

ENROLLMENT PLANNING RESOURCES

What do you need?	Where to get assistance	How to reach them
General benefits and enrollment information	TVA Service Center	1-888-275-8094 865-632-8800 Knoxville 423-751-8800 Chattanooga 1-800-848-0298 (TDD/TTY-TN Relay Service)
Benefit-plan details and enrollment information	Retiree Web site	www.tvaretirees.com
Health Plan Comparison Tool Medical Plan Information or Claims History	BlueCross BlueShield of Tennessee	1-800-245-7942 www.bcbst.com
Prescription-drug information My Rx Choices Tool or Claims History	Medco Health	1-800-818-0890 www.medcohealth.com
Vision-care information	EyeMed Vision Care	1-877-226-1115 www.eyemedvisioncare.com (if a member) www.enrollwiththeyemed.com/full (if not a member)
Supplement to Medicare Plan Prescription-drug questions	Medco Health	1-800-592-4520 (Supplement to Medicare plan members only)
Health Savings Account details and enrollment information	First Horizon Msaver	1-888-355-6124 www.firsthorizonmsaver.com/tva (general information) www.firsthorizonhsa.com/tvaretiree (to enroll in your HSA)

CALENDAR

WEEK OF OCT. 1 Health Plan Comparison Tool available at www.bcbst.com

WEEK OF OCT. 6 Informational letter mailed to homes of retirees who are currently taking a brand drug that has a generic equivalent

WEEK OF OCT. 13 Medical Plan 2009 booklet mailed to retirees' homes

OCT. 20 – NOV. 7 Medical Plan Election Period for 2009

NOV. 12 Deadline for the TVA Service Center to receive your election form

IT'S IMPORTANT TO REMEMBER...

- If you have coverage now and don't submit an election form during the election period, you will be automatically enrolled in the same medical plan with the same level of coverage – individual or family – you had in 2008.
- If you cancel your TVA medical coverage, you will not be allowed to enroll in a TVA medical plan in the future.
- If you, your spouse or an eligible dependent becomes eligible for Medicare before age 65, you must notify the TVA Service Center.
- You must open the Health Savings Account if you are enrolled in the CDHP medical option for 2009 in order to receive TVA's HSA contribution. Look for information that will be included with your Medical Plan 2009 booklet to learn how to enroll in the HSA.
- If you have not received your Medical Plan 2009 booklet by Friday, Oct. 24, call the TVA Service Center to request another booklet. The booklet also will be available on www.tvaretirees.com.
- You cannot change your medical-plan election after Jan. 1, 2009.
- Elect your medical plan Oct. 20-Nov. 7 by returning your election form. The TVA Service Center must receive your election form by Nov. 12.

A SPECIAL SECTION FOR MEDICARE ELIGIBLE RETIREES

When you become eligible for Medicare

TVA provides a Supplement to Medicare plan. When you – or a covered dependent – become eligible for Medicare at age 65, your medical-plan coverage will automatically be transferred to TVA's Supplement to Medicare plan. Any dependent(s) not eligible for Medicare will stay in the plan you select for next year.

You must notify the TVA Service Center if you – or a covered dependent – become eligible for Medicare before age 65 so your enrollment and premiums can be adjusted correctly.

Are you already a member of the TVA Supplement to Medicare plan?

If so, here is some important information:

- Medicare Part D (prescription drug) coverage will still be provided through TVA's Supplement to Medicare plan in 2009. Members do not need to enroll in another Medicare Part D plan when these plans begin enrollment in November for 2009.
- If you want to continue your Supplement to Medicare cov-

erage in 2009, you do not have to take any action. Your coverage will automatically continue in 2009.

- If you decide to cancel your Supplement to Medicare coverage, you will be canceling both the medical and prescription-drug portions of the plan. Coverage for all dependents will be canceled also. Once coverage is canceled, you (or dependent) will not have another opportunity to enroll in a TVA-sponsored retiree medical plan.
- There may be changes in covered medications for 2009. If you are currently enrolled in the Supplement to Medicare plan, you will receive an informational letter in November from Medco Health outlining the changes for 2009. If you have questions about coverage for a specific drug, call Medco at 1-800-592-4520.

TVA's Supplement to Medicare Plan 2009 premiums

Your monthly premium for your Medicare Supplement Plan includes the Medicare Part D prescription benefit, as well as medical coverage. You will receive a letter in late October from TVA with your 2009 Medicare Supplement premium.



