Benefits Summary for Terminating Employees

2024

Effective January 1, 2024

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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 information available on People Gateway, or contact the People First Solution Center at 888-275-8094.

MEDICAL PLAN

Active Employee Medical Coverage

If you currently have TVA medical coverage, it will term at the end of the month in which your employment ends. You may be eligible for retiree medical coverage (see below). If you are not eligible for retiree medical coverage, you may elect to continue coverage for up to three months (see page 13).

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:

- were hired on or after January 1, 2005, and you are at least ACTUAL AGE 55 with 10 years of actual TVA service; or
- were hired before January 1, 2005, are you are at least ACTUAL AGE 50 with at least 5 years of service as a full-time annual TVA employee; 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
- are any age, are eligible for a disability retirement benefit from the TVA Retirement System (TVARS), and have either been approved for a disability retirement benefit by TVARS or terminate TVA employment because of a disability, as determined by the Chief Human Resources Officer; or
- are any age, with at least 5 years of actual TVA service, not be eligible for a TVARS disability retirement benefit, and be currently approved and receiving core long-term disability benefits from TVA's long-term disability benefits administrator; 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 People First Solution Center (PFSC). *Retiree medical election forms must be received by the PFSC within 30 days after termination in order to maintain eligibility for retiree medical 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 TVA retiree medical coverage:

You must notify the PFSC 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 last day of the month of the date of legal separation or divorce. Coverage for a dependent child ends on the last day of the month of the date the child becomes ineligible (e.g., date child turns 26 or date of legal separation for step-children). Note that dependent children turning 26 years old will be automatically removed from coverage. No action is required by you.

Retiree Medical Plan Options

Retirees and dependents NOT eligible for Medicare

You, and any covered dependents, that are not yet eligible for Medicare, have a choice of the 80% PPO Plan or Consumer-Directed Health Plan (CDHP). See the *Retiree Medical Information and Forms* section for a comparison of the medical plans.

You will have the opportunity during the Annual Election Period, which happens during the fall, to select a medical plan option for the following year.

Retirees and dependents eligible for Medicare

You, and any covered dependents, that are eligible for Medicare and are at least age 65, cannot be covered by the 80% PPO or Consumer-Directed Health Plan. Instead, you will be eligible to enroll in healthcare coverage through a private Medicare exchange provided by Via Benefits. You may also enroll in coverage through insurance brokers or directly with an insurance company.

Most individuals will become eligible for Medicare upon reaching age 65. **To avoid a lapse in healthcare coverage, you, or your covered dependent, can contact Via Benefits to enroll in a supplemental Medicare plan prior to your active coverage ending.** There is a 63-day grace period after your active coverage ends, but coverage would not go into effect until the first day of the following month in which you enroll. Any covered family members not yet eligible for Medicare will be eligible to participate in the 80% PPO or Consumer-Directed Health Plan.

IMPORTANT: If you leave TVA on or after January 1, 2021, your dependent's eligibility to be covered in TVA's Retiree Medical plans will not be impacted by whether you enroll through VIA Benefits or not.

Regardless of when you leave TVA, if you do not enroll through Via Benefits, you may miss out on receiving all or part of your Healthcare Credit. Further, if any of your dependents are eligible for Medicare, at least age 65, and do not enroll in a medical plan through Via Benefits, your Healthcare Credit, if applicable, could be reduced.

Some individuals, however, will become eligible for Medicare before age 65 due to disability. You, and any covered dependents, that are eligible for Medicare and under age 65, have the option of enrolling in one of TVA's medical plan options (i.e., 80% PPO or Consumer-Directed Health Plan) or enrolling in a supplemental Medicare plan through Via Benefits. If you choose to enroll in a plan through Via Benefits, you should do so prior to your active coverage ending to avoid a lapse in coverage. Note that if you choose to enroll in a plan through Via Benefits, you will NOT have the opportunity to enroll in a TVA group plan in the future unless you lose your Medicare eligibility.

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.

