Medical Plan 2022

Pre-65 Retiree Medical Plan

The election period is from **October 13 - November 2, 2021**

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Follow these easy steps to make your 2022 Medical Plan Choice

1 **Read "What's New for 2022?" on page 3.**

2 **Review your medical plan costs. See page 16 for more information.**

3 **Do you want to change your current medical plan?**

YES – You must return the Election Form on page 27 to TVA. Read this booklet for enrollment information and important deadlines. Continue to step 4.

NO – You do not have to return the Election Form on page 27 to TVA. Continue to step 4.

4 **Be sure to read the Medicare information in this booklet to learn about your responsibilities and your coverage when you become Medicare-eligible.**

IF YOU WILL BE ENROLLED IN THE CDHP OPTION IN 2022, YOU MUST GO TO STEP 5.

5 **In order to contribute to or receive TVA's contribution to a Health Savings Account (HSA), you must have an HSA with HSA Bank.**

Do you have an HSA with HSA Bank?

YES – You do not need to take any action if your account is open. TVA's contribution will be automatically deposited.

NO – You have two options to open your HSA:

- Contact HSA Bank's TVA-dedicated customer service phone line at 844-650-8934, or
- Complete the HSA Bank Application Form that is included in this packet. Fax the form to 920-803-4184, or mail it to the address shown on the form.

See page 13 - 14 for more information about the HSA.

What's New for 2022?

Expanded virtual behavioral health services (effective 9/15/21)

BlueCross BlueShield of Tennessee has partnered with AbleTo to provide high-quality virtual mental health care and personalized mental health programs. You'll be paired with a licensed virtual therapist who will provide confidential 1-on-1 support by video chat or phone. These programs can help you manage depression, stress, and anxiety and teach you skills to help you feel better and live better. Standard cost share (deductible/coinsurance) will apply. For more information or to register, visit **member.ableto.com/bcbst/**.

Be sure to read the Medicare information on pages 5 - 7 about prescription drug coverage available when you become eligible for Medicare.

The following changes to your benefits begin Jan. 1, 2022.

1. NEW: Enhancements to Prescription Drug Benefits

- Coupled with diet and exercise, prescription weight loss drugs can help you achieve a healthier weight. Effective January 1, 2022, prescription weight loss drugs will be covered under the pharmacy plan. Consult with your medical provider to see if this might be a good option for you.
- Prescriptions filled via mail-order now qualify for discounts via coupons. Beginning on 9/1/2021, all applicable coupons will automatically be applied to the cost of prescriptions fulfilled via mail.
- Filling a 3-month supply of your long-term maintenance medication can help you save time, money and trips to the pharmacy. Express Script's Smart90 program is being expanded beyond Walgreens to Smart90 Anywhere. Employees' 90-day prescription coverage can be obtained at any participating pharmacy beginning January 1, 2022. To find a participating Smart90 pharmacy, login to **express-scripts.com/tva** and click "Find a pharmacy" from the menu under "Prescriptions," and search for pharmacies in your area.

2. NEW: Changes to the 80 Percent PPO Plan

In-network deductibles for the 80 Percent PPO will be $550 (Individual) and $1,100 (Family). Out-of-network deductibles will be $1,100 and $2,200. In-network out-of-pocket maximums will be $3,250 (Individual) and $6,500 (Family). Out-of-network out-of-pocket maximums will be $6,500 and $13,000. There are no changes to the deductibles or out-of-pocket maximums for the Consumer-Directed Health Plan (CDHP).

3. NEW: HSA Limits

The 2022 annual HSA contribution limit for CDHP participants will be increased to $3,650 for those with individual coverage and to $7,300 for those with family coverage.

4. NEW: Family Building Benefit

TVA is pleased to announce the expansion of our employee benefit offering to include our new Family Building Benefit. In addition to our existing family benefits--flexible work schedules, reduced hours when needed, dependent care FSA, and EAP--the Family Building Benefit is designed to support you throughout your journey to grow your family. Through TVA's partnerships with BCBST and Express Scripts, TVA has expanded its medical and pharmaceutical coverage to include fertility medications and treatments for members enrolled in TVA's medical plan.

General Information and Enrollment Instructions

Welcome to the annual Retiree Medical Plan Election Period. From **October 13 through November 2**, you may choose the medical plan you want for 2022.

Your medical plan options for 2022 are:

- 80-percent PPO
- Consumer-Directed Health Plan (CDHP)

See "What's New for 2022?" on page 2 for changes to the medical plan options. Premiums for each plan are available online: **www.tva.com/retireeportal**.

Which plan is right for you? Only you can decide which plan best meets your healthcare and financial needs. One tool that might help you is available at **www.bcbst.com**.

- Log in or register if a first-time user.
- Under Find Care, click Compare Health Plans.

You can compare your costs under the medical plan options.

You can also compare medication prices under both medical plan options at **www.express-scripts.com/tva**.

- Click Go in the middle section, Open Enrollment Information.
- Select the TVA medical plan option you want to review.
- Select Compare prescription medication costs.

Important enrollment information

If you want to change your medical coverage for 2022, you must complete the Election Form included in this booklet. Return by mail to the address at the bottom of the form, or by fax to **865-632-9682**.

If you have medical coverage in 2021 and your election form is not received by Nov. 2, 2021, you will be enrolled in the same medical plan for 2022 at the level of coverage – individual or family – you have in 2021.

Remember that you cannot change your election after Jan. 1, 2022.

If you wish to terminate your TVA coverage, you may do so by completing the Election Form. Please remember that canceling your coverage in a TVA-sponsored retiree medical plan means that you will not be allowed to enroll in a TVA medical plan in the future.

Remember that it is very important to keep your medical plan enrollment record current. Be sure to report any change of address.

It is your responsibility to notify the People First Solution Center when a dependent is no longer eligible for medical coverage. If a claim is paid for an ineligible dependent, you may be required to reimburse the medical plan for the amount of that ineligible payment.

Important information for CDHP enrollees if new to the CDHP:

In order to contribute to or receive TVA's contributions to a Health Savings Account, you must complete a separate Election Form to open your HSA. You have two options to open an HSA:

- Contact HSA Bank's TVA-dedicated customer service phone line at **844-650-8934**, or
- Complete the HSA Bank Application Form that is included in this packet. Fax the form to **920-803-4184**, or mail it to the address shown on the form. See pages 24 - 26 for forms.

If currently enrolled in the CDHP and will be remaining in it for 2022:

If you already have an HSA with HSA Bank, TVA's contribution will be automatically deposited.*

Note: If your account had a $0 balance and no activity for 6 months or more, it may have been closed by HSA Bank. To re-open your account contact HSA bank at 844-650-8934 or speak to a benefits specialist at 888-275-8094. Accounts must be open and able to accept deposits by Dec. 20th in order for you to receive the TVA HSA annual contribution on Jan 1st.

Will you be eligible for Medicare?

TVA offers medical and prescription drug coverage to Medicare-eligible retirees and spouses through a private Medicare exchange. Access to this private Medicare exchange, as well as support and enrollment assistance, is provided by Via Benefits. Via Benefits is a leading coordinator of individual coverage in the marketplace.

Additionally, Via Benefits offers vision and dental coverage; however, if you are currently enrolled in TVA's retiree dental plan through Delta Dental of Tennessee, you can keep that coverage and it will remain in effect unless you cancel your coverage directly with Delta Dental.

As early as your 64th birthday, or 12 months prior to becoming Medicare-eligible, you will begin receiving information from Via Benefits providing you details about your retiree healthcare benefits as well as information about how and when to enroll.

You can enroll through Via Benefits during the Initial Enrollment Period (IEP). The IEP is a seven-month period that starts three months before your Medicare-eligible date, includes the month of your Medicare-eligible date, and the three months after your Medicare-eligible date.

Note that when you or a covered dependent becomes eligible for Medicare at age 65, your TVA-sponsored medical coverage will automatically terminate at the end of the month prior to your Medicare effective date. You can enroll in supplemental Medicare coverage outside of Via Benefits. If you choose to do so, it is important that you know the following:

- If you are a TVA retiree, or the surviving dependent of a deceased TVA retiree, become eligible for Medicare at age 65, and do not enroll in a medical plan through Via Benefits, you will lose any TVA-provided assistance which would have been made available to you through a Via-administered Health Reimbursement Arrangement (HRA) account.
- If the spouse of a TVA retiree does not enroll through Via Benefits, the retiree's health care assistance may be reduced.

