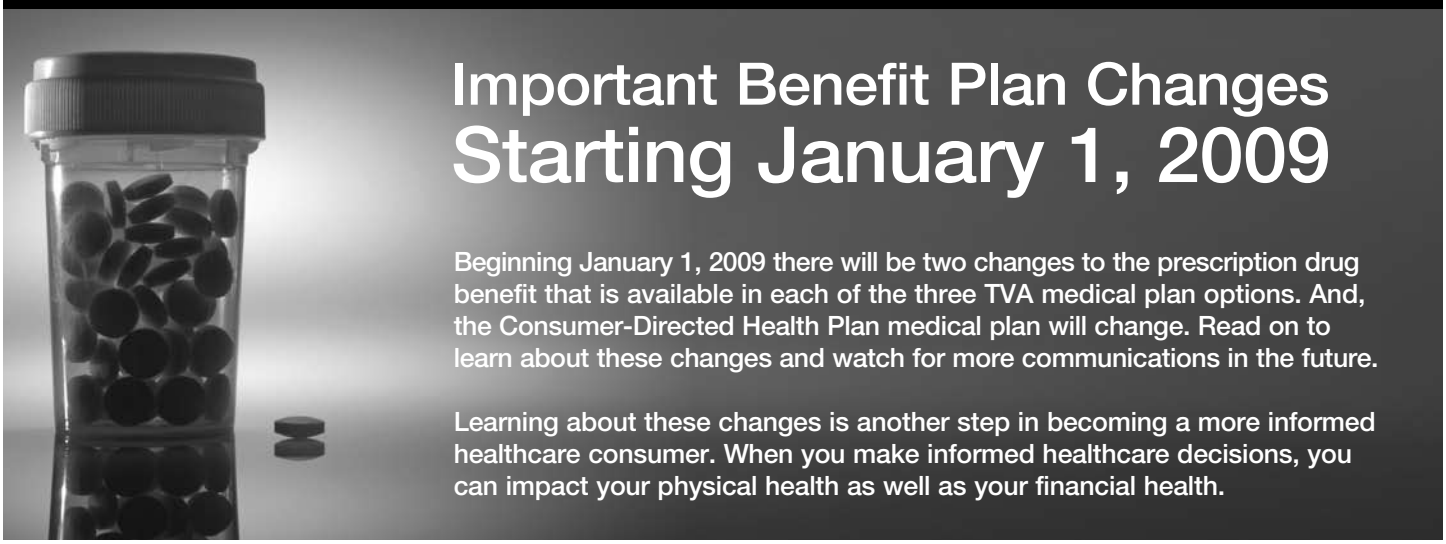
Your Health Count$



Important Benefit Plan Changes Starting January 1, 2009

Beginning January 1, 2009 there will be two changes to the prescription drug benefit that is available in each of the three TVA medical plan options. And, the Consumer-Directed Health Plan medical plan will change. Read on to learn about these changes and watch for more communications in the future.

Learning about these changes is another step in becoming a more informed healthcare consumer. When you make informed healthcare decisions, you can impact your physical health as well as your financial health.

Changes to your prescription drug plan in 2009

Have you tried a generic prescription drug yet? In 2007 alone, the U.S. Food and Drug Administration (FDA) approved 99 new generic drugs to be introduced into the marketplace. More than 50 generics have already been approved in 2008. Two changes will be made to TVA's prescription drug plan beginning January 1, 2009, concerning the use of generic drugs. Read on to learn how you can save money by choosing generic drugs.

How will the prescription drug plan change on January 1, 2009?

