

Medical Plan 2003

Election Period for Retirees

November 4-25, 2002

*Please note: This information does NOT apply to
retirees on TVA's Supplement to Medicare Plan*



What's New for 2003

PPO Plan Prescription-Drug Copayments

The costs of prescription drugs continue to rise drastically. The cost of drugs represented 18 percent of total costs in 1998 and rose to 30 percent in 2001. Despite the increase in total drug costs, there has been only a nominal increase in the drug copayments—that is, the amounts paid by the patients at the time drugs are purchased. That means that the health-care plan has in effect absorbed the entire amount of prescription-drug increases.

An increase in the prescription-drug copayments will take effect in January 2003. The copayments will be \$8 for generic drugs and \$14 for brand-name drugs purchased at local pharmacies. The home-delivery copayments will be \$16 for generic drugs and \$32 for brand-name drugs for up to a 90-day supply.

Premium Increases

The premiums charged for retiree medical plan coverage in recent years have not fully funded the plans. Premium increases for all plans are necessary for 2003 to ensure that the plans are fully funded.

The 2003 premiums are shown on page 12.

PPO or HMO?

If you are eligible for one of the HMOs offered to TVA retirees, you should pay close attention to the comparison chart on pages 6-7.

There are some changes to benefits under the CIGNA HMO, including the copayment for outpatient facilities, vision plan benefits, and the addition of guesting privileges that may allow you to receive CIGNA HMO benefits if you, or a covered family member, should relocate for a minimum of 60 days to another state served by CIGNA. If you are eligible for CIGNA HMO coverage, you will receive a separate information package from CIGNA, with additional information.

In 2002 United Healthcare made changes to its prescription-drug coverage. The new copayments are reflected in the comparison chart. If you are eligible for United Healthcare HMO coverage, you will receive a separate information package from United, with additional information on coverage.

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**Election Period for Retirees
November 4 - November 25, 2002**

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2003 General Information and Enrollment Instructions

Welcome to the annual Retiree Medical Plan Election Period. From November 4 to November 25, you may choose the medical plan you want for calendar year 2003.

If you want to keep your current benefit elections for 2003, you do not need to do anything.

Read the information in this booklet carefully and think about the plan that's best for you and your family. If you want to elect a different option for 2003, please call the Employee Service Center at 888-275-8094 to request a medical plan election form by November 25, 2002. A self-addressed envelope will be included with the election form sent to you. Completed and signed forms requesting a change in plan enrollment for next year must be received at the Employee Service Center **no later than December 9, 2002.**

Remember that it is very important to keep your medical plan enrollment record current.

Make sure you report any change of address.

It is your responsibility to notify TVA's Employee Service 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 repay the medical plan for the amount of that ineligible payment.

Eligible for Medicare?

When you or a covered dependent becomes eligible for Medicare at age 65, your coverage will automatically be transferred to TVA's Supplement to Medicare plan. Your dependent(s) not eligible for Medicare will remain in the plan you select for next year.

Make sure you notify the Employee Service Center if you or one of your covered dependents becomes eligi-

ble for Medicare before reaching age 65 so that your enrollment and premiums can be adjusted correctly.

When you receive notice of your eligibility for Medicare, be sure to look carefully at Part B of Medicare. If you do not elect Part B when first eligible, you may find yourself without any Medicare benefits for physician and other expenses.

Web site and E-mail addresses

Web site addresses:

TVA Retirees	www.tvaretirees.com
BCBST (Tennessee health care providers)	www.bcbst.com
BC/BS Blue Card (health care providers in other states)	www.bluecares.com/bluecard
CIGNA	www.cigna.com
United Healthcare	www.uhc.com
Healthcare Assistance Program	www.MyAccessHealth.com
E-mail address:	
TVA Employee Service Center	esc@tva.com

Your Medical Plan Options for 2003

If you are like most retirees, having adequate medical coverage is a primary concern. But different retirees have very different needs. In light of medical plan changes for 2003, you should look carefully at all available options to compare your total out-of-pocket costs, including premiums, to see which option best meets your needs at the best price to you. Some comparison information is included for you in this package.

Your options include:

- Three plans using preferred provider organizations (PPOs) with different levels of benefits and costs.
- HMOs for retirees who live in certain areas of Tennessee or Alabama.

