, if necessary, credit entries and adjustments for any debit entries in error to my (our) [ ] CHECKING  [ ] SAVINGS account indicated below and the depository named below, herein called DEPOSITORY, to debit and/or credit the same to such account.

DEPOSITORY NAME _______________________________________ BRANCH ________________________________
CITY ___________________________ STATE ___________________________
ROUTING NUMBER ___________________________ ACCT NUMBER ___________________________

This authorization is to remain in full force and effect until the COMPANY has received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

NAME(S) _______________________________ ID NUMBER _________________________________
(PLEASE PRINT)
DATE __________________ SIGNED __________________ SIGNED ______________________________

YOUR ACCOUNT WILL BE DRAFTED ON THE 24th DAY OF EACH MONTH
($1.00 will be added for each transaction)

ATTACH A VOIDED CHECK

SAMPLE CUSTOMER 1500
ANY STREET
ANY TOWN, STATE

DATE __________

PAY TO THE ORDER OF ________________________________ $ __________

AMOUNT ________________________________ 0000000000000000 DOLLARS

BANK
CITY, STATE

FOR
I:000000000 I:1500 00000000000 II

ROUTING NUMBER  ACCOUNT NUMBER
IF YOU DROP COVERAGE, YOU MAY NEVER RE-ENROLL
Choosing Your Dentist

You may choose any licensed dentist. However, it is to your advantage to choose a participating Delta Dental dentist. Here's why:

- Claim forms will be completed and submitted at no charge. Non-participating dentists may require you to complete forms yourself or to pay a service charge.

- Payment will be based on Delta Dental's Maximum Plan Allowance fee. You only have to pay your co-insurance; you are not responsible for charges exceeding the Maximum Plan fee.

- Because Delta Dental reimburses its dentists directly, they agree to charge you no more than your co-insurance and/or deductible; you don't have to pay the whole bill and wait for reimbursement.

- If a non-participating dentist's fees exceed the industry average Maximum Plan Allowance, you must pay the difference plus your co-insurance. You may also have to pay the entire bill in advance.

The Advantage of Pre-determination

If you're thinking about having dental work done that will cost you more than $300, ask your dentist to request a pre-determination before starting treatment. This will let you know approximately how much the work will cost and what your share of the costs will be. Pre-determination is not a guarantee of benefits.

Benefit Waiting Period

For retirees who did not enroll in the plan when first eligible, but enroll as a late applicant (i.e., beyond 30 days after retirement or during an open enrollment period), there is a six month waiting period for Crown Repair, Major Restorative Services, Relines and Repairs, Implant Repair, and Prosthodontic Services. This waiting period does not apply to retirees who enroll within 30 days of becoming eligible for this plan.

Optional Services

Services that a subscriber or covered dependent decide to have provided, which are more expensive than those that Delta Dental of Tennessee pays for, are called Optional Services. In these cases, Delta Dental of Tennessee’s payment will be limited to what would normally be paid and the subscriber will be responsible for the remainder of the dentist’s fee.

For example, if your benefit plan allows for amalgams only even though a metal or porcelain inlay is suggested by your dentist, Delta Dental of Tennessee will pay for only the cost of the amalgam.

What is not Covered?

- Cosmetic surgery or procedures for purely cosmetic reasons; services for congenital or developmental malformations; treatment to restore tooth structure lost from wear; treatment to rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion; treatment to stabilize teeth (equilibration, periodontal splinting or double abutting on bridges).

- Services for any disturbance of the temporomandibular joints (jaw joints) or myofacial pain dysfunction.

- Services rendered by a dentist beyond the scope of his license; services performed by any person other than a dentist or auxiliary personnel legally authorized to perform services under the supervision of a dentist.

- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the dentist for treatment in any such facility.

- Oral hygiene instruction, dietary instructions, prescribed drugs or other medication, experimental procedures, or conscious sedation.

- General anesthesia is only a benefit when administered by a properly licensed dentist in connection with covered surgery services.

- Dental services for which the eligible person incurs no charge; dental services to the extent that charges for such services exceed what would have been made and actually collected if no coverage existed hereunder.

- Temporary partial dentures are a benefit only when anterior teeth are missing.

- Porcelain, gold or veneer crowns are not covered benefits for children under 12; nor fixed bridges or cast partials for children under 16.

- Services for injuries or conditions which are compensable under Worker’s Compensation or Employer’s Liability Laws; services which are provided to the eligible person by any Federal, State or local agency, unless this exclusion is prohibited by law.