1 You will pay less for generic drugs.

PRESCRIPTION DRUGS	COPAYMENT PPO AND 80% PPO PLANS		CONSUMER-DIRECTED HEALTH PLAN (CDHP)	
	2008	2009	2008	2009
Generic – purchased at retail pharmacy	You pay a $12 copay	You pay a $10 copay	You pay 20% after deductible; $12 min; $100 max	You pay 20% after deductible; $10 min; $100 max
Generic – purchased at mail order pharmacy	You pay a $24 copay	You pay a $20 copay	You pay 20% after deductible; $24 min; $100 max	You pay 20% after deductible; $20 min; $100 max

2 You will pay more for using a brand drug if a generic equivalent is available.

Today, if you request a brand drug when a generic equivalent is available, you pay the brand copay, *plus* the difference in cost between the brand and the generic. However, if your doctor has indicated DAW (dispense as written) on your prescription, you pay the brand copay but not the additional cost difference between the brand and generic.

Beginning January 1, 2009, if you choose a brand drug instead of its *generic equivalent* you will be responsible for paying the difference in the cost between the brand and the generic *regardless of what your doctor writes on the prescription*. So, if you are taking a brand drug and there is a generic equivalent available you will have to make a choice. You can take the generic or take the brand.

Choosing the brand drug over generic means you will pay more. Here's an example:

PRESCRIPTION DRUG	COPAY	DRUG COST
Generic	$10	$40
Non-Preferred Brand	$43	$135

In this example (even if the doctor writes DAW on the prescription):

- If you take the generic, your cost will be $10 (the copay).
- If you continue to use a brand drug, your cost will be $138. You will pay the difference in cost between the generic and the brand ($135-$40) plus the $43 brand copay.

What if you don't want a generic?

If you prefer a brand drug you can still get that drug but you will have to pay the difference for your choice as explained above. Some brand drugs don't have a generic equivalent. If that is the case, you only pay the copay (or if enrolled in the CDHP, the coinsurance) for the brand drug.

What is the difference between brand name and generic drugs?

A pharmaceutical company markets a new drug under a brand name that is a registered trademark and protected by patent. The company has exclusive rights to manufacture and sell that drug.

The generic name of a drug describes the active chemical ingredient of the product. This name is available for anyone to use. When the drug patent expires, other companies can begin to make generic equivalents of the drug and sell them under the drug's generic name or under a different brand name.

The only differences between a brand drug and a generic equivalent drug may be the color, flavor, shape, or certain inactive ingredients, such as fillers and dyes – and the lower price of the generic.

Are generic drugs safe and effective?

Yes, generic drugs are as safe and effective as their brand drug equivalents. The FDA requires that generic drugs meet the same standards as their brand drug counterparts. When compared to their brand drug equivalents, generic equivalent drugs must do the following:

- Meet the same federal standards for quality, strength, purity and potency.
- Contain the same active chemical ingredients and produce the same effect on the body.
- Have the same dosage form (e.g., tablets, patches, etc.) and be administered the same way (e.g., swallowed, injected, etc.).
- Be "bioequivalent," meaning the generic drug must be absorbed into the blood at a rate similar to that of the brand drug equivalent.

Since generics use the same active ingredients and are shown to work the same way in the body, they have the same risks and benefits as their brand name counterparts.

Note: In rare situations your doctor may decide that due to certain clinical or therapeutic reasons a generic equivalent is not appropriate for you. If such a situation occurs, you can submit an appeal to the appropriate TVA Healthcare Committee requesting that you not be required to pay the cost difference between the brand and generic. The Healthcare Committee will review the information your doctor provides and, based on clinical guidelines, decide if the appeal should be upheld. Appeals can be submitted prior to January 1, 2009, or anytime thereafter.

How do you know if a generic drug is available?

There are several ways to find out if a generic drug is available for the brand drug you may be taking:

Informational letter. If you or a family member are currently taking a brand drug that has a generic equivalent, you will receive a letter from Medco, TVA's pharmacy benefit manager, in October. This letter will list possible generic equivalents for the brand drug currently being taken.

Ask Medco. Call Medco customer service at 800-818-0890 or visit its web site at www.medcohealth.com, where you'll find extensive information about generic and preferred brand drugs. The site includes the tool My Rx Choices, which offers information about different medications that may save you money. To get started, enter your login information or register. Then click on "My Rx Choices" and follow the easy steps provided.

