

 Your **Health**
Counts

Medical Plan 2009

The election period is from
October 20 to November 7, 2008.



Follow these easy steps to make your 2009 Medical Plan Choice

Your medical plan choices for 2009 are:

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

The 2009 medical plan costs are shown in this booklet.

1

Read “What’s New for 2009?” on page 2.

Do you want to keep the same medical plan you currently have?

YES – You do not have to return the Election Form on page 18 to TVA. Go to step 3.

NO – Go to Step 2

2

Do you want to change your current medical plan?

YES – You must return the Election Form on page 18 to TVA. Read this booklet for enrollment information and important deadlines. Go to Step 3.

3

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

WAIT! IF YOU WILL BE ENROLLED IN THE CDHP OPTION IN 2009, YOU MUST GO TO STEP 4.

4

In order to contribute to or receive TVA’s contributions to a Health Savings Account (HSA), you must complete a separate election to open your HSA.

You have two options to open your HSA:

- Go to www.firsthorizonhsa.com/tvaretiree to complete the online enrollment process, or
- Complete the First Horizon Msaver HSA Enrollment Form that is included in this packet. Fax the form to First Horizon at 913-317-2015, or mail it to the address on the bottom of the front page of the form.

See page 12 for more information about the HSA.

Your **Health** *Counts*

Medical Plan 2009

Election Period for Retirees
October 20 - November 7, 2008

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What's New for 2009?

The following outlines changes to your benefits beginning January 1, 2009.

Preventive care allowance increased

The preventive care allowance, available in all three of the medical plans, will increase to \$500/person per year from the current \$250/person per year. See page 6 for information on this benefit.

Changes to prescription drug coverage

There will be two changes to the prescription drug coverage in all three medical plan options.

1. The generic prescription drug copayment will be lowered to \$10/retail and \$20/mail order in the 80-percent and Copayment PPO medical plans. The minimum copayment for generic drugs will be decreased to \$10/retail and \$20/mail order in the Consumer-Directed Health Plan.
2. If you have a prescription for a brand drug and a generic equivalent is available, it will cost you more to choose the brand drug. You will pay the brand drug copayment (or in the CDHP, the coinsurance) *plus* the difference in cost between the brand drug and the generic equivalent regardless of how your doctor has written the prescription. This additional cost will apply even if the doctor indicates "Dispense as Written" or "DAW" on the prescription. Today, if a doctor indicates DAW, you just pay the copay (or coinsurance). You can take the generic or take the brand. Choosing the brand means you will pay more.

Here is an example:

You are enrolled in the 80-percent PPO medical plan in 2009 and have a prescription for a non-preferred brand drug that costs \$135. That brand drug, however, has a generic equivalent that costs \$45. If you choose to purchase the generic equivalent you will pay \$10/retail (or \$20/mail order). If you choose to purchase the brand

drug (non-preferred in this example), you will pay \$133. You will pay the \$43 non-preferred brand copay plus the cost difference (\$135 - \$45) between the generic and the brand.

See page 6 for more information about your prescription drug coverage.

Changes to the Consumer-Directed Health Plan (CDHP)

There will be two changes to the CDHP medical option provisions. See page 11 for details.

1. A Health Savings Account, or HSA, will replace the Health Reimbursement (HRA)

An HSA will be available to you if you enroll in the CDHP medical option. The HSA replaces the HRA now included in the plan. An HSA gives you more control over how and when you spend your healthcare resources.

An HSA is a tax-exempt account owned by you in which you and TVA can make contributions to pay for qualified medical expenses. There are advantages to putting money in an HSA, including favorable tax treatment.

2. Deductibles will increase

An HSA can only be offered in conjunction with a qualified high-deductible health plan (HDHP). So, the CDHP option will be changed to meet Internal Revenue Service (IRS) mandates for an HDHP. Annual deductibles will be increased to \$1,150/individual and \$2,300/family from the current \$1,000/individual and \$2,000/family. The IRS indexes the deductible amounts yearly.

Be sure to read the Medicare information on page 4 about prescription-drug coverage available when you become eligible for Medicare.