If you are the TVA retiree, or the surviving dependent of a deceased TVA retiree, AND enroll in a medical plan through Via Benefits during your IEP:

- Any covered dependents that are not yet eligible for Medicare will remain in the TVA-sponsored medical plan that you elect for next year. Note that they will receive new ID cards from BCBST and Express Scripts.
- The premium for any dependents remaining in the TVA group plan (i.e., 80% PPO or CDHP) will continue to be deducted from your retiree pension check or bank draft.
- If you currently have a Health Savings Account (HSA), once you are enrolled in Medicare, you will no longer be able to contribute to the account. You will, however, still be allowed to be reimbursed for eligible healthcare expenses from the account. If you have any dependents that continue to be enrolled in the CDHP medical plan and want to participate in an HSA, he/she must enroll with HSA Bank. See enclosed HSA enrollment material.

Important Information about the TVA Healthcare Credit When Becoming Medicare-Eligible

TVA's Healthcare Credit is based on, among other factors, plan enrollment. Therefore, if you are currently receiving the TVA Healthcare Credit, for the majority of retirees, this amount will be automatically reduced due to you or your covered dependent becoming eligible for Medicare. As noted above, if you are the dependent of as TVA retirees and do not enroll in a medical plan through Via Benefits, the retiree's Healthcare Credit could be reduced further.

Are you becoming eligible for Medicare before reaching 65?

If you or one of your covered dependents becomes eligible for Medicare before reaching age 65 due to disability, you will be given the option to stay in the plan you're currently enrolled in as secondary coverage to Medicare, or enroll in a plan through Via Benefits. If you want to enroll in a plan through Via Benefits, you must contact the People First Solution Center within three months of your Medicare effective date. Otherwise, you will remain in the plan you're currently enrolled in as your secondary coverage until reaching 65.

Medicare Information

Important information for retirees and covered dependents who become eligible for Medicare

If you are eligible for Medicare or will become eligible for Medicare in the next 12 months (or if you have a covered dependent eligible for or becoming eligible for Medicare), see the following important information about prescription drug coverage under Medicare and your TVA medical plan coverage.

When you (or a covered dependent) become eligible for Medicare, you are no longer eligible for coverage under the 80-percent PPO or Consumer-Directed Health Plan.

- You will, however, be eligible to enroll in healthcare coverage through a private Medicare exchange provided by Via Benefits.

Most people will become eligible for Medicare at age 65. Your TVA-sponsored coverage will automatically terminate at the end of the month prior to your Medicare effective date. As early as your 64th birthday, or 12 months prior to becoming Medicare-eligible, you will begin receiving information from Via Benefits providing you details about your retiree healthcare benefits as well as information about how and when to enroll.

You can enroll through Via Benefits during the Initial Enrollment Period (IEP). The IEP is a seven-month period that starts three months before your Medicare-eligible date, includes the month of your Medicare-eligible date, and the three months after your Medicare-eligible date.

If you or one of your covered dependents becomes eligible for Medicare before reaching age 65 due to disability, you will be given the option to stay in the plan you're currently enrolled in, or enroll in a plan through Via Benefits. If you want to enroll in a plan through Via Benefits, you must contact the People First Solution Center within three months of your Medicare effective date. Otherwise, you will remain in the plan you're currently enrolled in.

Creditable coverage notice for retirees not eligible for Medicare

Medicare offers prescription drug coverage (Part D) to eligible individuals. When you become eligible for Medicare, you will also have an opportunity to enroll in a Part D prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage.

Read the following notice carefully and keep it where you can find it should you have questions about prescription drug coverage when you become eligible for Medicare.

Prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because prescription drug coverage under the TVA-sponsored retiree medical plan (the 80-percent PPO or Consumer-Directed Health Plan) is on average at least as good as standard Medicare prescription drug coverage, TVA has determined that your prescription drug coverage from the TVA plan is creditable and you will not pay a higher premium (penalty) when you enroll in a Medicare Part D prescription drug plan.

When you cancel or lose your coverage under the TVA-sponsored retiree medical plan (the 80-percent PPO or Consumer-Directed Health Plan) and are eligible for Medicare, you will be eligible to sign up for a Medicare Part D prescription drug plan at that time.

If you cancel or lose your coverage under the TVA-sponsored retiree medical plans, are eligible for Medicare, and do not enroll in Medicare prescription drug coverage after your TVA coverage ends, you may have to pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium for Medicare prescription drug coverage will go up at least 1 percent per month for every month that you did not have that coverage. For example, if you go 19 months without coverage, your premium will always be at least 19 percent higher than what many other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll.

For more information about this notice, you may call the People First Solution Center at 865-632-8800, 423-751-8800 or toll-free at 888-275-8094.

Note: You may receive this notice at other times in the future, such as before the next Medicare prescription drug enrollment period or if this coverage changes. You may also request at any time a copy of this notice or a personalized notice specific to your creditable coverage under the TVA medical plans.

More detailed information about Medicare plans that offer prescription drug coverage is available in the "Medicare and You" handbook. If you are eligible for Medicare, you will get a handbook in the mail. You may also be contacted directly by Medicare prescription drug plans. You can get more information about Medicare prescription drug plans from the following:

- Visit **www.medicare.gov**.
- Call your state health insurance assistance program (see your copy of the "Medicare and You" handbook for the telephone number).
- Call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov**, or call **1-800-772-1213 (TTY 1-800-325-0778)**.

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage, you may need to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and whether or not you are required to pay a higher premium.

Date: Oct. 1, 2021
Name of Entity/Sender: Tennessee Valley Authority
Contact: People First Solution Center
Address: 400 West Summit Hill Drive, Knoxville, TN 37902
Phone: 888-275-8094

Your TVA Medical Plan Options

The medical plan options are:

- 80-Percent PPO plan
- Consumer-Directed Health Plan (CDHP)

The medical options are self-funded plans which are administered by BlueCross BlueShield of Tennessee. These plans are not fully insured plans and the plan administrator has no financial risk for the expenses of these plans. The funds from which claims are paid under these plans are a combination of contributions paid by those covered under the plan and TVA contributions on behalf of those covered. The premiums for these plans are based on the expenses incurred by the members of the plan. Premiums for each plan are available online: www.tva.com/retireeportal.

Both options include:

Medical benefits

Medical benefits are administered through BlueCross BlueShield of Tennessee. Both options are PPO plans – that is, they both use the BlueCross BlueShield PPO networks that are available nationwide, so you have access to PPO network providers no matter where you live or where you are receiving medical care. Both options cover the same types of medical and surgical services needed for the diagnosis and treatment of illness and injury – physician, hospital, most durable medical equipment, etc. But the services are covered at different levels with differing deductibles and patient payments under each option.

You will receive greater benefits when using PPO providers (in-network providers). If you use out-of-network providers, benefits will be paid at a lower level and you will pay more out of your pocket for the services you receive, including any charges that are higher than the amounts allowed.

To find PPO network providers in your area, go to www.bcbst.com, log in and select "Find a Doctor" under "Find Care," and follow the instructions. You can also call the BlueCard/BlueCard PPO Participating Doctor and Hospital Information Line at 1-800-810-BLUE (2583).

Preventive care benefit

Each person covered under one of the medical plan options is eligible for plan payments for routine exams. This benefit is not subject to the deductible, and you do not have to pay coinsurance or a copayment for services covered under the preventive care benefit.

Any office visit, screening exam, lab work or other service in connection with a routine physical as defined by the American Medical Association is covered under the preventive care benefit. Services can include, but are not limited to:

- Gynecological exam, annual routine exam, mammogram screenings, pap smears, prostate screening, audiology screening, flu shots (both seasonal and H1N1), pneumonia shots, colonoscopies and related routine diagnostic services.
- Annual preventive health exams for adults and children age 6 and older, including screenings and counseling services with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) and performed by the physician during the preventive health exam.
- Preventive health exams for children through age 5, including screenings with an A or B recommendation by the United States Preventive Services Task Force (USPSTF) and performed by the physician during the preventive health exam ("Well Child Care").