Retiree Medical Plan Premiums and Assistance

As of January 1, 2024, the full monthly premiums are:

	Individual	Family
80% PPO Plan	$886	$2,129
Consumer-Directed Health Plan (CDHP)	$520	$1,238

TVARS Supplemental Benefit for TVARS Members

Many retirees will receive a supplemental benefit from TVARS if they meet eligibility requirements. If eligible, this amount will be provided as additional income on your retirement benefit statement. You do *not* have to enroll in a TVA-sponsored medical plan (i.e., 80% PPO or Consumer-Directed Health Plan) or a supplemental Medicare plan through Via Benefits to receive this vested benefit.

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 (i.e., 80% PPO or Consumer-Directed Health Plan) OR a supplemental Medicare plan through Via Benefits. If eligible, this contribution will be provided as a credit against the retiree's TVA-sponsored medical plan if applicable; otherwise to a Health Reimbursement Arrangement administered by Via Benefits.

The TVA Contribution will not exceed the actual amount of your TVA retiree medical premiums (i.e., 80% PPO or Consumer-Directed Health Plan). If Medicare-eligible and enrolled through Via Benefits, the calculation assumes a premium of $290.

Eligibility:

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, 2024, the TVA contribution for eligible retirees is $12.00 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, 2024, individuals eligible for a TVA contribution will also receive an additional contribution of $99.58 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

The TVA Health-Care Credit provides a credit to those eligible based on years of TVA service and monthly base pension amount. Retirees who meet the eligibility criteria below will receive a credit 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 (i.e., 80% PPO or Consumer-Directed Health Plan) OR a supplemental Medicare plan through Via Benefits. If eligible, this credit will be provided as a credit against the retiree's TVA-sponsored medical plan if applicable; otherwise to a Health Reimbursement Arrangement administered by Via Benefits.

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. **The TVA 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). Disabled retirees are exempt from the 20 year service requirement.
- 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 $290 if the retiree is eligible for Medicare and enrolled through Via Benefits or the cost of the 80% PPO medical plan if the retiree is not yet eligible for Medicare. Retirees not eligible for Medicare (or those eligible for Medicare but are under age 65) 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:

20 years of TVA service	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.
25 years of TVA service	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.
30 years of TVA service	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.

*Premium is based on $290 if Medicare-eligible *or* the cost of the 80% PPO medical plan if not Medicare-eligible.

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

20 years of TVA service	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.
25 years of TVA service	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.
30 years of TVA service	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.

*Premium is based on $290 if Medicare-eligible *or* the cost of the 80% PPO medical plan if not Medicare-eligible.

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

Examples of TVA Health-Care Credit Calculation

25 Years of TVA Service Base Pension At Least $2,000/month Age 58	
80% PPO Plan Premium, Family	$2,129.00
25% of Premium*	-$532.25
Difference to be covered by TVARS Supplemental Benefit and TVA Credit	$1,596.75
Less TVARS Supplemental Benefit and Additional Benefit (for example)	-$435.49
TVA Health-Care Credit	450.00**

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

**Maximum credit amount per credit plan guidelines

Examples of TVA Health-Care Credit Calculation, continued

20 Years of TVA Service Base Pension At Least $2,000/month Age 58	
80% PPO Plan, Individual, + One Medicare-Eligible Enrolled Through Via Benefits	$1,176.00
30% of Premium*	-$352.80
Difference to be covered by TVARS Supplemental Benefit and TVA Credit	$823.20
Less TVARS Supplemental Benefit and Additional Benefit (for example)	-$435.49
TVA Health-Care Credit	$387.71

25 Years of TVA Service Base Pension Less Than $2,000/month Age 66	
2 Medicare-Eligibles Enrolled Through Via Benefits	$580.00
20% of Premium*	-$116.00
Difference to be covered by TVARS Supplemental Benefit and TVA Credit	$464.00
Less TVARS Supplemental Benefit and Additional Benefit (for example)	-$435.49
TVA HRA	$28.51

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

Paying for Your TVA Retiree Medical Coverage

Your monthly cost for retiree medical coverage through TVA 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 you do not see a medical premium deduction listed by your third pension check, contact the PFSC immediately.

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.*

If you or your dependent are eligible for Medicare and enroll in supplemental Medicare coverage though Via Benefits, you will pay your premium directly to the insurance carrier with whom you choose to enroll. Premiums will not be paid to TVA or deducted from your monthly retirement pension.