Your Health
Count\$

MEDICAL PLAN 2009

2009 Medical Plan Election Period (for non-Medicare retirees)

Oct. 20 – Nov. 7, 2008

Review your healthcare claims history to help you predict future costs:

Medical and prescription-drug claims
www.bcbst.com

Prescription-drug claims only
www.medcohealth.com

THE THREE C'S FOR 2009

CHANGES | CHOICES | COSTS

To prepare for the medical-plan election period, you need to know the three C's...changes, choices and costs. With this information, you can then evaluate your current situation, estimate your future needs and determine which medical plan is best for you and your family in 2009. Choosing a medical plan is like any other purchase: you want to get the most value for your money. So take advantage of all the communications and tools provided in making your decisions.

TVA non-Medicare retirees can select their medical plan for 2009 from Oct. 20 – Nov. 7. The choice will be in effect throughout calendar year 2009. You must be enrolled in a TVA medical plan to participate in the election period. And, if you have individual coverage now, you cannot elect family coverage now.

CHANGES FOR 2009

The following changes will be effective Jan. 1, 2009.

The Consumer-Directed Health Plan (CDHP) will have two changes.

1 A Health Savings Account, or HSA, will replace the Health Reimbursement Account (HRA) now associated with the plan. An HSA is a trust or custodial account that can receive tax-favored contributions for eligible individuals enrolled in a high-deductible health plan (HDHP). You decide whether or not to make contributions to your HSA. TVA will contribute \$500/individual or \$1,000/family. An HSA gives you, the healthcare consumer, more control over how and when you spend your healthcare resources.

2 Since an HSA can only be offered along with a qualified high-deductible health plan, the CDHP deductibles will change in order to qualify it as an HDHP. The Internal Revenue Service mandates the deductibles for an HDHP and indexes the amounts yearly. Annual deductibles will be increased to \$1,150/individual and \$2,300/family from the current \$1,000/individual and \$2,000/family.

Two changes will be made to prescription-drug coverage in all three medical-plan options.

1 The generic prescription-drug copay will be lowered to \$10/retail and \$20/mail order in the 80% and Copayment PPO medical plans. The minimum copays for generic

drugs will be decreased to \$10/retail and \$20/mail order in the CDHP medical plan. Today, these amounts are \$12/retail and \$24/mail order.

2 If you choose a brand drug instead of its generic equivalent, you will pay the brand copay (in the CDHP, the co-insurance) plus the difference in the cost between the brand and the generic regardless of what your doctor writes on the prescription. So you will have to make a choice if you are taking a brand drug, and a generic equivalent is available. You can take either the generic or the brand. If you choose the brand, you will pay more.

Today, if your doctor indicates DAW (dispense as written) on your prescription, you pay the brand copay but not the additional cost difference between the brand and generic.

If a brand drug does not have a generic equivalent, you only pay the copay for the brand drug.

The preventive-care benefit, available in all three of the medical plans, will change. To promote the use of preventive care and healthy lifestyles, the benefit will increase to \$500/person per year from the current \$250/person per year. Routine physicals and preventive services as defined by the American Medical Association are covered under this benefit for medical-plan members age six and older. Services are not subject to a deductible, and you do not pay a copay or co-insurance.

CHOICES AND COSTS FOR 2009

Medical Plan

You can choose:

- Copayment PPO
- 80% PPO
- Consumer-Directed Health Plan (CDHP)
- No coverage

See the Changes for 2009 section for details of plan changes.

The 2009 monthly premiums shown in the chart 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.

If your medical coverage payment is deducted from your monthly pension benefit, you will see a change in the deduction amount on the check you receive at the end of December 2008. This is the deduction for January 2009 coverage.

A BlueCross BlueShield of Tennessee (BCBST) online tool can help you estimate your medical costs for each of the plans.

Go to www.bcbst.com

1. Click Self Service, Members, TVA employees, then Health Plan Comparison
2. Enter TVARET2009 (all upper case) for the Group ID and Authentication ID
3. Click Go.