These services are subject to guidelines under the Patient Protection and Affordable Care Act. If the services are billed as routine or preventive services, the claim(s) will be processed under the preventive care benefit. Contact BCBST for a complete listing or to verify coverage of preventive services.

Prescription drug coverage

Both options include prescription drug benefits administered by Express Scripts.

Both plans have a three-tier prescription drug plan – generic, preferred brand (sometimes called formulary), and nonpreferred brand (nonformulary). When you use generics or preferred brand-name drugs, you can save

money for yourself and the plan. Express Scripts establishes the preferred listing of brand-name drugs based on findings of a committee made up of physicians and pharmacists. The committee reviews the clinical effectiveness of the drugs as well as their cost-effectiveness to assign preferred status.

To find out if a particular brand-name medication is preferred or not, if it has a generic equivalent, or if it is not covered, call Express Scripts Member Service at **800-935-6203** or visit Express Scripts' website at www.express-scripts.com/tva. The list is reviewed by the Express Scripts committee quarterly and is subject to change.

Retail purchases

Your Express Scripts identification card allows you to access more than 67,000 retail pharmacies for short-term or emergency prescriptions. Prescriptions for up to a 30-day supply of eligible prescription drugs can be purchased at local pharmacies. You may be able to get 90-day supplies of maintenance medications as well. See below for information on the Maintenance Medication Refill program.

The Maintenance Medication Refill Program

The Maintenance Medication Refill Program provides you with two options to obtain refills of certain maintenance medications (those drugs you take regularly for ongoing conditions such as high blood pressure, diabetes, or high cholesterol). Under this program, the prescription plan will cover up to three retail pharmacy purchases of covered maintenance medications.

You then have two options to obtain up to a 90-day supply and typically pay less than you would pay for three 30-day supplies purchased at retail. Use Express Scripts Home Delivery for convenient and easy mail-order purchases through mail, telephone or the internet at Express Scripts' website, www.express-scripts.com/tva.

You will also have the option to obtain up to a 90-day supply at a participating retail SMART90 pharmacy. Your costs will be the same as through mail-order.

This prescription drug plan covers only legend drugs – that is, drugs that can only be dispensed with a prescription. The plan does not cover drugs with over-the-counter equivalents.

Specialty Drugs

Specialty drugs may be filled through Express Scripts' specialty pharmacy, Accredo. Eligible specialty prescriptions up to a 30-day supply can be purchased through Accredo at the retail prices shown on page 11. Mail-order pricing does not apply to Accredo specialty drugs and you cannot get greater than a 30-day supply at a time. If you want to determine if the medication you are taking can be purchased through Accredo, please call **Express Scripts** at **800-935-6203**.

Vision Coverage

Each option includes vision benefits administered by BlueCross BlueShield of Tennessee and includes a network of providers. Retirees receive a higher level of benefits when network providers are used (see the table below).

More information on these medical plan options is available at the TVA retirees website (www.tva.com/retireeportal) or the BlueCross BlueShield of Tennessee website (www.bcbst.com).

VISION BENEFITS	IN-NETWORK	OUT-OF-NETWORK
	MEMBER PAYS	MEMBER IS REIMBURSED
Exam with Dilation as Necessary (once per calendar year):	$10 Copay	Up to $35
Standard Plastic Lenses (once per calendar year):		
Single Vision	$10 Copay	Up to $25
Bifocal	$10 Copay	Up to $40
Trifocal	$10 Copay	Up to $55
Standard Progressives	$10 Copay	Up to $55
Lenticular	$10 Copay	Up to $55
	$10 Copay	Up to $45
Frames (once every other calendar year):*	$10 Copay; $130 Allowance; 20% off balance over $130	
Lens Options (added to the base price of the lenses):		
UV Coating	$12	
Tint (Solid and Gradient)	$12	
Scratch-resistant	$12	
Standard Polycarbonate	$35	
Standard Anti-reflective	$45	
Contact Lenses (in lieu of standard plastic lenses; includes fit, follow-up and materials):		
Conventional*	$10 Copay; $150 Allowance; 15% off balance over $150	Up to $98
Disposables*	$10 Copay; $150 Allowance	Up to $98
Medically Necessary		Up to $200

*For in-network benefits, children under 19 have a selection of frames and contacts to choose from. The allowance does not apply. For out-of-network benefits, children under 19 will be reimbursed up to 60% of maximum allowable charge.

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: $1,400 Individual Contract / $2,800 Family Contract Out-of-network: $2,800 Individual Contract / $5,600 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 Specialist referral required	In-network covered 80% after deductible No	In-network covered 80% after deductible 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 Diagnostic services	In-network covered 80% after deductible In-network covered 80% after deductible	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 (covered once per calendar year) Lenses (covered once per calendar year) Frames (covered once every other calendar year) Contacts* **Children under 19 have a selection of frames and contacts to choose from. The allowance does not apply.*	$10 copay $10 copay $10 up to $130 80% amount over $130 $10 up to $150	$10 copay $10 copay $10 up to $130 80% amount over $130 up to $150
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 Outpatient	In-network covered 80% after deductible In-network covered 80% after deductible	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 (see page 11), or for more information on the plan documents, 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 Pharmacy 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 (see below), or for more information on the plan documents, please contact the People First Solution Center.

Summary of Benefits and Coverage

In addition to the Comparison of Medical Benefit Plans on pages 10 to 11, a Summary of Benefits and Coverage (SBC) for the TVA Medical Plan options is also available to you. The SBC provides information to help you understand your medical plan options and make decisions about which medical plan to choose. In addition to providing a benefits and coverage summary, the SBC also includes details, called “coverage examples,” which are comparison tools that allow you to see what the plan would generally cover in two common medical situations.

To view and/or print a copy of the TVA Medical Plan’s SBC, go to **www.tva.com/retireeportal** and click on Health Care Benefits.

To have a copy sent to you free of charge, contact the People First Solution Center at **1-888-275-8094** (toll-free), **1-423-751-8800 (Chattanooga)**, **1-865-632-8800 (Knoxville)** or **1-800-848-0298 (TDD/TTY TN Relay Service)**.

TVA Medical Plans - Pharmacy Coverage

80-Percent PPO Plan

The 80-Percent PPO plan includes a deductible that must be met before medical benefits are paid (that is, benefits for doctors, hospitals, etc.). The deductible does not apply, however, to preventive care, prescription drugs or to vision-care services.

Prescription drug copayments you will make at the time of purchase are:

	RETAIL (UP TO 30-DAY SUPPLY)	MAIL-ORDER OR SMART90
Generic	You Pay $10	You Pay $20
Preferred Brand	You Pay $30	You Pay $60
Nonpreferred Brand	You Pay $50	You Pay $100

The vision benefits are shown on page 9.

Consumer-Directed Health Plan (CDHP)

The CDHP is a high-deductible health plan in which you assume more control of your healthcare spending and more financial responsibility in exchange for lower premiums. After the deductible is met, the CDHP provides 80 percent coverage for in-network medical services and prescription drugs until the out-of-pocket maximum is reached. Participants in the CDHP may be eligible for a Health Savings Account (see below).

<table>
<tr><td rowspan="6">Preventive Care Benefit
(Plan pays 100%)</td><td>In-Network Deductible
$1,400 Individual Contract
$2,800 Family Contract</td><td>Out-of-Network Deductible
$2,800 Individual Contract
$5,600 Family Contract</td></tr>
<tr><td colspan="2">After you meet your deductible</td></tr>
<tr><td rowspan="3">In-Network Medical
Plan pays 80%

Out-of-Network Medical
Plan pays 60%
(based on allowable amounts)</td><td>Prescription-Drug Coverage
Plan pays 80%</td></tr>
<tr><td>Minimum to be paid by you:
Retail:
$10 generic
$24 preferred
$39 nonpreferred

Mail-order or SMART90:
$20 generic
$48 preferred
$78 nonpreferred</td></tr>
<tr><td>Maximum to be paid by you:
Retail:
$100 for any covered drug

Mail-order or SMART90:
$200 for any covered drug</td></tr>
<tr><td colspan="2">100% After Out-of-Pocket Maximum
$4,500 Individual / $9,000 Family In-Network
$9,000 Individual / $18,000 Family Out-of-Network</td></tr>
</table>

An HSA is a tax-exempt account you own for the purpose of paying qualified medical expenses for yourself, your spouse and your dependents. You decide whether to use your HSA money now for qualified medical expenses or save it for future use.