Off-Cycle Premium Payments

If, at anytime, your medical premium becomes too large to deduct from the pension check and/or you have an outstanding balance due, you may be required to pay your medical premium to TVA directly. Follow the instructions below to make a premium payment:

1. Go to **www**.pay.gov
2. Select **FIND AN AGENCY** at the top of the page
3. Select the letter '**T**' under the Find an Agency category
4. Select **Tennessee Valley Authority (TVA)**
5. Select **TVA Medical Benefit Form** – click **Continue**
6. Select **Continue to the Form**
7. Select **TVA Retiree Medical Benefits** as the type of payment

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; or
- divorce or legal separation from the spouse; or
- 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; or
- retiree/spouse turns 65 and becomes Medicare-eligible.

Example: You and your spouse both worked for TVA. Your spouse retired and has been covered on your active employee medical plan as a dependent. You are now retiring. If your spouse qualified for retiree medical at the time he/she retired from TVA, your spouse has the option to enroll in retiree medical as a subscriber so long as he/she does so within 30 days of your termination. 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 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, follow the instructions below:

1. Go to www.pay.gov
2. Select **FIND AN AGENCY** at the top of the page
3. Select the letter '**T**' under the Find an Agency category
4. Select **Tennessee Valley Authority (TVA)**
5. Under **TVA Medical Benefit Form**, select **Continue.**
6. Select **Continue to the Form.**
7. Select **TVA Employee Extended Medical Benefits Coverage** as the type of payment and complete and submit the form.

You will not be billed by TVA. 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 by October 1. November's payment is due by October 15. December's payment is due by November 15. *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, 2024, the full monthly premiums are:

	Individual	**Family**
80% PPO Plan	$886	$2,129
Consumer-Directed Health Plan (CDHP)	$520	$1,238

Note that if you select Extended Medical coverage beyond termination, TVA will not provide any further contribution to your Health Savings Account

Well-Being Benefit Credit

If you are currently receiving a benefit credit earned from your participation in the well-being program, 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.

Retiree Dental Coverage

A retiree with at least 5 years of TVA service has the option to purchase dental coverage from Delta Dental Plan of Tennessee. 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.

Retiree Dental Plan Premiums

As of January 1, 2024, the monthly premiums are:

Employee Only: $33.42

Family: $78.87

For more detailed information see the *Delta Dental Information and Forms* section at the end of this guide for a description of the Retiree Dental Plan.

LIFE AND DISABILITY PLANS

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.

Conversion rates are different from current rates and are established by the insurance company. For additional information regarding conversion, contact MetLife (See Contact Information on page 17).

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 elect to receive an immediate retirement benefit. TVARS will provide information on continuing FEGLI as a retiree.

If you are not eligible for a TVARS-provided retirement benefit, or you elect to receive a lump-sum payout of your cash balance account, you may convert FEGLI coverage to a direct-pay policy. The FEGLI conversion form may be obtained by contacting the People First Solution Center 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 www.opm.gov/healthcare-insurance/life-insurance/.

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. For additional information regarding conversion, contact MetLife (See Contact Information on page 17).

Optional Long-Term Disability

If your employment is ending due to a disability, you may qualify for disability benefits from Unum. For more information, or to initiate a claim, contact Unum.

Optional long-term disability insurance coverage stops on the date your employment terminates.

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 2024, prior to date of termination, by March 15, 2025. All claims are filed with TASC at www.TASConline.com. For more information, contact TASC.