2009 General Information and Enrollment Instructions

Welcome to the annual Retiree Medical Plan Election Period. From October 20 through November 7, you may choose the medical plan you want for 2009.

Your medical plan options for 2009 are:

- 80-percent preferred-provider organization (PPO)
- Copayment PPO
- Consumer-Directed Health Plan (CDHP)

There are no changes to the 80-percent and Copayment PPO medical plans for 2009. Deductibles, coinsurance, copayments, and all other plan provisions remain the same. Two changes are being made to the CDHP. See page 11 for details. Premiums are on page 15.

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.

Click on:

- Self-Service, Members, then
- TVA employees, then
- Health Plan Comparison

You will be prompted to enter both a Group ID and an Authentication ID. You should enter TVARET2009 (*letters are uppercase*) for both IDs.

You can compare your costs under the medical plan options. This site also gives you access to information on average costs of many medical procedures, hospital cost and quality information, and information on medical conditions.

Important enrollment information

If you want to change your medical coverage for 2009, you must complete the election form included in this book and return it in the postage-paid envelope. The TVA Service Center must receive your election form by November 12, 2008.

If you have medical coverage in 2008 and your election form is not received by November 12, 2008, you will be enrolled in the *same* medical plan for 2009 at the level of coverage—individual or family—you have in 2008.

Remember that you cannot change your election after January 1, 2009.

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 TVA 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.

Important information for 2009 CDHP enrollees

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

- Go to www.firsthorizonhsa.com/tvaretiree to complete the online enrollment process, or
- Complete the First Horizon Msaver HSA Enrollment Form that is included in this packet. Fax the form to First Horizon at 913-317-2015, or mail it to the address on the bottom of the front page of the form.

Will you be 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 TVA Service Center if you or one of your covered dependents becomes eligible 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.

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, Copayment PPO, or Consumer-Directed Health Plan. You will, however, be eligible for the TVA Medicare Supplement plan. Most people will become eligible for Medicare at age 65, and your TVA coverage will be automatically transferred to the Medicare Supplement plan at that time. However, if you become eligible for Medicare before age 65 (or if your dependent becomes eligible before age 65), you must notify the TVA Service Center so that your enrollment can be transferred to the Medicare Supplement plan.

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, Copayment 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 TVA's Medicare prescription drug plan (or any other Medicare prescription drug plan).

When you cancel or lose your coverage under the TVA-sponsored retiree medical plan (the 80-percent PPO, Copayment 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 using an Employer Group Special Enrollment Period.

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 (through TVA's Medicare Supplement plan or another Medicare prescription drug plan) 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 November to enroll.

TVA retirees, or their dependents, enrolled in TVA's Medicare Supplement plan will receive their Medicare prescription drug coverage under the TVA Medicare Supplement and will not need to enroll in a separate Part D plan.

The TVA Medicare Supplement plan includes both medical and prescription drug benefits. Should you decide to cancel your TVA Medicare Supplement coverage to enroll in another Medicare prescription drug plan, you would also be canceling your medical coverage under the TVA Medicare Supplement plan. Coverage for all your dependents would end as well. If you cancel your TVA medical coverage, you will not have another opportunity to enroll in a TVA-sponsored medical plan. If you have questions about canceling coverage, you may call the TVA Service Center at 865-632-8800, 423-751-8800, or toll-free at 888-275-8094.

For more information about this notice or your current prescription drug coverage, you may call the TVA Service 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 and 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 & 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	October 15, 2008
Name of Entity/Sender	Tennessee Valley Authority
Contact	TVA Employee Benefits
Address	400 West Summit Hill Drive Knoxville, Tennessee 37902
Phone	TVA Service Center 888-275-8094

Your 2009 Medical Plan Options

The 2009 medical plan options are:

- 80-percent PPO plan
- Copayment 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 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 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 shown on page 15.

All of the options include:

Medical benefits

All of the medical plans are administered through BlueCross BlueShield of Tennessee. All of the options are PPO plans—that is, they all use the Blue Cross Blue Shield 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. All of the 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.