Your 2003 Benefit Plan Options

Comparing PPO and HMO Plans

PPO	HMO
Patients must use in-network health care providers to receive the higher level of benefits. Patients may use out-of-network providers and receive lower level of benefits.	Patients must use HMO providers for all medical care. No benefits are paid for care furnished outside the HMO network, except in emergencies as determined by the HMO.
Patients may select health care providers, including specialists. Primary-care physicians are not required.	CIGNA requires that all care and referrals be furnished by or coordinated with a primary-care physician. United Healthcare does not require primary-care physician referral.
Deductible required. After deductible is met, patient coinsurance is based on percentage of allowable charge and network status of health care provider.	No deductible. Fixed-dollar copayment payable by patient at time of service.
Network providers file claims for patients. Patients must file claims when out-of-network providers are used.	Network providers file claims for patients. Patients must file claims when out-of-network providers are used but no benefits are payable for out-of-network services except in emergencies as determined by the HMO.
Customer service handled by the plan administrators (medical, prescription drug, and vision care) and TVA Employee Service Center.	Customer service handled by the HMO.
In-network providers available in all states under the available PPO networks. Dependents in other states can access in-network providers.	In-network providers available only within the HMO service area. Dependents in other states may not have access to in-network providers—an important point to consider if you have dependents residing in another state or attending school outside the HMO service area.

Available PPO networks

Tennessee—Blue Network P

Alabama—Preferred Medical Doctor

Kentucky—Blue Access

Mississippi—Comprehensive Blue

For other states, the Blue Cross/Blue Card network in that state must be used to receive the in-network level of benefits. To identify a network provider in another state, you may call 800-810-BLUE (2583) or access the Blue Cross Web site at www.bluecares.com/bluecard.

All the options cover a range of medical and surgical services needed for the diagnosis and treatment of illness and injury. For example:

- **Class I** services include hospital/institutional care, home health care, and hospice care.
- **Class II** services include doctor-office visits and services, surgery, maternity care, therapy services, and emergency care.
- **Class III** services include medical equipment and certain routine immunizations.

Medical Plan Options		
OPTION	IN-NETWORK	OUT-OF-NETWORK
Option 0 – No Coverage		
Option 1 – (90% In-Network)		
Annual Deductible	\$200 Individual \$400 Family	\$200 Individual \$400 Family
Hospital Deductible	None	\$400 per admission
Coinsurance for Class I and Class II Expenses	90% Plan pays 10% You pay	70% Plan pays 30% You pay
Coinsurance for Class III Expenses	80% Plan pays 20% You pay	80% Plan pays 20% You pay
Annual Out-of-Pocket Maximum	\$1,500 Individual \$3,000 Family	\$5,000 Individual \$10,000 Family
Option 2 – (80% In-Network)		
Annual Deductible	\$300 Individual \$600 Family	\$300 Individual \$600 Family
Hospital Deductible	None	\$400 per admission
Coinsurance for Class I and Class II Expenses	80% Plan pays 20% You pay	70% Plan pays 30% You pay
Coinsurance for Class III Expenses	80% Plan pays 20% You pay	80% Plan pays 20% You pay
Annual Out-of-Pocket Maximum	\$1,500 Individual \$3,000 Family	\$5,000 Individual \$10,000 Family
Option 3 – (70% In-Network)		
Annual Deductible	\$400 Individual \$800 Family	\$400 Individual \$800 Family
Hospital Deductible	None	\$400 per admission
Coinsurance for Class I and Class II Expenses	70% Plan pays 30% You pay	50% Plan pays 50% You pay
Coinsurance for Class III Expenses	80% Plan pays 20% You pay	80% Plan pays 20% You pay
Annual Out-of-Pocket Maximum	\$1,500 Individual \$3,000 Family	\$5,000 Individual \$10,000 Family
Option 4 – United Healthcare of Alabama, where available (see chart on pages 6-7)		
Option 5 – CIGNA, where available (see chart on pages 6-7)		
Option 6 – United Healthcare of Tennessee, where available (see chart on pages 6-7)		

Options 1, 2, and 3—PPO Options—Medical Coverage

These medical options are self-funded plans which are administered by Blue Cross Blue Shield of Tennessee. These plans are not true 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 the 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.

Options 1, 2, and 3 cover the same services but at different levels with different deductible amounts as shown on page 4 (medical plan options chart). If you enroll in option 1, 2, or 3, 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.