HEALTH SAVINGS ACCOUNT	
TVA Contribution	$600 Individual/$1,200 Family
Retiree Contribution (Optional)	The retiree chooses whether or not to contribute.
Maximum Contribution (all sources)*	**$3,650/$7,300 for 2022**
Unused balance can carry over for future years with no limits.	

*If you are 55 or older, you can also make additional "catch-up" contributions. The maximum annual catch-up is $1,000.

Deductibles

There are in-network and out-of-network deductibles in the CDHP. The deductibles must be met on a contract basis under a CDHP. That means that if you have a family contract under the CDHP you must meet the entire family deductible before anyone in the family receives benefit payments under the plan. The family deductible can be met by one member of the family or it can be met by a combination of charges from any of the covered family members.

After you have satisfied the deductible in the CDHP, you will receive plan benefits for covered medical and prescription drug expenses. Prescription drugs are covered by the plan at 80 percent, and you pay the remaining 20 percent – subject to the minimum and maximum payments as follows.

If your 20-percent share of a covered drug is less than the minimum shown below, you will pay the minimum amount (or the price of the drug, whichever is less). If your 20-percent share of a covered drug is greater than the maximum shown below, you will pay the maximum amount.

	RETAIL (UP TO 30-DAY SUPPLY)	MAIL ORDER OR SMART90 (UP TO 90-DAY SUPPLY)
Generic	Minimum you will pay: $10 Maximum you will pay: $100	Minimum you will pay: $20 Maximum you will pay: $200
Preferred Brand	Minimum you will pay: $24 Maximum you will pay: $100	Minimum you will pay: $48 Maximum you will pay: $200
Nonpreferred Brand	Minimum you will pay: $39 Maximum you will pay: $100	Minimum you will pay: $78 Maximum you will pay: $200

Some examples of how the prescription drug coverage works under the CDHP:

Generic, 30-day supply at retail, cost is $80	**Preferred Brand, 30-day supply at retail, cost is $90**	**Nonpreferred Brand, 90-day supply through mail-order or SMART90 pharmacy, cost is $200**	**Preferred Brand, 90-day supply through mail-order or SMART90 pharmacy, cost is $1,200**
20% = $16 You pay $16	20% = $18 (below minimum) You pay $24 (minimum)	20% = $40 (below minimum) You pay $78 (minimum)	20% = $240 You pay $200 (maximum)

After you have met your deductible, medical benefits are payable at 80 percent for in-network PPO services and at 60 percent of the allowable amount for out-of-network PPO services. If you choose to use providers not in the PPO network, you will pay 40 percent of the allowable amount plus any charges in excess of the allowable amount.

Out-of-pocket maximums

The amounts you pay to meet your deductible and the coinsurance you pay for covered prescription drugs, medical services and vision after the deductible is met count toward your out-of-pocket maximum. Once you have reached the out-of-pocket maximum, the plan pays 100 percent of your covered expenses for the remainder of the calendar year.

Health savings account

The HSA is a tax-exempt account owned by you to which you and TVA can make contributions to pay for qualified medical expenses.

Amounts contributed to the HSA accumulate on a tax-free basis, and withdrawals are not subject to tax if they are used to pay for eligible medical expenses for you and your dependents. Contributions made in one year and not used to pay expenses in that year may be used to pay eligible medical expenses in later years.

An HSA is fully vested at all times and portable, meaning that it can move with you as your circumstances change. Once you reach age 65, you may use the HSA funds to pay for Medicare premiums (but not Medigap policies) or other medical expenses on a tax-free basis, or you may take a distribution for any other reason and pay only ordinary income tax.

The HSA is serviced by HSA Bank.

REMINDER: If you are newly enrolling in the Consumer-Directed Health Plan (CDHP) in 2022 you must open an HSA to receive the TVA contribution.

HSA eligibility requirements

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

- Must be covered by a 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 or Tricare.
- 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).

HSA fees

HSA Bank will deduct a monthly administrative fee of $0.25 if your account balance is under $3,000. There is no fee if you maintain a balance of $3,000 or more. Other fees, such as those for checks and account closing, will be highlighted in the welcome kit you receive upon enrolling in the HSA.

Contributing to your HSA

You choose whether or not to contribute to the HSA. Your contributions are tax-deductible. TVA will make a contribution to the HSA. If you have an individual contract under the CDHP, TVA places $600 in the HSA. If you have a family contract under the CDHP, TVA places $1,200 in the account. You must have opened your account in order for your TVA contribution to be deposited.

You can make contributions by mailing contributions using deposit slips from your HSA checkbook or automatically transferring monthly contributions from a personal checking or savings account.

The maximum annual HSA contribution from all sources (including TVA's contribution) for 2022 is $3,650 per individual and $7,300 per family. If you are age 55 or older, you can also make additional "catch-up" contributions. The maximum annual catch-up contribution is $1,000. These amounts are mandated by the IRS.

The money in your HSA earns tax-free interest daily. You have the choice to invest the money, and which investments to select. If you do not use all of the money in the account, it is rolled over year to year. There is no limit to the amount that can be rolled over.

TVA contributions will be made to HSA Bank. If you wish, you have the option to move your funds to another trustee of your choice. If you discontinue your enrollment in the CDHP in the future, you can continue to use the funds in your HSA for qualified medical expenses until they are depleted, but can no longer contribute to the account.

Using your HSA

You decide whether to use the money in your HSA to pay for current medical expenses, including your deductible, or save for future medical needs.

After opening your account you will be sent an HSA Bank Visa® debit card. Checks are also available. You can use one of these methods to access your HSA money to pay for any qualified medical expense permitted under federal tax law that you incur after you open your HSA. You can use the money to pay for medical expenses for yourself, your spouse and dependent children. You can pay for expenses of your spouse and dependent children even if they are not covered by the CDHP.

In order to be considered qualified, the expense has to be primarily for the prevention or alleviation of a physical or mental defect or illness. This would include office visits, hospitalization or prescription drugs. Qualified medical expenses are defined in section 213(d) of the Internal Revenue Code, and a list of qualified expenses is available on the IRS web site, **www.irs.gov**, Publication 502, "Medical and Dental Expenses."

Any HSA money used for purposes other than to pay for qualified medical expenses is taxable as income and subject to an additional 20-percent tax penalty. After you turn age 65, the 20-percent additional tax penalty no longer applies.

Maintaining your HSA

The trustee of your HSA will track the total dollar amount spent from your HSA and provide that information to both you and the IRS. You will receive a quarterly statement similar to the one you get for your regular checking account showing average balance, closing balance, and any debits or credits to the account. You also have online access to your account. Each year you will receive a 1099-SA and a 5498-SA statement for filing income tax. Keep copies of your medical receipts to verify how you use your funds. You are responsible to the IRS for all types of withdrawals made from your HSA.

For more HSA information

Call **HSA Bank at 844-650-8934** or visit **www.hsabank.com/tva**. Questions can be directed to a customer service representative by phone or email at **askus@hsabank.com**. More information is also available at **www.tva.com/retireeportal**.

How the CDHP works with an HSA

TVA will deposit $600 into your HSA for individual coverage or $1200 for family coverage.

Meeting your deductible

You and your family members go to the physician and purchase prescription drugs just as you would normally do, presenting your BlueCross identification card for physician and hospital services and your Express Scripts identification card for prescription drug purchases.

You can use your HSA funds to pay for the covered services by using your HSA debit card or checks drawn on your HSA. If you have already paid for expenses out of your own pocket, you may reimburse yourself by writing a check out of your HSA.

However, you may choose to save the money in your HSA for a future expense. If you do not use your HSA funds and have not met your deductible, you will pay for the expenses out of your pocket.

After your HSA funds have been used (or if you decide not to use your HSA), you must pay in full for all covered medical and prescription drug purchases for your family until you have met the deductible. You must continue to present your BlueCross or Express Scripts identification cards even though you are paying out of your pocket in order to get credit for the amounts you pay and have those payments applied toward your deductible.