CONTACT INFORMATION

Vendor/Customer Service	Contact	Website
People First Solution Center	888-275-8094 8:00 a.m. – 4:45 p.m. ET Monday – Friday	www.tva.com/retireeportal email: HRSupport@tva.gov
BlueCross BlueShield of Tennessee (Medical)	800-245-7942 24 hours a day, seven days a week	www.bcbst.com
BlueCross BlueShield of Tennessee (Vision)	877-342-0737 7:30 a.m. – 11:00 p.m. ET Monday – Saturday 11:00 a.m. – 8:00 p.m. ET Sunday	www.bcbst.com
Delta Dental (Dental)	800-223-3104 8:00 a.m. – 8:00 p.m. ET Monday – Friday	www.deltadentaltn.com
Express Scripts (Prescription Drugs)	800-935-6203 24 hours a day, seven days a week	www.express-scripts.com
HSA Bank (Health Savings Account)	844-650-8934 8:00 a.m. – 10:00 p.m. ET Monday – Friday 10:00 a.m. – 2:00 p.m. ET Saturday Member Live Online Chat: 7:00 a.m. – 9:00 p.m. ET Monday – Friday	www.hsabank.com/tva To enroll online: https://secure.hsabank.com/tvaenroll/tva.aspx
MetLife	877-275-6387	www.MetLife.com
Unum (Claims)	866-673-9940 8:00 a.m. – 8:00 p.m. ET Monday – Friday	www.unum.com
Via Benefits (Medicare-eligible)	844-620-5725 8:00 a.m. – 9:00p.m. ET Monday – Friday	www.my.viabenefits.com/tva
TASC (Total Administrative Services Corp)	800-422-4661 8:00 a.m. – 5:00p.m. Monday – Friday – All time Zones	www.TASConline.com
TVA Retirement System (TVARS)	800-824-3870 8:00 a.m. – 4:45 p.m. ET Monday – Friday	www.tvars.com

Be sure to notify TVARS and the People First Solution Center if you have a change in address.

BENEFITS CHECKLIST FOR RETIREES

To enroll in retiree medical coverage:

- If you or a covered dependent are eligible for Medicare, contact Via Benefits and/or other providers to enroll in a supplemental Medicare plan up to 3 months prior to your active coverage ending.
- Complete TVA form 17328 Retiree Medical Application, even if Medicare-eligible.
- Complete TVA form 17534 Retiree Medical Bank Draft if necessary.
- Return forms and proof of payment to the People First Solution Center within 30 days of retirement.
- If enrolling in the CDHP, you must follow the instructions on page 2 of the Retiree Medical Application in regards to opening an HSA, even if you already have a HSA as an employee.

To enroll in retiree dental coverage:

- Complete enrollment form and direct debit form or choose other payment method
- Return forms to Delta Dental within 30 days of retirement

To convert life insurance coverage:

- Complete conversion application and submit to MetLife within 31 days of termination

To convert accidental death & dismemberment coverage:

- Complete conversion application and submit to MetLife 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 the People First Solution Center
  - Submit application within 31 days of termination

Reminders

- Review your service dates in the PLUS Portal before you terminate
- Notify PFSC if you or any of your dependents become eligible for Medicare before age 65
- Notify TVARS and PFSC if you have a change in address
- Notify PFSC if a spouse or dependent child is no longer eligible for coverage

BENEFITS CHECKLIST FOR TERMINATING EMPLOYEES (OTHER THAN RETIREES)

To continue medical coverage for up to 3 months:

- Pay your premium online at www.pay.gov
    - 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 convert life insurance coverage:

- Complete conversion application and submit to MetLife within 31 days of termination

To convert accidental death & dismemberment coverage:

- Complete conversion application and submit to MetLife 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 the People First Solution Center
    - Submit application within 31 days of termination

RETIREE MEDICAL PLAN INFORMATION AND FORMS

The following information and forms can be found on pages 21 – 26.

- TVA Medical Plan Information
- Retiree Medical Application
- Bank Draft Authorization

RETIREE DENTAL PLAN INFORMATION AND FORMS

The following information and forms can be found on pages 27 – 30.