Each option includes an annual allowance of \$250 per person to be used for routine physical expenses. This allowance is not subject to the annual deductible. You will pay your share of the expenses based on the option you select, and the plan will pay up to \$250 for routine physical expenses in accordance with standard plan provisions.

Well-baby and well-child care—in addition to the initial in-hospital physician examination at birth, four well-baby exams will be covered in a calendar year before the child's

first birthday. Routine immunization will be included with these eligible well-baby exams. The plan will cover two exams between the first and second birthdays, including routine immunizations with each exam. The plan will cover one well-child exam per year between age two and age six, including routine immunizations covered with each exam.

Routine examinations for children age six and older are covered without having to meet an annual deductible and are subject to the plan maximum of \$250 per patient per calendar year.

Each option includes benefits for mental health and substance-abuse treatment. The annual benefit for substance-abuse treatment is 30 visits per person for outpatient treatment, and the lifetime limit is 150 days per person for inpatient treatment.

More information on these medical plan options is available at the TVA retiree Web site—www.tvaretirees.com

Important information for Alabama retirees: If you live in Alabama and elect option 3 (the 70% option), you must follow a special benefit payment procedure for your medical claims. The network physicians in Alabama will not accept plan reimbursement at 70 percent, so the network physicians will be reimbursed in full by Blue Cross, and Blue Cross will bill you for your 30% coinsurance. You must make payment to Blue Cross for your share of the expenses, which will in turn be credited to the plan. **If you do not make the required payments, additional steps will be taken to ensure that the plan provisions are followed.**

Comparison of Medical Benefit Plans

BENEFITS	UNITED HEALTHCARE	BC/BS OPTION 2 (Deductible: \$300/single; \$600/family)	CIGNA
Physicians Services <i>Preventive care and treatment for illness & injury in the physician's office, including:</i> Periodic health exams Routine office visits Well-child care Immunizations Surgery and related services Diagnostic testing	\$10 copayment per office visit to primary care physician (PCP) No referral from PCP required to see participating network specialist \$15 copayment per office visit (Specialist)	In-network covered 80% after deductible (PCP and Specialist) Routine physical exams not subject to deductible as follows: 4 exams per year birth to age 1; 2 exams per year age 1-2; 1 exam per year age 2-6 Age 6 and above-1 exam per year, subject to \$250 maximum benefit	\$10 copayment per office visit (PCP) \$20 copayment per office visit (Specialist)
Specialist referral required	No: United Healthcare Choice Open Access—no referral necessary for participating network specialist	No	Yes
Annual OB/GYN exam	\$15 copayment per office visit (One routine exam every 12 months)	In-network physician covered 80%	\$10 copayment for PCP \$20 copayment for specialist (No PCP referral required for OB/GYN related care with a network OB/GYN)
Allergy Services	\$15 copayment per office visit; \$0 copayment for injections only if no professional fee is charged	In-network covered 80% after deductible—allergy serum 80% after deductible	Office visit copay or cost of visit, whichever is less; (waived if immunization is only service provided)
Maternity Services <i>Physician services</i> Prenatal, delivery, postnatal care Neonatal care Well-care for newborn in hospital <i>Inpatient hospitalization</i> Maternity hospitalization	Office visit copayment for initial visit \$250 copayment per admission	In-network covered 80% after deductible In-network covered 80% after deductible	\$20 specialist copayment/\$10 PCP copayment: (copay applies to initial visit to confirm pregnancy; no charge for other office visits) \$200 copayment per admission
Approved Hospital Inpatient Services Semi-private room	\$250 copayment per admission	In-network covered 80% after deductible	\$200 copayment per admission
Approved Outpatient Services Surgery Diagnostic services	\$100 copayment per visit \$0 copayment	In-network covered 80% after deductible In-network covered 80% after deductible	\$100 copayment Covered in full
Emergency Room Services	\$50 copayment per visit—(ER copayment waived if patient is admitted to the hospital through ER)	In-network covered 80% after deductible	\$50 copayment \$25 copayment Urgent Care Centers
Emergency Ambulance Services	\$0 copayment	Covered 80% after deductible	Covered in full
Approved Home Care Services	\$0 copayment* (Covered up to 60 consecutive days per Benefit Period)	In-network covered 80% after deductible	Covered in full
Skilled Nursing Services	\$0 copayment* (Covered up to 60 days per lifetime)	In-network covered 80% after deductible	No charge; 60 days per year