Plan benefits

Covered prescription drugs are paid by the plan at 80 percent after the in-network deductible has been met. If your 20-percent share of the cost is less than the minimum, you will pay the minimum, not to exceed the full cost of the drug. If your 20-percent share is greater than the maximum, you will pay only the maximum.

After meeting the deductible, hospital, physician and other covered medical services will be paid at 80 percent if they are received from PPO in-network providers, and you will be responsible for 20 percent. If you use out-of-network providers, the plan will pay 60 percent of the allowable amount, and you will pay 40 percent plus any charge that exceeds the allowable amount.

Out-of-pocket maximum

You will continue to pay your share of prescription drug expenses and covered medical expenses until you reach the out-of-pocket maximum. The payments you make to meet your deductible and your share of prescription drug, medical expenses and vision apply toward the out-of-pocket maximums shown on the chart on page 11. If you reach the out-of-pocket maximum, plan benefits are payable at 100 percent (based on in-network and out-of-network usage) for the remainder of the calendar year.

Vision coverage

Vision coverage is not subject to the deductible.

When using in-network providers, you are responsible for set copays as defined in the Vision Benefits chart on page 9. If out-of-network providers are used, you will pay in advance and then be reimbursed up to the dollar amounts shown in the Vision Benefits chart.

Your 2022 Medical Plan Costs

Important Terms to Know

Copayment, or coinsurance

The amount you pay for services covered by the medical plan once you have paid your deductible.

Eligible dependents

- Your spouse
- Your natural child, adopted child, foster child, stepchild, or child for whom you are the legal guardian or of whom you have legal custody, under the age of 26.

Out-of-pocket maximum

In the medical plan, the most you pay for covered services during a benefit period. This maximum can be met by a combination of in-network or out-of-network providers' eligible charges. Those do not include any charges in excess of the allowable usual, customary and reasonable (UCR) amount or any penalty paid for a failure to follow preadmission certification requirements. Once you reach the maximum amount, the plan pays 100 percent of your covered expenses for the remainder of the plan year.

The following monthly premiums are the total premiums and do not reflect any pension supplement or contribution you may receive to help offset the cost of your medical coverage.

2022 TVA Retiree Monthly Premiums

	INDIVIDUAL	FAMILY
80 Percent PPO	$769	$1,850
CDHP	$460	$1,095

Remember, if your payment for medical plan coverage is deducted from your monthly pension benefit and you change coverage, you will see a change in the deduction amount on the check you receive at the end of December. This is the deduction for January coverage.

Premiums for each plan are also available online at:
www.tva.com/retireeportal

How do you pay your premium?

Look closely at the premium amount for the plan you select. If you are currently having premiums deducted from your monthly pension benefit but your monthly pension will not be large enough for the premium to be deducted, you must change your method of premium payment to automatic bank drafting. TVA will review records in early 2022 and will notify you if it appears that your premium can no longer be deducted from your monthly pension benefit. If, however, you want to go ahead and change to automatic bank drafting, please call please call the People First Solution Center at **888-275-8094**.

Healthcare Assistance Program (Chronic Condition Management)

This voluntary and confidential program provides health education, information, support and assistance to employees, retirees and their covered dependents. Its features include a 24-hour nurse line, an online personal health record and support from specialty nurses or health coaches to members dealing with certain chronic medical conditions.

Nurses working with members in the program will be able to access information from Express Scripts regarding your current prescriptions and can contact your physician upon request.

You may access your personal health record at **www.bcbst.com**, or speak to a nurse by calling **1-800-245-7942**.

FAQ

Do I have to submit the Retiree Medical Plan Election Form to continue my coverage for next year?

TVA encourages you to review the options for next year carefully. If you want to change your medical plan, you must return the Election Form. If you don't want to change your plan, do not return the Election Form.

If you have medical coverage in 2021 and your election form is not received by Nov. 2, 2021, you will be enrolled in the same medical plan for 2022 at the level of coverage – individual or family – you have in 2021.

If you wish to waive, or terminate, your TVA coverage, you may do so by completing the Election Form. Please remember that canceling your coverage in a TVA-sponsored retiree medical plan means that you will not be allowed to enroll in a TVA medical plan in the future.

Do I have to submit the enclosed HSA Bank enrollment form?

If you will be enrolled in the CDHP option in 2022 and do not have an HSA with HSA Bank, you must complete a separate election in order to receive TVA's contributions or contribute to your HSA yourself. You have two options to open your HSA:

- Contact HSA Bank's TVA-dedicated customer service phone line at **844-650-8934**, or
- Complete the HSA Bank Application Form that is included in this packet. Fax the form to **920-803-4184**, or mail it to the address shown on the form.

If you already have an HSA with HSA Bank, do not submit the form.

Is this an open election period for all retirees?

No. Retirees not eligible for Medicare who currently participate in TVA's medical plan can choose from the available medical plan options. Retirees who do not now have medical coverage may not elect coverage at this time.

What if I change my mind and want to change my plan option after the first of the year?

The plan you choose during this election period will remain in effect for all of 2022. You may not change your plan option during the year. You will be given an opportunity next fall to make an election for 2023.

I'll go on Medicare in 2022. What will happen to coverage for my spouse?

When you become eligible for Medicare at age 65, your TVA-sponsored coverage will automatically terminate at the end of the month prior to your Medicare effective date. As early as your 64th birthday, or 12 months prior to becoming Medicare-eligible, you will begin receiving information from Via Benefits providing you details about your retiree healthcare benefits. If your spouse (or any eligible dependent covered on your medical plan) is not yet eligible for Medicare, his or her coverage will continue under the TVA-sponsored plan you elect for 2022. Your spouse or dependent will receive a new medical plan identification card.

Please remember

If you or one of your covered dependents becomes eligible for Medicare before reaching age 65 due to disability, you will be given the option to stay in the plan you're currently enrolled in, or enroll in a plan through Via Benefits. If you want to enroll in a plan through Via Benefits, you must contact the People First Solution Center within three months of your Medicare effective date. Otherwise, you will remain in the plan you're currently enrolled in.

Who can answer my questions about the medical plan options?

BlueCross BlueShield of Tennessee administers the medical plans. Its Member Service can assist you. The People First Solution Center can also help you. See contact information on page 22 of this booklet.

Who can answer my questions about the Health Savings Account?

Call HSA Bank at **844-650-8934** or visit **www.hsabank.com/tva**. Questions can be directed to a customer service representative by phone or email at **askus@hsabank.com**.

Notice of Privacy Practices

Legal Obligations

The group health plan (the Plan) sponsored by the Tennessee Valley Authority (TVA) is required by the Health Insurance Portability and Accountability Act of 1996, commonly referred to as HIPAA, to maintain the privacy of all protected health information (PHI) in accordance with HIPAA; provide this notice of privacy practices to all enrollees; inform enrollees of our legal obligations with respect to their PHI; and advise enrollees of additional rights concerning their PHI. The Plan must follow the privacy practices contained in this notice from its effective date of September 23, 2014, and continue to do so until this notice is changed or replaced. As used in this notice, the Plan means the self-insured health plans sponsored by TVA for the payment of medical, dental, or prescription drug and vision claims. The Plan also includes the self-referral Employee Assistance Program to the extent you request medical services under it, the health care flexible spending account to the extent that you maintain one to help reimburse medical expenses, the Health Check Program, and the TVA-sponsored Disease Management Program.

Since 1974, TVA has maintained its records under the Federal Privacy Act, which requires TVA to protect employees' personal information. The requirements under HIPAA reinforce TVA's current practices relating to the protection of employees' personal information.

HIPAA privacy requirements are related to PHI. PHI includes all individually identifiable health information transmitted or maintained by the Plan, regardless of the form (oral, written, or electronic). PHI also includes genetic information as defined in Title I of the Genetic Information Nondiscrimination Act (GINA), which includes information about an individual's genetic tests, genetic tests of the individual's family members, or the "manifestation of a disease or disorder" in these family members (i.e., family medical history).

The Plan reserves the right to change its privacy practices and the terms of this notice at any time, provided applicable law permits the changes. Any changes made in these privacy practices will be effective for all PHI that is maintained, including information created or received before the changes were made. All present enrollees of the Plan and all past enrollees for whom the Plan still maintains PHI will be notified of any material changes by receiving a new Notice of Privacy Practices.