- Dental Plan Information
- Dental Plan Application
- Bank Draft Authorization

Comparison of Medical Benefit Plans

BENEFITS	80% COINSURANCE PPO	CONSUMER-DIRECTED HEALTH PLAN
Deductible	**Medical Only:** In-network: $550 Individual $1,100 Family Out-of-network: $1,100 Individual $2,200 Family	**Medical and Prescription Drugs Combined** In-network: $1,600 Individual Contract/ $3,200 Family Contract Out-of-network: $3,200 Individual Contract/ $6,400 Family Contract
Health Savings Account (HSA)	N/A	TVA Contribution: $600 Individual Contract/ $1,200 Family Contract
Preventive Care – Age 6 and above	In-network covered 100% with no dollar limit	In-network covered 100% with no dollar limit
Preventive Care – Children under age 6	100% Birth to age 1 - 5 exams Age 1 up to 2 - 3 exams Age 2 up to 3 - 2 exams Age 3 up to 6 - 1 exam per year	100% Birth to age 1 - 5 exams Age 1 up to 2 - 3 exams Age 2 up to 3 - 2 exams Age 3 up to 6 - 1 exam per year
Physician Services in Physician's Office	In-network covered 80% after deductible	In-network covered 80% after deductible
Specialist referral required	No	No
Allergy Services	In-network covered 80% after deductible – allergy serum 80% after deductible	In-network covered 80% after deductible – allergy serum 80% after deductible
Maternity Services *Physician services* Prenatal, delivery, postnatal care Neonatal care Well care for newborn in hospital	In-network covered 80% after deductible	In-network covered 80% after deductible
Inpatient hospitalization Maternity hospitalization	In-network covered 80% after deductible	In-network covered 80% after deductible
Approved Hospital Inpatient Services Semi-private room	In-network covered 80% after deductible	In-network covered 80% after deductible
Approved Outpatient Services Surgery	In-network covered 80% after deductible	In-network covered 80% after deductible
Diagnostic services	In-network covered 80% after deductible	In-network covered 80% after deductible
Emergency Room Services	In-network covered 80% after deductible	In-network covered 80% after deductible
Emergency Ambulance Services	In-network covered 80% after deductible	In-network covered 80% after deductible
Vision Care Exam (once per calendar year)	$10 copay	$10 copay
Lenses (once per calendar year)	$10 copay	$10 copay
Frames (once every other calendar year)*	$10 up to $130 80% amount over $130	$10 up to $130 80% amount over $130
Contacts* **Children under 19 have a selection of frames and contacts to choose from. The allowance does not apply.*	$10 copay up to $150 allowance	$10 copay up to $150 allowance
Approved Durable Medical Equipment	In-network covered 80% after deductible	In-network covered 80% after deductible
Approved Prosthetic Devices	In-network covered 80% after deductible	In-network covered 80% after deductible
Mental Health/Substance Abuse Inpatient	In-network covered 80% after deductible	In-network covered 80% after deductible
Outpatient	In-network covered 80% after deductible	In-network covered 80% after deductible
Hearing Aids	$1,500 every three years	$1,500 every three years

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 or for more information on the plans, please contact the People First Solution Center.

Comparison of Medical Benefit Plans

BENEFITS	80% COINSURANCE PPO	CONSUMER-DIRECTED HEALTH PLAN
Covered Prescription Drugs		
Generic	$10 copayment	Covered 80% after deductible Minimum of $10 Maximum of $100
Preferred Brand	$30 copayment	Covered 80% after deductible Minimum of $24 Maximum of $100
Nonpreferred Brand	$50 copayment	Covered 80% after deductible Minimum of $39 Maximum of $100
Mail-order or SMART90 pharmacy (Mail-order pricing does not apply to Accredo specialty drugs)	2x retail copayment for up to a 90-day supply	Covered 80% after deductible 2x retail minimums and maximums for up to 90-day supply
Out-of-pocket maximum Medical, Prescription Drugs and Vision Combined	In-network: $3,250 Individual $6,500 Family Out-of-network: $6,500 Individual $13,000 Family	In-network: $4,500 Individual $9,000 Family Out-of-network: $9,000 Individual $18,000 Family

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 or for more information on the plans, please contact the People First Solution Center.

RETURN THIS FORM TO THE PEOPLE FIRST SOLUTION CENTER WITHIN 30 DAYS OF RETIREMENT

TVA Retiree Medical Application

People First Solution Center, 400 West Summit Hill Drive, WT 8D-K, Knoxville, TN 37902 Telephone - 888-275-8094

Last Name	First	Middle	Employee ID

Street Address	Apt. No.	City	State	Zip

Telephone Number	Marital Status	Termination Date (mm/dd/yyyy):
( )		

I and/or my dependent is eligible for Medicare: ☐ Yes ☐ No

***If Yes, see important note below regarding contacting Via Benefits for enrollment**

Please Mark All Appropriate Elections

	TVA Medical Plan	Via Benefits Medicare
A.	☐ Self ☐ Spouse ☐ Dependent Child(ren)	☐ Self ☐ Spouse ☐ Dependent Child(ren)

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.