Comparison of Medical Benefit Plans (continued)

BENEFITS	UNITED HEALTHCARE	BC/BS OPTION 2 (Deductible: \$300/single; \$600/family)	CIGNA
Vision Care	\$15 copayment per visit (one routine vision exam every 12 months at participating network ophthalmologist or optometrist)	\$10 copayment for exam in-network. See page 8 for more information.	\$10 copay, exam every 12 months, hardware every 24 months subject to maximums
Approved Durable Medical Equipment	\$0 copayment*	Covered 80% of UCR after deductible	No Charge \$3,500 Maximum per year (excludes elastic stockings)
Approved Prosthetic Devices	\$0 copayment*	Covered 80% of UCR after deductible	\$200 Deductible \$1,000 Maximum per year
Mental Health/Detoxification			
Inpatient	50% coverage (detox limited to 3 days per admission; subject to limitations below)	Covered 80% after deductible Substance abuse maximum of 150 days per lifetime	Inpatient - \$200 Copayment per admission; inpatient limit is 30 days for mental health and another 30 days for substance abuse treatment
Outpatient	\$50 copayment per visit Limitations: 20-day combined limit for Mental Health and Detoxification services per Benefit Period 20-visit combined limit for Mental Health and Detoxification services per Benefit Period	Covered 80% after deductible Substance abuse maximum of 30 days per year	Outpatient - Same as primary care physician, up to 25 visits per year for mental health
Covered Prescription Drugs			
<i>Generic Brand</i>	\$8 copayment per prescription order or refill	Administered through Merck-Medco \$8 copayment	\$5 copayment
Preferred Brand	\$18 copayment per prescription order or refill	\$14 copayment	\$15 copayment
Non-Preferred Brand	\$28 copayment per prescription order or refill	\$14 copayment	\$35 copayment
<i>Mail-Order Pharmacy</i>	3 x retail copayment for up to a consecutive 90-day supply	\$16 copayment for generic; \$32 copayment for name brand. Receive up to a 90-day supply	3 x retail copayment for up to a 90-day supply

Note: This is a summary of benefits and explains the plans in general terms. Plan documents are available for review from Employee Benefits, Knoxville. For more information on the plan documents, please call the Employee Service Center.

*Please refer to certificate for more details.

Options 1, 2, and 3—PPO Options—Prescription Drug Coverage

Options 1, 2, and 3 include prescription drug benefits administered by Medco Health (formerly Merck-Medco).

Retail purchases—Your Medco (or Merck-Medco) identification card allows you to access more than 52,000 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.

Mail-order purchases—If you are on maintenance medication for a chronic or long-term condition, you should use the home-delivery program. Under this program, you can obtain up to a three-month supply and pay less than you would pay for three one-month supplies purchased at retail. Home delivery saves money for you and the medical plan, in addition to providing convenience and easy refills through mail, telephone, or the Internet at Medco’s Web site, www.medcohealth.com.

The **Maintenance Medication Refill Program** provides that the home-delivery service pharmacy must be used to obtain refills of certain maintenance medications to receive benefits under the plan. Under this program, the prescription plan will cover up to three retail pharmacy purchases of the covered maintenance medications. After three retail purchases of these medications, the home-delivery pharmacy must be used to continue receiving plan benefits for these medications. If these medications are purchased at a retail pharmacy after the third purchase, the patient will pay the full cost for the medication and will not receive any plan discount

or any plan reimbursement for the medication. If you have questions about the home-delivery feature of the prescription-drug plan or if you want a list of the maintenance medications which must be purchased through home delivery after three refills, please call the Employee Service Center at 888-275-8094.

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

cessation products, appetite suppressants or other weight-loss medications, or drugs with over-the-counter equivalents.

Options 1, 2, and 3—PPO Options—Vision Coverage

All retirees enrolled in medical option 1, 2, or 3 are eligible for a vision plan benefit. The plan is offered through Eyemed Vision Care and includes a network of providers. Retirees receive a higher level of benefits when network providers are used.