You may request a copy of this Notice of Privacy Practices at any time by contacting the Tennessee Valley Authority group health plan at 400 W. Summit Hill Drive, WT 8D-K, Knoxville, Tennessee 37902.

Uses and Disclosures of Protected Health Information

Treatment, Payment and Health Care Operations

Your PHI may be used and disclosed by the Plan or its business associates for treatment, payment, and health care operations without your authorization.

Treatment: Treatment generally means the provision, coordination or management of health care. For example, the Plan may disclose information to a doctor or hospital that asks for it for purposes of your medical treatment.

Payment: Payment generally encompasses the activities of the Plan to fulfill its coverage responsibilities and to provide benefits on your behalf. For example, information on Plan coverage and benefits may be used or disclosed to pay claims for services provided to you by doctors or hospitals which are covered under your health insurance policy.

Health Care Operations: Health Care Operations generally means the activities which the Plan must undertake to operate the Plan and to support your treatment and the payment of your claims. For example, PHI may be used and disclosed to conduct quality assessment and improvement activities, to engage in care coordination, to provide disease management or case management, and to pursue rights of recovery and subrogation.

Other Uses and Disclosures for Which Authorization Is Not Required

Your PHI may also be used or disclosed by the Plan without your authorization under the following circumstances:

Disclosures to Family and Friends: Your PHI may be disclosed under certain circumstances to family members, other relatives and your close personal friends who can reasonably demonstrate that they are involved with your care or payment for that care if the information is directly relevant to such involvement or payment. If you do not wish any particular family member, relative or friend to receive any of your information, you may send a letter to us, at the address listed at the end of this notice, making this request.

Plan Sponsors: Your PHI and that of others enrolled in the Plan may be disclosed to the Plan's sponsor, TVA, so that it can assist in the administration of the Plan.

Research: Your PHI may be used or disclosed for research purposes in limited circumstances.

As Required by Law: Your PHI may be used or disclosed as required by law. For example, PHI must be disclosed to the U.S. Department of Health and Human Services upon request for purposes of determining the Plan's compliance with Federal privacy laws.

Court or Administrative Order: PHI may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

Health or Safety: PHI may be released to the extent necessary to avert a serious and imminent threat to your health or safety or to the health or safety of others under certain circumstances.

Health Oversight and Law Enforcement Activities: PHI may be disclosed to Health Oversight agencies for oversight activities, including TVA's Office of Inspector General, and Law Enforcement agencies for law enforcement purposes, under certain circumstances.

Public Health Activities: PHI may be disclosed to public health authorities for purposes of certain public health activities. PHI may also be used or disclosed under certain circumstances if you have been exposed to a communicable disease, are at risk of spreading a disease or condition, or to a school as proof of immunization.

Abuse or Neglect: Your PHI may be disclosed when authorized by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence.

Coroners and Funeral Directors: PHI may be disclosed to a coroner or medical examiner under certain circumstances. PHI may also be disclosed to a funeral director as necessary to carry out their duties with respect to the decedent.

Specialized Government Functions: PHI of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. PHI may be disclosed under certain circumstances to authorized Federal officials for the conduct of lawful intelligence, counter-intelligence and other national security activities and for the provision of protective services to the President and other authorized officials.

Workers' Compensation: PHI may be disclosed as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs established by law.

Uses and Disclosures Pursuant to Authorization

Written Authorizations: You may provide written authorization to use your PHI or to disclose it to anyone for any purpose. You may revoke this authorization in writing at any time, but this revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

Psychotherapy Notes: Except under certain circumstances, your written authorization must be obtained before the Plan will use or disclose psychotherapy notes about you from your psychotherapist. The Plan may use and disclose such notes when needed by the Plan to defend against you in litigation filed by you.

Marketing: The Plan cannot use your PHI for marketing purposes without your authorization, unless the activity relates to certain specific exceptions as permitted by HIPAA. The Plan will never sell your PHI unless you have authorized the Plan to do so.

Genetic Nondiscrimination

The Plan will use genetic information only as permitted by GINA. As required by GINA, the Plan will not (i) adjust premiums based on genetic information; (ii) request or require that an individual or family member undergo a genetic test; (iii) request, require or purchase genetic information for underwriting or before enrollment in the Plan; or (iv) use or disclose genetic information for underwriting purposes (even with an authorization).

Individual Rights

Breach Notification

The Plan will notify individuals if a breach of their unsecured PHI occurs in accordance with and as required by HIPAA as amended by the American Recovery and Reinvestment Act of 2009 (P.L. 111-5, "ARRA"), ARRA's Health Information Technology for Economic and Clinical Health (HITECH) Act and their implementing final rules. Unsecured PHI is PHI that is not secured using a technology or methodology specified by the U.S. Department of Health and Human Services (i.e., encryption or destruction).

Other Rights

You have the right to look at or get copies of your PHI, with limited exceptions. You must make the request in writing to obtain access to your PHI. You may obtain a form to request access by using the contact information at the end of this notice, or you may send a letter to us, at the address listed at the end of this notice, requesting access to your PHI. If you request copies of your PHI, you will be charged a reasonable fee for the copies and postage if you want the copies mailed to you. You may also request information from our plan administrators (e.g., BlueCross BlueShield of Tennessee, WageWorks, Express Scripts, Delta Dental, etc.), who maintain information regarding claims, diagnoses, and treatment in order to pay your claims. In the event the Plan maintains electronic health records ("EHRs"), you have the right to request an electronic copy of your EHR.

You have the right to receive an accounting of the disclosures of your PHI by the Plan or by a business associate of the Plan. This accounting will list each disclosure that was made of your PHI to anyone other than you or someone authorized by you for any reason, other than treatment, payment, health care operations and certain other activities not subject to an accounting as set forth in HIPAA, since six

(6) years prior to the date of the request. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the PHI disclosed, the reason for the disclosure, and certain other information. You may also request an accounting of disclosures from our plan administrators. In the event the Plan maintains EHRs, you have the right to receive an accounting of the disclosure of your EHR by the Plan, which will list each disclosure that was made of your EHR to anyone other than you or someone authorized by you for any reason, including for purposes of treatment, payment, and healthcare operations.

You have the right to request restrictions on the Plan's use or disclosure of your PHI. While we will consider all requests for restrictions carefully, we are not required to agree to all requests. You may also request this of our plan administrators.

You have the right to request confidential communications about your PHI by alternative means or alternative locations. While we will consider reasonable requests carefully, we are not required to agree to all requests, unless the request is to restrict the disclosure of PHI for purposes of plan payment or health care operations where you have already paid the provider in full out-of-pocket for the services related to that PHI. You may also request this of our plan administrators.

You have the right to request that the Plan amend your PHI. Your request must be in writing, and it must explain why the information should be amended. The Plan may deny your request if the PHI you seek to amend was not created by the Plan, if the PHI is accurate and complete, or for certain other reasons. You may also request this of our plan administrators.

Your rights may be exercised through a personal representative. Your personal representative will be required to provide evidence of authority to act on your behalf. Once this has been determined, except under certain limited circumstances, the personal representative will have all the rights you have as listed above. If under applicable law an executor, administrator or other person has authority to act on your behalf upon death or behalf of your estate, the Plan will treat such person as a personal representative with respect to PHI relevant to such personal representation.

Questions and Complaints

If you want more information concerning the Plan's privacy practices or have questions or concerns, please contact the Complaint Official listed below.

If you are concerned that the Plan has violated your privacy rights, or you disagree with a decision made about access to your PHI, or in response to a request you made to amend or restrict the use or disclosure of your PHI or to have us communicate with you by alternative means or at alternative locations, you may file a complaint with us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. The address to file a complaint with the U.S. Department of Health and Human Services will be provided upon request.

The Plan supports your right to protect the privacy of your PHI. There will be no retaliation in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Privacy Official:

Director
Benefits and Well-Being
400 W. Summit Hill Drive, WT 8D
Knoxville, TN 37902

Complaint Official:
Program Manager
400 W. Summit Hill Drive, WT 8D
Knoxville, TN 37902

Or call the People First Solution Center at 1-888-275-8094.