*** To enroll in a supplemental Medicare plan through Via Benefits, you should contact them at 844-620-5725 prior to your active coverage ending. This form does NOT constitute enrollment.**

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

	Last Name	First	Middle
1.			
2.			
3.			
4.			

If you are enrolling in the CDHP and wish to elect a Health Savings Account:

HSA Authorization - CHECK ONE BOX

☐ By checking this block, I certify that, as a retiree, I will be eligible to receive a TVA HSA contribution and request that TVA notify HSA Bank to reassign my current active employee account as a retiree account. I understand my request will be forwarded to HSA Bank for processing. Eligible accounts that are not reassigned as a retiree account will not receive the annual TVA contribution.

If, as a retiree, you will no longer be eligible to participate in an HSA, but have any eligible dependents that will remain in the Consumer-Directed Health Plan and are eligible to participate in an HSA, follow the instructions on page 3.

OR

☐ I am newly eligible for an HSA account and need to open an account as a retiree, I understand that I must go to https://secure.hsabank.com/tvaenroll/tva.aspx and complete the online enrollment process. Alternatively, I may complete a paper application form and fax to HSA Bank at 877-851-7041 or mail to HSA Bank, PO BOX 939, Sheboygan, WI 53082. **Accounts that are not opened utilizing one of these two methods will not receive the TVA contribution.**

HSA eligibility requirements are listed on page 3.

Method for Ongoing Payments: If you do not receive a monthly pension, or your monthly pension does not allow for your full medical plan deduction, you must 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 People First Solution 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: Signature _____ Date _____

Return completed form to the People First Solution Center:

Email – HRSupport@tva.gov

Tennessee Valley Authority
People First Solution Center WT 8D-K
400 West Summit Hill Drive,
Knoxville, Tennessee 37902

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 People First Solution Center if you have questions about your service dates.

Consumer-Directed Health Plan (CDHP) enrollees

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, TriCare, or have accessed your VA medical benefits in the past 90 days
- 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)

Spouses of retirees, or the eldest dependent child (minimum age of 18), who remain on the Consumer-Directed Health Plan that are eligible to receive the TVA contribution, will be responsible for opening an account in their name with HSA Bank by visiting https://secure.hsabank.com/tvaenroll/tva.aspx and completing the online enrollment process. Alternatively, they may complete the paper application form and fax to HSA Bank at 877-851-7041 or mail to HSA Bank, PO BOX 939, Sheboygan, WI 53082. **Accounts that are not opened utilizing one of these two methods will not receive the TVA contribution.**

For more information about health savings accounts, contact HSA Bank at (844)-650-8934 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 an intellectual or physical disability 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 retiree's responsibility to report to TVA any changes in your dependent eligibility. (For example: divorce or dependent child's loss of eligibility.)

Tennessee Valley Authority
People First Solution Center, WT 8D-K
400 West Summit Hill Drive
Knoxville, Tennessee 37902

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 the People First Solution 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 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 cashiers 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 | | | | | | | | Check Digit | |

Account Number: _____ ☐ 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 CHECK
AND RETURN WITH THIS FORM

TVA 17534

DELTA DENTAL®

TVA Retirees

Group #1500 Effective Date 01/01/24

Delta Dental PPO Plus Premier Network	
Calendar Year Maximum	**$1,500**
Annual Deductible Applies to Basic and Major Only	**Per Person $50** **Family $150**
Diagnostic and Preventive Services • Oral examinations (2 exams in a calendar year) • Prophylaxis cleanings (limit of 2 in a calendar year) • X-rays (covered as required but not more frequently than 1 set of bitewing x-rays in a calendar year; full mouth x-rays once every 36 months) • Fluoride treatment (covered not more than twice in a calendar year for persons to age 19) • Space maintainers to age 15	**100%**
Basic Services • Restorative (fillings) • Sealants to age 16 (1st and 2nd permanent molars, once per tooth per lifetime) • Repairs (full and partial dentures) • Simple Extractions	**80%**
Major Services • Crowns • Bridges • Partial dentures • Full Dentures • Denture Reline & Rebase • Oral Surgery (surgical extractions) • Periodontics (treatment of gums and bones supporting teeth) • Endodontics (root canal therapy) • Implants	**50%**