	In-Network	Out-of-Network
	MEMBER PAYS	MEMBER IS REIMBURSED
Exam with Dilation as Necessary:	\$10 Copay	Up to \$35
Standard Plastic Lenses:		
Single Vision	\$10 Copay	Up to \$25
Bifocal	\$10 Copay	Up to \$40
Trifocal	\$10 Copay	Up to \$55
Basic Progressives	\$10 Copay	Up to \$55
Lenticular	\$10 Copay	Up to \$55
Frames:	\$10 Copay; \$100 Allowance; 80% of retail over \$100	Up to \$45
Lens Options (added to the base price of the lenses):		
UV Coating	\$12	
Tint (Solid and Gradient)	\$12	
Scratch-Resistant	\$12	
Basic Polycarbonate	\$35	
Standard Anti-Reflective	\$45	
Other Add-Ons and Services	20% Off Usual and Customary charges	
Contact Lenses (in lieu of a frame and lenses; includes fit, follow-up & materials):		
Conventional	\$10 Copay; \$115 Allowance; 15% off balance over \$115	Up to \$98
Disposables	\$10 Copay; \$115 Allowance; balance over \$115	Up to \$98
Medically Necessary	\$250 Allowance; balance over \$250	Up to \$200

Frequency	
Examination	Once every 12 months
Frame	Once every 24 months
Lenses	Once every 12 months
Contact Lenses	Once every 12 months

Options 4, 5, and 6— HMO Options

The HMOs are insured plans—the premiums are set by the HMOs and the HMOs bear the financial risk. If you enroll in an HMO, all of your medical plan benefits, including prescription drug and vision benefits, are provided through the HMO.

The HMOs offered by TVA, where available, are United Healthcare (Alabama and Tennessee), 800-842-2989, extension 6760, for enrollment information or www.uhc.com, and CIGNA (Tennessee), 800-515-7378, or www.cigna.com.

The following evaluation examples may be helpful to you as you consider your out-of-pocket costs if you choose option 1, 2, or 3. Think about whether you will have individual or family coverage and estimate what your total eligible health care expenses might be for next year.

The total out-of-pocket costs include your annual premium plus your deductible and coinsurance—all of these amounts are paid by you.

For example, if you have individual coverage and expect to have eligible health care expenses of \$1,000, you would pay \$3,964 under option 1. That is, your annual premium of \$3,684 (\$307 times 12), plus your \$200 deductible, plus 10 percent of the charges.

Total Out-of-Pocket Cost			
	Option 1 90%	Option 2 80%	Option 3 70%
Individual Plan			
Eligible Individual Health Care Expenses of:			
\$1,000	\$3,964	\$3,752	\$3,748
\$2,500	\$4,114	\$4,052	\$4,198
\$5,000	\$4,364	\$4,552	\$4,668
\$10,000	\$4,864	\$4,812	\$4,668
\$25,000	\$5,184	\$4,812	\$4,668
\$50,000	\$5,184	\$4,812	\$4,668
Family Plan			
Eligible Family Health Care Expenses of:			
\$2,000	\$10,136	\$9,496	\$9,392
\$5,000	\$10,436	\$10,096	\$10,292
\$10,000	\$10,936	\$11,096	\$11,232
\$20,000	\$11,936	\$11,616	\$11,232
\$50,000	\$12,576	\$11,616	\$11,232
\$100,000	\$12,576	\$11,616	\$11,232

Assuming:

- The services are covered by the plans
- Amounts charged are within the allowable fee schedules
- Participating physicians and hospitals are used

What Would You Pay?

To help you choose the medical plan that best meets your needs, the following examples are provided for financial comparison purposes. In these examples, it is assumed that:

- the services are covered by the plans
- the retiree has family coverage
- the charges are for an individual patient’s medical expenses
- the premium rates used are 2003 rates
- the amounts charged are within the allowable fee schedules
- participating physicians and hospitals are used, and
- no deductible has been met, where applicable.