Privacy Act Statement

TVA Benefit Plans

Enrollment and Administration

The information requested in the forms you complete and return to the human resources department becomes part of the TVA Personnel Files or Medical Records Privacy Act systems of records (TVA-2 or TVA-9). Authority for maintenance of these systems of records is provided by the Tennessee Valley Authority Act of 1933, as amended, 16 U.S.C. §§831-831ee (2012).

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. You may not be able to participate in certain benefit programs if you do not provide the requested information.

TVA uses the requested information to provide and administer its employee benefit programs. 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.

Contact Information

VENDOR/CUSTOMER SERVICE	CONTACT	WEBSITE
People First Solution Center	888-275-8094 865-632-8800 Knoxville 423-751-8800 Chattanooga 7:00 a.m. – 7:00 p.m. ET, Monday – Friday Fax: 865-632-9682	**www.tva.com/retireeportal**
BlueCross BlueShield of Tennessee (Medical and Chronic Condition Management)	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**
Express Scripts (Prescription Drugs)	800-935-6203 24 hours a day, seven days a week	**www.express-scripts.com/tva**
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	**www.hsabank.com/tva**
Via Benefits (Medicare Supplements)	844-620-5725 8:00 a.m.-9:00 p.m. ET Monday-Friday	**my.viabenefits.com/tva**

This booklet explains the plan in general terms and does not give details of all terms of the plan. In the event that any conflict should occur between the wording contained in this booklet and the official plan document, the official plan document will serve as the final authority in all matters relating to plan interpretations.

Copies of the plan document are available for review by all members of the plan. They can be examined in the Benefits & Well-Being office, Knoxville, during normal working hours.

You may obtain a copy of the plan document by submitting a written request to the People First Solution Center, Knoxville. A reasonable fee may be charged for all copies provided.

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 (1) obtain coverage and/or administrative services from additional or different insurance carriers or third party administrators, (2) revise the amount of the retirees' contributions toward the cost of coverage, and (3) revise or eliminate TVA's contributions toward the cost of coverage.

Notes

Setting up your Health Savings Account (HSA) with HSA Bank.

October 2021

Attached is the HSA Bank HSA Application Form.

If you will be enrolled in the Consumer-Directed Health Plan (CDHP) in 2022 and do not have a Health Savings Account (HSA) with HSA Bank, you will need to complete a separate election to open your HSA. If you already have an HSA with HSA Bank, you do not need to take any action. To contribute to or receive TVA's contributions to an HSA, you must be eligible for and open an HSA.

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

- Must be covered by an HSA-qualified health plan. This means you must be enrolled in the CDHP medical option to be eligible for the HSA.
- Cannot be enrolled in Medicare or Tricare.
- 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)

There are two ways you can open your HSA:

- Go to **https://secure.hsabank.com/tvaenroll** to complete the online enrollment process (see included instructions). Be sure to use this link and not the HSA Bank retail page. If you do not use this link, your account will not be associated with TVA and TVA cannot make the Employer Contribution.

  Or:

- Complete the attached HSA Bank HSA Application Form. Fax the form to 920-803-4184 or mail it to the address shown on the front page of the form.

See enclosed booklet for more information about the HSA. You can call HSA Bank at **1-844-650-8934** or visit **www.hsabank.com/tva**. Representatives are available 8 a.m.- 10 p.m. ET, Monday-Friday. You can also email questions to **askus@hsabank.com**.

Group Online Enrollment Instructions

It takes just four easy steps to enroll in a Health Savings Account (HSA) using HSA Bank's Group Online Enrollment system. Simply use any computer, any time and follow these instructions.

Step 1: Type or copy and paste this customized link into your Internet browser/address bar:

https://secure.hsabank.com/tvaenroll

You will be taken to an enrollment page created specifically for your group. Click on "Begin Online Enrollment" to get started.

Step 2: Complete the online enrollment application. You will need to supply the following information:

- First and Last Name
- Street Address (P.O. boxes not accepted)
- Date of Birth
- Citizenship Status
- Type of Health Plan Coverage
- Deductible Amount
- Social Security Number
- Home and/or Business Phone
- Email address
- Employer Information
- Effective Date of your Health Plan

You will also be able to order checks and up to two complimentary Visa® debit cards, one for yourself and one for your Authorized Signer (a person you authorize to act in your place with respect to your account), if you choose to designate one. If you wish to designate more than one Authorized Signer, there will be a fee for each additional debit card beyond the two complimentary ones (see your Health Savings Account Fee and Interest Schedule for details). In order to add an Authorized Signer, you will need to provide his or her:

- First and Last Name
- Phone Number
- Social Security Number
- Street Address
- Date of Birth

You can also sign up for online banking via our Member Website. With the Member Website, you have 24/7 access to view account details, change your address, and sign up for email notifications; you can also opt to receive the following items electronically: statements, tax forms, and bank disclosures and notices.

Identity Verification

Note: In order to comply with the Customer Identification Program (CIP), regulation 31 CFR 103.121, and section 326 of the USA PATRIOT Act, we must gather information for identity verification. This means that when you open an account, we will need you to provide the information as noted above for you and your Authorized Signer (should you choose to designate one). If your identity or the identity of your Authorized Signer is not verified by our automated process, you will receive a letter from us requesting additional information.

Step 3: Your account will open in conjunction with the effective date supplied in the enrollment.

Step 4: Once you have completed your enrollment, your debit card(s) and welcome kit will be mailed to the address you provided and should arrive within 7-10 business days.

For assistance, please contact the Client Assistance Center:

800-357-6246
Monday – Friday, 7 a.m. – 9 p.m., and Saturday, 9 a.m. - 1:00 p.m., CT
www.hsabank.com | 605 N. 8th Street, Ste. 320, Sheboygan, WI 53081

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Health Savings Account (HSA) Application and Eligibility Form

☑ HSA offered through employer – *Upon completion, submit this form to your employer.*

Employer Federal Tax ID or **Employer Code:** TV300A

☐ HSA not offered through employer – *Upon completion, mail this form to HSA Bank, P.O. Box 939, Sheboygan, WI 53082; fax to 920-803-4184; or email to askus@hsabank.com. (Alternatively, you may apply online at hsabank.com.)*

If you need assistance, our U.S.-based Client Assistance Center has representatives available 24 hours a day, 7 days a week, at 800-357-6246.

*Required

Part 1: General Information for Primary Accountholder

*First Name:	MI:	*Last Name:	*Date of Birth (mm/dd/yyyy) **(Must be 18)**:	*Social Security Number:

*Physical Street Address:	*City:	*State:	*ZIP:
P.O. Box:	City:	State:	ZIP:

*Preferred Mailing Address: ☐ Physical Street Address ☐ P.O. Box

Email:

*Home Phone:

Business Phone:

*Citizenship Status: ☐ U.S. Citizen ☐ Resident Alien ☐ Non-Resident Alien

Country of Citizenship if Not a U.S. Citizen:

*Health Plan Insurance: ☐ Single ☐ Family/Single + Dependent(s)

*Effective Date of Your Health Insurance:

*Deductible Amount: $

Part 2: Employment Information (Note: The Employer Federal Tax ID or Employer Code above is required for an employer-offered HSA.)

*Employment Status: ☐ Employed ☐ Self Employed ☑ Not Employed/Retired

Employer Name: **(Required if employed/self employed)** Tennessee Valley Authority Retiree

Part 3: Authorized Signer (Such as a Spouse or Another Third Party) – Optional

By completing all of the fields below, you are authorizing the person designated as "authorized signer" to access and initiate transactions on your account as your agent. HSA Bank will rely upon this designation until HSA Bank receives your written revocation of this authorization and has had a reasonable time to act upon it. You hold harmless and indemnify HSA Bank against any claims against or losses arising out of HSA Bank's reliance on this authorization, and release HSA Bank from any liability arising from such reliance, unless otherwise prohibited by law. You remain solely responsible for any tax consequences that result from any actions taken by the authorized signer regarding your account.
Important: If you wish to designate an authorized signer to your account, all fields in this section are **required**.