2009 MEDICAL PLAN PREMIUMS

Medical Plan Options	2009 Monthly Premium
Copayment PPO	
Individual	\$800
Family	\$1,518
80% PPO	
Individual	\$536
Family	\$983
CDHP	
Individual	\$316
Family	\$602

COMPARISON OF MEDICAL BENEFIT PLANS

Benefits	Copayment PPO		80% PPO		Consumer-Directed Health Plan	
HSA (Health Savings Account)	—		—		TVA Contribution: \$500 Individual/\$1,000 Family	
HSA Maximum Contribution (all sources)	—		—		\$3,000 Individual/\$5,950 Family No Rollover Limits	
HSA Administration Fee	—		—		\$2.25/month automatically deducted from your HSA	
Annual Deductible In-network and out-of-network expenses are combined	None		\$300 Individual/\$600 Family		In-Network: \$1,150 Individual contract \$2,300 Family contract Out-of-Network: \$2,000 Individual contract \$4,000 Family contract	
	In-Network	Out-of-Network*	In-Network	Out-of-Network*	In-Network	Out-of-Network*
Office Visit	\$25 co-payment	70% Plan pays 30% You pay	80% Plan pays 20% You pay	70% Plan pays 30% You pay	80% Plan pays 20% You pay	60% Plan pays 40% You pay
Emergency Room Visit	\$100 co-payment	70% Plan pays 30% You pay	80% Plan pays 20% You pay	70% Plan pays 30% You pay	80% Plan pays 20% You pay	60% Plan pays 40% You pay
Inpatient Service	\$500 co-payment	70% Plan pays 30% You pay	80% Plan pays 20% You pay	70% Plan pays 30% You pay	80% Plan pays 20% You pay	60% Plan pays 40% You pay
Outpatient Service	\$200 co-payment (surgery)	70% Plan pays 30% You pay	80% Plan pays 20% You pay	70% Plan pays 30% You pay	80% Plan pays 20% You pay	60% Plan pays 40% You pay
Out-of-Pocket Maximum In-network and out-of-network expenses are combined	\$1,500 Individual \$3,000 Family	\$3,000 Individual \$6,000 Family	\$2,500 Individual \$5,000 Family	\$5,000 Individual \$10,000 Family	\$4,500 Individual contract \$9,000 Family contract	\$9,000 Individual contract \$18,000 Family contract
Preventive Care Allowance	\$500 annual allowance, not subject to deductible, co-payment or co-insurance		\$500 annual allowance, not subject to deductible, co-payment or co-insurance		\$500 annual allowance, not subject to deductible, co-payment or co-insurance	
Mental Health Inpatient	See inpatient benefits above; limit 60 days per person per calendar year		See inpatient benefits above; limit 60 days per person per calendar year		See inpatient benefits above; limit 60 days per person per calendar year	
Outpatient	In-network: \$25 co-payment per visit Out-of-network: plan pays 70%; limit 60 visits per person per calendar year		See outpatient benefits above; limit 60 visits per person per calendar year		See outpatient benefits above; limit 60 visits per person per calendar year	
Covered Prescription Drugs (Administered through Medco Health) Generic	\$10 co-payment		\$10 co-payment		Covered 80% after deductible. Minimum of \$10 to be paid by patient; maximum of \$100 to be paid by patient	
Preferred Brand	\$24 co-payment		\$28 co-payment		Covered 80% after deductible. Minimum of \$24 to be paid by patient; maximum of \$100 to be paid by patient	
Non-Preferred Brand	\$39 co-payment		\$43 co-payment		Covered 80% after deductible. Minimum of \$39 to be paid by patient; maximum of \$100 to be paid by patient	
Mail-Order Pharmacy	2x retail co-payment for up to a 90-day supply		2x retail co-payment for up to a 90-day supply		2x retail minimums and maximums for up to a 90-day supply	
Vision Care (in network)	\$10 co-payment exam every 12 months		\$10 co-payment exam every 12 months		NOT AVAILABLE	
Lenses	\$10 co-payment every 12 months		\$10 co-payment every 12 months		NOT AVAILABLE	
Frames (every 2 years)	\$10 co-payment up to \$100, then 80% of amount over \$100		\$10 co-payment up to \$100, then 80% of amount over \$100		NOT AVAILABLE	
Contacts	\$10 up to \$115 allowance per year		\$10 up to \$115 allowance per year		NOT AVAILABLE	

This is a summary of benefits and explains the plans in general terms. For more information on the plan documents, call the TVA Service Center.

* Payments are based on allowable fees for covered services as determined by BlueCross BlueShield of Tennessee. When out-of-network providers are used, you may also be responsible for paying any amount charged beyond the allowable fee.

Comparison charts are also available at www.bcbst.com. Click on Self Service, Members, TVA employees, then Plan Details. You also can find answers to frequently asked questions by clicking on "How Do I..."