Example A - Inpatient hospital surgery					
Charge	Option 1 (BCBS 90%)	Option 2 (BCBS 80%)	Option 3 (BCBS 70%)	Options 4 and 6 (United Healthcare)	Option 5 (CIGNA)
Hospital \$6,000	You pay \$200 deductible* plus \$580	You pay \$300 deductible* plus \$1,140	You pay \$400 deductible* plus \$1,100**	You pay \$250	You pay \$200
Surgeon \$1,500	You pay \$150	You pay \$60**	You pay \$0**	You pay \$0***	You pay \$0***
Anesthesia \$390	You pay \$39	You pay \$0**	You pay \$0**	You pay \$0***	You pay \$0***
Annual premium	You pay \$9,576	You pay \$8,616	You pay \$8,232	You pay \$8,748	You pay \$8,424
Total	You pay \$10,545	You pay \$10,116	You pay \$9,732	You pay \$8,998	You pay \$8,624

Example B - Five office visits to primary care physician, with blood tests					
Charge	Option 1 (BCBS 90%)	Option 2 (BCBS 80%)	Option 3 (BCBS 70%)	Options 4 and 6 (United Healthcare)	Option 5 (CIGNA)
Office visits \$250 (5 x \$50)	You pay \$200 deductible* plus \$5	You pay \$250 deductible	You pay \$250 deductible	You pay \$50 (5 x \$10)	You pay \$50 (5 x \$10)
Lab work \$85	You pay \$8.50	You pay \$50 deductible* plus \$7	You pay \$85 deductible*	You pay \$0***	You pay \$0***
Annual premium	You pay \$9,576	You pay \$8,616	You pay \$8,232	You pay \$8,748	You pay \$8,424
Total	You pay \$9,789.50	You pay \$8,923	You pay \$8,567	You pay \$8,798	You pay \$8,474

Example C - Prescription drug purchases

Charge	Option 1 (BCBS 90%)	Option 2 (BCBS 80%)	Option 3 (BCBS 70%)	Options 4 and 6 (United Healthcare)	Option 5 (CIGNA)
Retail brand \$40	You pay \$14	You pay \$14	You pay \$14	You pay \$18 for preferred brand (\$28 nonpreferred)	You pay \$15 for preferred brand (\$35 nonpreferred)
Mail-order brand \$120	You pay \$32	You pay \$32	You pay \$32	You pay \$54 for preferred brand (\$84 nonpreferred)	You pay \$45 for preferred brand (\$105 nonpreferred)
Retail generic \$18	You pay \$8	You pay \$8	You pay \$8	You pay \$8	You pay \$5
Mail-order generic \$54	You pay \$16	You pay \$16	You pay \$16	You pay \$24	You pay \$15
Annual premium	You pay \$9,576	You pay \$8,616	You pay \$8,232	You pay \$8,748	You pay \$8,424
Total	You pay \$9,646	You pay \$8,686	You pay \$8,302	You pay \$8,852 for preferred (\$8,892 non-preferred)	You pay \$8,504 for preferred (\$8,584 non-preferred)

*Annual deductible must be satisfied every calendar year. Once the deductible is met for that year, no additional deductible would apply unless you are admitted to an out-of-network hospital.

**Maximum out-of-pocket is reached.

***No additional payment is made by the patient for this service

Your Medical Plan Options Costs 2003

Rate Increases

In recent years, medical costs have increased, but the increases in the premiums charged for medical plan coverage have not kept up with the actual costs of the medical plans. In other words, retirees have not been charged enough to cover the cost of their medical coverage. For 2003, the premiums must be set at amounts that will fully cover the actual costs for next year. The 2003 rates are shown below. **These are the total monthly rates and do not reflect any pension supplement or contribution you may receive to help offset the cost of your medical coverage.**

Comparison information is included in this book to help you consider all medical plan options as you make a selection for 2003.

Remember, if your payment for medical plan coverage 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 2002. This is the deduction for January 2003 coverage.

PPO Options & HMO Options

PPO Options (Blue Cross-Blue Shield)	Individual	Family
Option 1—90%	\$307.00	\$798.00
Option 2—80%	\$276.00	\$718.00
Option 3—70%	\$264.00	\$686.00
HMO Options	Individual	Family
Option 4—United Healthcare AL	\$285.00	\$729.00
Option 5—CIGNA	\$263.00	\$702.00
Option 6—United Healthcare TN	\$285.00	\$729.00

Healthcare Assistance Program

Don't forget the Healthcare Assistance Program implemented in 2001. This voluntary and confidential program provides health education, information, support, and assistance to employees, retirees, and their families. Its features include a 24-hour nurse line, a Web site especially designed for TVA's program, and care management programs to provide individual support from specialty nurses to members dealing with chronic medical conditions.

The services available to you depend upon the medical plan under which you are covered.