\$500 preventive care allowance

Each person covered under one of the medical plan options is eligible for plan payments of up to \$500 per calendar year 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 allowance. 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 allowance. Services can include but are not limited to: gynecological exam, annual routine

exam, mammogram screenings, pap smears, prostate screening, audiology screening, flu and pneumonia shots, and related routine diagnostic services. The preventive care benefit does not include colonoscopies, as these are considered medical. If the services are billed as routine, or preventive, services, the claim(s) will be processed under the \$500 preventive care allowance. If routine or preventive services exceed the \$500 preventive care allowance, you are responsible for charges beyond \$500.

Prescription drug coverage

All options include prescription drug benefits administered by Medco Health.

All plans have a three-tier prescription drug plan—generic, preferred brand (sometimes called formulary), and non-preferred brand (nonformulary). When you use generics or preferred brand-name drugs, you can save money for yourself and the plan. Medco 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 or if it has a generic equivalent, visit Medco's web site at www.medcohealth.com, or call Medco at 800-818-0890. The list is reviewed by the Medco committee quarterly and is subject to change.

Retail purchases

Your 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 90-day supply and pay less than you would pay for three 30-day 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 TVA 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.

Vision coverage

The Copayment PPO plan and 80-percent PPO plan include vision-care benefits. 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. The Consumer-Directed plan does not include vision-care benefits.

More information on these medical plan options is available at the TVA retirees web site (www.tvaretirees.com) or the BlueCross BlueShield of Tennessee web site (www.bcbst.com).

	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
Standard 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	
Standard Polycarbonate	\$35	
Standard Anti-Reflective	\$45	
Other Add-Ons and Services	20% Discount	
Contact Lenses (in lieu of standard plastic 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
Standard Plastic Lenses or Contact Lenses	Once every 12 months

Comparison of Medical Benefit Plans

BENEFITS	COPAYMENT PPO	80% COINSURANCE PPO	CONSUMER-DIRECTED HEALTH PLAN
Deductible	No deductible	\$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
Health Savings Account (HSA)	N/A	N/A	TVA contribution: \$500 Individual Contract/ \$1,000 Family Contract
Preventive Care – Age 6 and above	In-network covered 100% up to \$500 annual limit per person; not covered after limit reached	In-network covered 100% up to \$500 annual limit per person; not covered after limit reached	In-network covered 100% up to \$500 annual limit per person; not covered after limit reached
Preventive Care – Children under age 6	Birth to age 1 – 4 exams; Age 1 up to 2 – 2 exams; Age 2 up to 6 – 1 exam per year	Birth to age 1 – 4 exams; Age 1 up to 2 – 2 exams; Age 2 up to 6 – 1 exam per year	Birth to age 1 – 4 exams; Age 1 up to 2 – 2 exams; Age 2 up to 6 – 1 exam per year
Physician Services in Physician’s Office	In-network \$25 copayment per office visit	In-network covered 80% after deductible	In-network covered 80% after deductible
Specialist referral required	No	No	No
Allergy Services	In-network office visit copay or cost of visit, whichever is less (waived if immunization is only service provided)	In-network covered 80% after deductible – allergy serum 80% after deductible	In-network covered 80% after deductible – allergy serum 80% after deductible
Maternity Services <i>Physician services</i> Prenatal, delivery, postnatal care Neonatal care Well care for newborn in hospital	In-network \$25 copayment (copay applies to initial visit to confirm pregnancy; no charge for other office visits)	In-network covered 80% after deductible	In-network covered 80% after deductible
<i>Inpatient hospitalization</i> Maternity hospitalization	In-network \$500 copayment per admission	In-network covered 80% after deductible	In-network covered 80% after deductible
Approved Hospital Inpatient Services Semi-private room	In-network \$500 copayment per admission	In-network covered 80% after deductible	In-network covered 80% after deductible
Approved Outpatient Services Surgery	In-network \$200 copayment per facility use	In-network covered 80% after deductible	In-network covered 80% after deductible
Diagnostic services	Routine – in-network covered in full Non-routine (e.g., MRI, CT) – in-network \$50 copayment per procedure	In-network covered 80% after deductible	In-network covered 80% after deductible
Emergency Room Services	In-network covered in full after \$100 copayment per visit	In-network covered 80% after deductible	In-network covered 80% after deductible
Emergency Ambulance Services	Covered in full	Covered 80% after deductible	Covered 80% after deductible