First Name:	MI:	Last Name:	Date of Birth (mm/dd/yyyy):	Social Security Number:

☐ Address same as accountholder

Street Address:

City:	State:	ZIP:	Phone Number:

If you would like to designate a beneficiary for your account, please complete our *HSA Designation of Beneficiary Form*, which is available on our website at: hsabank.com/BeneficiaryForm. Alternatively, you may designate a beneficiary for your account on HSA Bank's Member Website after your account is opened. If you fail to designate a beneficiary, then your estate will be your beneficiary upon your death.

Part 4: Account Selections

*Please select the account options and enter an amount where appropriate.

☐ Primary accountholder debit card (no charge) *(Note: We do not charge for the first two debit cards on your account. Additional cards are $6.00 each.)*
☐ Authorized signer debit card (if applicable)
☐ Checks **($7.95 – check must be included to process order)** $______________
☐ Initial contribution $______________ Contribution Year:______________

*Transfer: ☐ Yes ☐ No (If yes, please attach the HSA transfer/rollover form or IRA form.)

Part 5: Account Authorization

By signing below, I certify that:

- I am or will be covered by an HSA-qualified high deductible health plan (HDHP), I am not enrolled in Medicare or covered under other health insurance that is not compatible with an HSA, and I may not be claimed as a dependent on another person's tax return (excluding spouses per the Internal Revenue Service [IRS]).
- HSA Bank is hereby appointed to serve as custodian of my Health Savings Account.
- To help the government fight the funding of terrorism and money laundering activities, federal law requires that all financial institutions obtain, verify, and record information that identifies each person who opens an account. What this means to you: when you open an account, we will need you and your authorized signer to provide name, street address, date of birth, and other information that will enable us to identify you and your authorized signer. We may also ask to see your driver's license or other identifying documents.

After your application is processed, you will receive a Welcome Kit by mail in 7-10 business days. The Welcome Kit contains your account number and account disclosures. It also outlines our services and provides details on how to manage your account. Your debit card and any debit card requested for an authorized signer will each arrive in a separate envelope about 10-14 business days after your application is processed. If you don't receive your Welcome Kit or debit card(s), please contact us at 800-357-6246.

***Accountholder Signature:** ***Date:**

For Tracking Purposes (to be completed by employer or insurance/financial representative) Internal Use Only:

Health Plan Code	Broker Dealer	AIN#	SVC	Software	MGA	Marketing

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HSA Designation of Beneficiary Form

Please complete, sign, and mail this form to: HSA Bank, P.O. Box 939, Sheboygan, WI 53082 or email it to hsaforms@hsabank.com.
Valid Social Security numbers must be on file for your designated beneficiary(ies) in order to process them.
Required*

Step 1: Accountholder Information

*Employer Name *(If sponsored by an employer plan)*:	Accountholder Name (First, MI, Last):
*Date of Birth:	*Day Telephone:
*Full 9-digit Social Security Number: ___ ___ ___ – ___ ___ – ___ ___ ___ ___	

Step 2: Designation of Beneficiary(ies)

☐ **New Beneficiary(ies)** – The following individual(s) or entity shall be my primary and/or contingent beneficiary(ies). If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary.

☐ **Replace Beneficiary(ies)** – I designate the individual(s) or entity named below as my primary and/or contingent beneficiary(ies) of this HSA and hereby revoke all prior beneficiary(ies) designations, if any, made by me.

☐ **Add Beneficiary(ies)** – I designate the individual(s) or entity named below as my primary and/or contingent beneficiary(ies) of this HSA. This list supplements, but does not replace, the beneficiary(ies) previously designated by me on the date specified.

If neither primary nor contingent is indicated, the individual or entity will be deemed to be a primary beneficiary. If any primary or contingent beneficiary dies before me, his or her interest and the interest of his or her heirs shall terminate completely, and the percentage share of any remaining beneficiary(ies) shall be increased on a pro rata basis. If more than one primary beneficiary is designated and no distribution percentages are indicated, the beneficiaries will be deemed to own equal share percentages in the HSA. Multiple contingent beneficiaries with no share percentage indicated will also be deemed to share equally. If no primary beneficiary(ies) survives me, the contingent beneficiary(ies) shall acquire the designated share of my HSA.

If you designate your spouse as primary beneficiary or contingent beneficiary of the HSA, the dissolution, termination, annulment, or other legal termination of your marriage will automatically revoke such designation.

Name and Address (or of Trust and Trustee)	**Date of Birth (mm/dd/yyyy) (creation date, if Trust)**	**Social Security Number (TIN, if Trust)**	**Relationship**	**Primary or Contingent**	**Share % *(Must be a whole number)***
				☐ Primary ☐ Contingent	%
				☐ Primary ☐ Contingent	%
				☐ Primary ☐ Contingent	%
				☐ Primary ☐ Contingent	%

Step 3: Marital Status

☐ I Am Not Married – I understand that if I become married in the future, I must complete a new *HSA Designation of Beneficiary Form.*

☐ I Am Married – I understand that if I choose to designate a primary beneficiary other than my spouse, my spouse must sign below.

I am the spouse of the above-named Accountholder. I acknowledge that I have received a fair and reasonable disclosure of my spouse's property and financial obligations. Due to the important tax consequences of giving up my interest in this HSA, I have been advised to see a tax professional. I hereby give the HSA Beneficiary any interest that I have in the funds or property deposited in this HSA and consent to the beneficiary designation(s) indicated above. I assume full responsibility for any adverse consequences that may result. No tax or legal advice was given to me by HSA Bank.

*Spouse Signature:	*Date:	*Signature of Witness: *(Required. Cannot be spouse. Must be 18 or older.)*	*Date:
*Accountholder Signature:	*Date:	*Signature of Witness: *(Required. Cannot be spouse. Must be 18 or older.)*	*Date:

Complete the following only if designating a primary beneficiary other than your spouse.

State of _________ County of _________________________

On this, the ______ day of ___________, 20_____, before me, a notary public, the undersigned officer, personally appeared ______________________________, the spouse of the above named accountholder, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument, and acknowledged that he/she executed the same for purposes therein contained.

In witness hereof, I hereunto set my hand and official seal. ____

Notary Public

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TO KEEP YOUR CURRENT COVERAGE, DO NOT RETURN THIS FORM.

Retiree Medical Plan Election Form 2022

PLEASE PRINT

Retiree Name (Last, First, Middle Initial)	Retiree SSN
Subscriber Name (if not retiree)	Subscriber SSN (if not retiree)
Address (Street, City, State, Zip Code)	Phone Number

My retiree medical plan election for 2022 is: (Check the appropriate box)

80-Percent PPO Plan	☐ Individual	☐ Family
Consumer-Directed Health Plan If you select this plan, review the enclosed HSA enrollment information.	☐ Individual	☐ Family

☐ **Waive all coverage***

☐ **Cancel spouse coverage only**

☐ **Cancel dependent (other than spouse) coverage only**

List the dependents (other than spouse) for whom you are canceling medical coverage effective 01/01/2022.

Dependent Name	Dependent SSN

This authorizes a change in my monthly premium to be effective with the payment for January 2022 coverage.

I understand that this option will remain in effect for all of calendar year 2022. I understand that I may not change my election during 2022.

*By waiving all medical coverage, I understand that I will not be offered another opportunity to enroll in a TVA- sponsored retiree medical plan. By canceling coverage for my spouse, I understand that my spouse will not be offered another opportunity to enroll in a TVA-sponsored retiree medical plan. By canceling coverage for my dependent for reasons other than loss of eligibility, I understand that my dependent will not be offered another opportunity to enroll in a TVA-sponsored retiree medical plan. By canceling coverage for my dependent due to loss of eligibility, I understand that my dependent will not be allowed coverage in the future unless the dependent again becomes eligible.

Signature ____ Date ___________________________

This form must be received by TVA Benefits no later than Nov. 2, 2021, in order for this change to be made. Mail your completed form to:

Tennessee Valley Authority
ATTN: Benefits & Wellbeing, WT 8D
400 W. Summit Hill Drive
Knoxville, TN 37902

Tennessee Valley Authority
400 West Summit Hill Drive
Knoxville, Tennessee 37902-1401

FIRST-CLASS MAIL
PRESORTED
U.S. POSTAGE PAID
TENNESSEE VALLEY AUTHORITY

Important Information 2022 Medical Coverage Options

OPEN IMMEDIATELY