- If you are covered under one of the PPO medical plans, you have access to all features of this plan, including the 24-hour nurse line and the Web site for health information, in addition to care management services.
- If you are covered under the Medicare supplement plan, you have access to the 24-hour nurse line and the Web site for health information. (Care management services cannot be offered because Medicare is the primary insurance plan for these individuals.)
- If you are covered under an HMO, you have access to the Web site under this program. (Nurse lines and care management services are often offered by the HMOs to their members.)

You can reach a nurse 24 hours a day by calling toll-free 877-598-3972 (800-793-7044 TTY).

The Web site address is www.myaccesshealth.com

The program is administered by Health International, a nationally recognized provider of care management services, working closely with Blue Cross Blue Shield and Medco Health.

Important Definitions

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 or adopted child who is unmarried and under the age of 19. You must provide at least 50% of the child's support or be required by divorce decree or other court order to provide medical coverage for the child. The child must not be employed on a full-time basis (30 hours or more per week) except during school vacations. Coverage can be continued to the dependent's 25th birthday provided that he or she is a full-time student and satisfies the other conditions listed above.
- A foster child, stepchild, or child of whom you are the legal guardian or for whom you have legal custody, and who is under age 19 and living with you in a regular parent-child relationship. The requirement that the child be living with you in a regular parent-child relationship will be waived if the child is attending school full-time but would otherwise live with you in a regular parent-child relationship. The child must be dependent on you for at least 50% of his or her support and must not be employed on a full-time basis (30 hours or more per week), except during school vacations. Coverage can be continued to the dependent's 25th birthday provided that he or she is a full-time student and satisfies the other conditions listed above.

Fee schedule or Fee for services—Refers to the maximum amount allowed by the insurance carrier or plan administrator as payment for specified covered services.

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 UCR amount or any penalty paid for a failure to follow preadmission certification requirements. Once you reach the maximum amount, the plan pays 100% of your covered expenses for the rest of the plan year.

Frequent Questions

What if I want to keep my current coverage for next year?

You do not need to complete an election form if you want to continue your present coverage for 2003. The coverage you have now will be automatically continued unless you submit a form to change your election.

Are there any changes in the medical plans for the year 2003?

Premium rates will increase with January 2003 coverage as shown on page 12 of this book.

Is this an open enrollment period for all retirees?

No. Retirees 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 option after the first of the year?

The plan you choose during this election period will remain in effect for all of 2003. You may not change your option during the year. You will be given an opportunity next fall to make an election for the year 2004.

I'll go on Medicare in 2003. What will happen to the coverage for my spouse?

If you become eligible for Medicare at age 65, your coverage will be automatically transferred to TVA's Supplement to Medicare plan. You will receive a new medical plan identification card for the supplement. If your spouse (or any eligible dependent) is not yet eligible for Medicare, his or her coverage will continue under the plan you elect for 2003. In that case, your spouse or dependent will receive a new medical plan identification card.

Please remember—if you, your spouse, or an eligible dependent becomes eligible for Medicare before age 65, you must notify the Employee Service Center so that your enrollment and premiums can be adjusted correctly. You must also notify the Employee Service Center if your dependent is no longer eligible for coverage.

How will I know if I'm eligible for an HMO?

If you are eligible to enroll in one of the HMOs available in Alabama or Tennessee, you will also receive an information package from the HMO. You may also call the Employee Service Center at 888-275-8094 to see if you are eligible for one of the HMOs.

What do I need to do if I want to change my coverage for next year?

Call the Employee Service Center before November 25 to request a medical plan election form. A self-addressed envelope will be included with the election form sent to you. Completed forms must be returned to the Employee Service Center no later than December 9, 2002.

Who can answer my questions about the medical plan options?

The Employee Service Center at 888-275-8094 can answer your questions about the PPO options—Options 1, 2 and 3.

Questions about the benefits under the HMOs must be directed to the HMOs. You may call United Healthcare at 800-842-2989, extension 6760, for enrollment information and CIGNA at 800-515-7378.

Privacy Act Statement

TVA Retiree Medical Plan

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 (16 U.S.C. 831-831dd).

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.

This magazine 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 magazine 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 Employee Benefits office, Knoxville, during normal working hours.

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

Although TVA expects and intends to continue this plan indefinitely, as well as the separate coverages available under it, the plan, the separate benefit plans, or any provisions contained therein may be amended or terminated by TVA at any time.

For alternate formats of this document, call 865-632-6824
and allow five working days for processing.