Age and frequency limitations apply. For a detailed description of your benefit plan, please review your Certificate of Coverage

Finding a Participating Delta Dental Dentist
There are over 189,000 participating dental locations in the nation. To verify participation status, visit Delta Dental's web site at **www.DeltaDentalTn.com** (choose Delta Dental PPO or Premier), call our Customer Service Department at 615- 255-3175 inside the Nashville calling area or 1-800-223-3104 outside of Nashville, ask your group administrator, or simply ask your dentist if he/she is a participating Delta Dental dentist.

Maximum Plan Allowance (MPA)
You are not responsible for charges exceeding the MPA if you go to a participating Delta Dental dentist. You are responsible for charges exceeding the MPA if you go to a non-participating dentist. The MPA charges are based on fees charged in your geographic area.

When do Benefits Start?
Benefits are available immediately for any services you receive after the effective date of your plan.

This form is not a contract of insurance. Terms and conditions are set forth in the Master Group Policy issued directly to your group administrator.

Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228
1-800-223-3104
(615) 255-3175
www.DeltaDentalTn.com

MONTHLY RATES

Employee Only: $33.42
Family: $78.87

(Other payment options may be available for those who do not receive a pension check. If your payment is not made on an annual basis or monthly deduction from TVARS, there will be a service fee of $1.00 per transaction.)

Please see your enclosed enrollment form for payment options.

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 during an open enrollment period, there is a six month waiting period for Crown Repair, Certain 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.

DELTA DENTAL®

TVA RETIREES ENROLLMENT
GROUP 1500

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

Subscriber Information

Name: _____ (First / Middle / Last)
Address: _____
City: _____
Email: _____

St: _____ Zip: _____
Phone: _____ Birth Date: _____
SSN: _____ Sex: ☐ Male ☐ Female
Retirement Date: _____

Dependents to be covered (if any)

Name (First, Middle, Last)	Birth Date (mm/dd/yy)	Relation (Spouse or Child)	Sex (M/F)

Method of Payment (Select One)

☐ TVARS Deduction- Monthly: ☐ Single - $33.42 ☐ Family - $78.87
Please Note: These deductions will begin on the 4th month. Applicants must include a check or money order in the amount of $100.26 for single or $236.61 for family for first 3 months of premium.

Or

☐ Monthly Bank Draft:* *Applicant must complete Direct Debit Application*
Please Note: $1.00 fee per transaction

Or

☐ Monthly Credit Card:* ☐Visa ☐MasterCard ☐Discover ☐American Express
Please Note: $1.00 fee per transaction

Card Number | *CVV* | *Exp. Date (mm/yy)*

Or

☐ Annual Premium: ☐ Single - $401.04 ☐ Family - $946.44
Send check with enrollment form: Make payable to Delta Dental of Tennessee

**Monthly bank draft and credit card deductions are made on the 24th of each month.*

Certification and Agreement

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

Printed Name: _____ Signature: _____ Date: _____

NOTE: IF YOU DROP COVERAGE, YOU MAY NOT RE-ENROLL

For Delta Use Only: E.D: _____

DELTA DENTAL®

Mail or Fax to:
TVA Administrator
Delta Dental of Tennessee
240 Venture Circle
Nashville, TN 37228
FAX (615) 244-8108

Delta Dental of Tennessee
Authorization for Direct Debit (ACH Debits)

Name: _____ Social Security Number: _____

I (we) hereby authorize Delta Dental 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 or [ ] 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: _____ Account 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.

Printed Name(s): _____

Date: _____ Signature: _____

Date: _____ Signature: _____

Note: Your account will be charged on the 24th of each month, or the next business day following it. A $1.00 service fee will be added per transaction.

Please Attach a Voided Check