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

Comparison of Medical Benefit Plans

BENEFITS	COPAYMENT PPO	80% COINSURANCE PPO	CONSUMER-DIRECTED HEALTH PLAN
Vision Care	\$10 copay exam every 12 months	\$10 copay exam every 12 months	Not available
Lenses	\$10 copay every 12 months	\$10 copay every 12 months	
Frames (Every 2 years)	\$10 up to \$100 80% amount over \$100	\$10 up to \$100 80% amount over \$100	
Contacts	\$10 up to \$115	\$10 up to \$115	
Approved Durable Medical Equipment	Covered in full after \$200 annual copayment per calendar year	Covered 80% after deductible	Covered 80% after deductible
Approved Prosthetic Devices	Covered in full after \$200 annual copayment per calendar year	Covered 80% after deductible	Covered 80% after deductible
Mental Health/Detoxification			
Inpatient	In-network Substance abuse – \$500 copayment per admission Limit 150 days per lifetime Mental health – \$500 copayment per admission Limit 60 days per calendar year	In-network Covered 80% after deductible Substance abuse maximum of 150 days per lifetime Mental health limit of 60 days per calendar year	In-network Covered 80% after deductible Substance abuse maximum of 150 days per lifetime Mental health limit of 60 days per calendar year
Outpatient	In-network Mental health – Same as physician office copay Limit 60 visits per calendar year Substance abuse outpatient – Same as physician office copay	In-network Covered 80% after deductible - Mental health limit of 60 visits per calendar year Substance abuse maximum of 30 visits per year	In-network Covered 80% after deductible - Mental health limit of 60 visits per calendar year Substance abuse maximum of 30 visits per year
Covered Prescription Drugs <i>Administered through Medco Health</i>			
Generic	\$10 copayment	\$10 copayment	Covered 80% after deductible Minimum of \$10 Maximum of \$100
Preferred Brand	\$24 copayment	\$28 copayment	Covered 80% after deductible Minimum of \$24 Maximum of \$100
Non-Preferred Brand	\$39 copayment	\$43 copayment	Covered 80% after deductible Minimum of \$39 Maximum of \$100
Mail-Order Pharmacy	2x retail copayment for up to a 90-day supply	2x retail copayment for up to a 90-day supply	2x retail minimums and maxi- mums for up to 90-day supply
Out-of-pocket maximum	In-network \$1,500 Individual \$3,000 Family Out-of-Network \$3,000 Individual \$6,000 Family	In-network \$2,500 Individual \$5,000 Family Out-of-Network \$5,000 Individual \$10,000 Family	In-network \$4,500 Individual Contract \$9,000 Family Contract Out-of-Network \$9,000 Individual Contract \$18,000 Family Contract

Copayment PPO Plan

Under the Copayment PPO plan, you pay fixed-dollar copayments for covered services when you use in-network providers. You have freedom of choice, however, and you can choose to use providers not in the PPO network. If you use out-of-network providers, the plan will pay benefits for covered medical services at 70 percent of the allowable fee schedule and you will pay 30 percent plus any amount in excess of the allowable fee schedule. There is no deductible to be met under the Copayment PPO plan.

For example:

	In-Network	Out-of-Network
Physician Office Visit	You pay \$25	Plan pays 70%; you pay 30%*
Emergency Room (includes all related charges)	You pay \$100	Plan pays 70%; you pay 30%*
Outpatient Diagnostic Services		
Routine (e.g., EKG, x-ray, lab)	You pay \$0	Plan pays 70%; you pay 30%*
Nonroutine (e.g., MRI, CT)	You pay \$50 per procedure	Plan pays 70%; you pay 30%*
Inpatient Hospital Stay (includes all related charges)	You pay \$500	Plan pays 70%; you pay 30%*

* Based on allowable fee schedule

All the medical plan options are PPO plans using Blue Cross PPO networks.

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.bcbs.com.

Your prescription drug copayments—amounts to be paid by you at the time of purchase—are:

	Retail (up to 30-day supply)	Home-delivery (up to 90-day supply)
Generic	You Pay \$10	You Pay \$20
Preferred Brand	You Pay \$24	You Pay \$48
Non-preferred Brand	You Pay \$39	You Pay \$78

The vision benefits are shown on page 7.

80-Percent PPO Plan

This is the “core” plan available to eligible retirees. If you wish to “buy up” to a plan that pays higher benefits, you may elect the Copayment PPO plan. The 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 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)	Home-delivery (up to 90-day supply)
Generic	You Pay \$10	You Pay \$20
Preferred Brand	You Pay \$28	You Pay \$56
Non-preferred Brand	You Pay \$43	You Pay \$86

The vision benefits are shown on page 7.

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).

Preventive Care Allowance (\$500 per person)	In-Network Deductible \$1,150 Individual Contract \$2,300 Family Contract Out-of-Network Deductible \$2,000 Individual Contract \$4,000 Family Contract	
	AFTER YOU MEET YOUR DEDUCTIBLE	
	In-Network Medical Plan pays 80% Out-of-Network Medical Plan pays 60% (based on allowable amounts)	Prescription-Drug Coverage Plan pays 80% Minimum to be paid by you: Retail \$10 generic \$24 preferred \$39 non-preferred Home-delivery \$20 generic \$48 preferred \$78 non-preferred Maximum to be paid by you: Retail \$100 for any covered drug Home-delivery \$200 for any covered drug
	100% After Out-of-Pocket Maximum \$4,500 Individual/\$9,000 Family In-Network \$9,000 Individual/\$18,000 Family Out-of-Network	

An HSA is a tax-exempt trust 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 (HSA)
TVA Contribution \$500 Individual/\$1,000 Family
Retiree Contribution (Optional) The retiree chooses whether or not to contribute.
Maximum Contribution (all sources) \$3,000 Individual/\$5,950 Family
Unused balance can carry over for future years with no limits.

\$500 preventive care allowance

The CDHP includes the same Preventive Care benefit as the other plans. This benefit is not subject to the deductible or coinsurance.

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 any one 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(s) 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, with you paying 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)	Home-delivery (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
Non-preferred 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:

<p>Generic, 30-day supply at retail, cost is \$80 20% = \$16 You pay \$16</p>	<p>Preferred Brand, 30-day supply at retail, cost is \$90 20% = \$18 (below minimum) You pay \$24 (minimum)</p>	<p>Nonpreferred Brand, 90-day supply through home delivery, cost is \$200 20% = \$40 (below minimum) You pay \$78 (minimum)</p>	<p>Preferred Brand, 90-day supply through home-delivery, cost is \$1,200 20% = \$240 You pay \$200 (maximum)</p>
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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 prescription drugs and medical services 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 (HSA)

The HSA is a tax-exempt account owned by you in 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 (except “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 will be serviced by First Horizon Msaver, a subsidiary of First Tennessee Bank National Association.

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.
- 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

First Horizon will deduct a monthly administrative fee of \$2.25 from your HSA. Other fees, such as those for investment fund options and account closing, will be highlighted in the Welcome Kit you will 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 \$500 in the HSA. If you have a family contract under the CDHP, TVA places \$1,000 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 2009 is \$3,000/individual and \$5,950/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 for 2009. 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 First Horizon. 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 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 needs. You may use TVA's contribution to your HSA to help in meeting your CDHP deductible.

After opening your account you will be sent a First Horizon HSA 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 10% tax penalty. After you turn age 65, the 10% 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 monthly 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 to assist you with income tax filing.

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.

Current CDHP enrollees with a HRA balance

There are specific rules regarding the transfer of an HRA balance to an HSA. In general, a one-time transfer of the balance remaining in your HRA is considered a qualified HSA distribution. The IRS governs a transfer of this type

and states the amount you can transfer is the value of the HRA on a cash basis at September 21, 2006, or December 31, 2008, whichever is less.

Example: Sue had \$200 in her HRA on September 21, 2006. Her current HRA has a balance of \$500 on December 31, 2008. The lesser amount of \$200 is eligible to be transferred to the HSA.

Example: Don's September 21, 2006, HRA balance was \$500. On December 31, 2008, he has an HRA balance of \$200. He can only transfer \$200 since it is the lesser amount.

Balances on December 31, 2008, that are not eligible to be transferred to the HSA can be credited to a limited-purpose HRA. With a limited-purpose HRA funds can only be used for preventive care, dental, and vision expenses. The limited-purpose HRA will be administered by SHPS and you would file claims for reimbursement. You will be notified if you have a balance that can be transferred.

For more HSA information

Call the First Horizon Msaver Customer Care Center at 1-888-355-6124, or visit www.firsthorizonmsaver.com/tva. The Care Center and web site are available 24 hours a day, seven days a week. Questions can be directed to a customer service representative or submitted through the web site. More information is also available at www.tvaretirees.com.

How the CDHP works with an HSA

Assume you have a family contract, with TVA providing \$1,000 in your HSA.

Meeting your deductible

You and your family members go to the physician and purchase prescription drugs just as you would normally do, presenting your Blue Cross identification card for physician and hospital services and your Medco 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 is empty (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 Blue Cross or Medco 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

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.

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 and medical expenses 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

The CDHP does not include vision-care benefits.

Your 2009 Medical Plan Costs

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.

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 2008. This is the deduction for January 2009 coverage.

How do you pay your premium?

Look closely at the 2009 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 2009 premium to be deducted, you must change your method of premium payment to automatic

bank-drafting. TVA will review records in early 2009 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 the TVA Service Center at 888-275-8094.

Plan Costs		
	Individual	Family
Copayment PPO Plan	\$800	\$1,518
80% PPO Plan	\$536	\$983
Consumer-Directed Health Plan	\$316	\$602

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 for whom you are the legal guardian or of 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.

Your Health Counts

There are things you can do to maintain your health . . . to improve your health . . . to improve your quality of life.

Screening exams

All of the medical plan options have a \$500 preventive care allowance for routine health screenings. Remember, you are responsible for any charges over \$500. Your provider will determine if a particular test or service is preventive. The recommendations for certain screening tests are:

Test	For	Recommendation
Mammogram	Breast Cancer	For women over 40, every 1-2 years; first screening exam between 35-39
Pap Smear	Cervical Cancer	Within three years of becoming sexually active or at age 21; at least every three years
PSA	Prostate Cancer	Every year for men over 50; younger if defined as "at risk"
Cholesterol	High Cholesterol	Men over 35 and women over 45 if at risk; some recommend men or women over 20 if at risk
Glucose	Diabetes	If you have high blood pressure or high cholesterol
Bone Density	Osteoporosis	Women over 65; over 60 if at risk
Scope <i>(Note: Colonoscopies are considered medical, not preventive.)</i>	Colorectal Cancer	Men and women over 50 should have flex sigmoidoscopy every five years or colonoscopy every 10 years

Discuss your individual situation with your physician to determine if you are at risk.

Flu shots

It's that time of year. The Centers for Disease Control and Prevention recommends annual flu shots for persons age 50 and older. People who have chronic illnesses such as heart disease, lung disease, or kidney disease are especially encouraged to get the shots. The best time to get a flu shot is in October or November.

The CDC also recommends pneumonia immunizations for people under 65 if they have a chronic illness, with a booster vaccine 5-10 years later. It further recommends a pneumonia vaccine for all people over 65 if they have not received one before age 65.

Healthcare Assistance Program

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.

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 SHPS, a nationally recognized provider of care management services, working closely with BlueCross BlueShield and Medco Health.

BlueCross BlueShield of Tennessee

www.bcbst.com

Health Information Library

800-656-8123

Frequent Questions/Contact Information

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 2009 carefully and submit an election form indicating the plan you want for next year.

If you have coverage in 2008 and do not submit an election form for 2009, you will be enrolled in the same medical plan for next year at the level of coverage—individual or family—that you have in 2008. Election forms must be received by November 12, 2008.

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 First Horizon Msaver HSA enrollment form?

If you will be enrolled in the CDHP option in 2009, you must complete a separate election in order to receive TVA's contributions to or to contribute to your HSA. You have two options to open your HSA:

- Go to www.firsthorizonhsa.com/tvaretiree to complete the online enrollment process, or
- Complete the enclosed HSA enrollment form. Fax the form to First Horizon at 913-317-2015, or mail it to the address on the bottom of the front page of the form.

Is this an open enrollment 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 option after the first of the year?

The plan you choose during this election period will remain in effect for all of 2009. You may not change your option during the year. You will be given an opportunity next fall to

make an election for 2010.

I'll go on Medicare in 2009. What will happen to 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 covered on your medical plan) is not yet eligible for Medicare, his or her coverage will continue under the plan you elect for 2009. 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 TVA Service Center so that your enrollment and premiums can be adjusted correctly. You must also notify the TVA Service Center if your dependent is no longer eligible for coverage. Failure to provide such information could result in your having to repay the amounts of claims that were paid incorrectly.

Who can answer my questions about the medical plan options?

The TVA Service Center can help you. You can call the Center at 888-275-8094. Representatives are available 7:00 a.m. to 5:30 p.m. ET, Monday – Friday. You can also reach the Center by e-mail at esc@tva.gov. BlueCross BlueShield of Tennessee administers the medical plans. Its Member Service can also assist you. You can reach a representative at 800-245-7942, 8:00 a.m. to 5:15 p.m. ET, Monday – Friday.

Who can answer my questions about the Health Savings Account?

Call the First Horizon Msaver Customer Care Center at 1-888-355-6124 or visit www.firsthorizonmsaver.com/tva. The Care Center and web site are available 24 hours a day, seven days a week. Questions can be directed to a customer service representative or submitted through the web site.

Contact Information

Vendor/Customer Service	Contact	Web site
TVA Service Center	888-275-8094 7:00 a.m. - 5:30 p.m. ET, Monday - Friday	www.tvaretirees.com e-mail: esc@tva.gov
BlueCross BlueShield of Tennessee (Medical)	800-245-7942 8:00 a.m. - 5:15 p.m. ET, Monday - Friday	www.bcbst.com
Healthcare Assistance Program (24-hour nurse line)	877-598-3972, 800-793-7044 TTY 24 hours a day, 7 days a week	www.myaccesshealth.com
Medco Health (Prescription Drugs)	800-818-0890, 24 hours a day, 7 days a week	www.medcohealth.com
First Horizon (Health Savings Account)	888-355-6124, 24 hours a day, 7 days a week	www.firsthorizonmsaver.com/tva

Retiree Medical Plan Election Form 2009

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 2009 is: (Check the appropriate box)

Copayment PPO Plan Individual Family

80% PPO Plan Individual Family

Consumer-Directed Health Plan Individual Family

If you select this plan, review the enclosed HSA enrollment information.

Waive all coverage*

Cancel spouse coverage only

Cancel dependent (other than spouse) coverage only

List the dependents (other than spouse) for which you are canceling medical coverage.

Dependent Name	Dependent SSN	Coverage Termination Date

This authorizes a change in my monthly premium to be effective with the payment for January 2009 coverage.

I understand that this option will remain in effect for all of calendar year 2009. I understand that I may not change my election during 2009.

*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 the TVA Service Center no later than November 12, 2008 in order for this change to be made.

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 April 14, 2003, 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 Live Well 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).

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, ET 8C-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, pay-

ment, 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 or are at risk of spreading a disease or condition.

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.

INDIVIDUAL 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, CIGNA, Medco Health, etc.), who maintain information regarding claims, diagnoses, and treatment in order to pay your claims.

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, healthcare operations and certain other activities not subject to an accounting as set forth in HIPAA, since the earlier of April 14, 2003 or 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.

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. 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.

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:

Senior Manager
Employee Benefits
400 W. Summit Hill Drive, WT 8D
Knoxville, Tennessee 37902

Complaint Official:

Program Manager
Healthcare Consumerism and Education
400 W. Summit Hill Drive, WT 8D
Knoxville, Tennessee 37902

Or call the TVA Employee Service 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 (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 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 Employee Benefits office, Knoxville, during normal working hours.

You may obtain a copy of the plan document by submitting a written request to the TVA 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.