Ask your doctor. Contact your doctor to see if a generic is available and appropriate for you for any new or current medication you may be taking. See the Medco web site for questions you may want to ask your doctor about generics. You may even ask for a prescription for only a few generic pills so you can try them first to judge their effectiveness compared to the brand drug you are currently taking.

Ask your pharmacist. Talk to your pharmacist about your medications and see if a generic is available for your current or new prescriptions.

A new way to plan and pay for your healthcare

Beginning January 1, 2009, a Health Savings Account, or HSA, will be available to employees and retirees who are enrolled in TVA's Consumer-Directed Health Plan (CDHP). The CDHP, first offered in 2005, is a high-deductible medical plan in which you assume more control of your healthcare spending and more financial responsibility in exchange for lower premiums. The HSA will replace the Health Reimbursement Account (HRA) currently associated with the CDHP, giving you, the consumer, 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. Since HSAs were first established in the U.S. in 2003, more than six million people have enrolled in HSA-qualified health plans. And, it's not simply a passing trend: the U.S. Treasury Department estimates that 25 to 30 million Americans will use HSAs by 2010.

The HSA and your medical plan

An HSA works in conjunction with a high-deductible health plan (HDHP).

High-deductible health plan

An HDHP is a health plan with a deductible amount that qualifies you to open a Health Savings Account.

- To participate in an HSA, a person must be enrolled in an HDHP. The Internal Revenue Service (IRS) provides HDHP deductibles, HDHP maximum out-of-pocket spending amounts, and annual HSA contribution limits each year and adjusts for inflation.

- TVA's CDHP option will be changed January 1, 2009, in order to meet IRS mandates for a high-deductible health plan. Specifically, 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.

Health Savings Account

An HSA is a tax-exempt account that you can use to pay for current qualified medical expenses or to save for future qualified medical and retiree health care expenses.

- How do consumers manage the responsibility of a higher deductible? That's where the HSA comes into play: Funds in an HSA can be used to pay for out-of-pocket medical expenses until the deductible has been met. In this manner, the CDHP and HSA work together to help you manage healthcare costs more carefully and cost-effectively.

- You decide whether or not you want to make contributions to your HSA. TVA will make a contribution of $500/individual or $1,000/family after you open your HSA account. These are the same as the current HRA annual amounts. The maximum HSA contribution from all sources for 2009 is $3,000/individual and $5,950/family.

What are the benefits?

There are many important benefits to an HSA:

Portability

Unlike an HRA, HSAs are owned by the individual. Funds in an HSA belong to you for life – even if you switch jobs, change insurance plans, or retire.

Savings vehicle

With an HSA, unused money rolls over year-to-year, earning interest tax-free. There is no "use it or lose it" rule, because the money belongs to the individual who owns the account. As a result, an HSA is more than just a tool to manage healthcare expenses – it's also a valuable savings vehicle.

Tax advantages

HSAs provide triple tax savings through tax-deductible contributions (even for individuals who do not itemize deductions), tax-free earnings on investments, and tax-free withdrawals for qualified medical expenses.

Choice and control

Your HSA belongs to you, so you can choose if and when to contribute to your account, how to invest your contributions, and when and how to use your HSA funds. You do not have to have distributions pre-qualified or approved by an employer, and you always have access to the funds in your HSA with debit cards and checks.

Flexibility

Funds in your HSA can be used to pay for a variety of medical expenses and treatment options, including many not typically covered by a traditional health insurance plan. For example, you can withdraw money tax-free to pay for deductibles, coinsurance, contact lenses, prescription medicines, certain over-the-counter drugs, vision care, and dental treatment.

TVA Benefits
Tennessee Valley Authority
400 W. Summit Hill Drive
Knoxville, Tennessee 37902

How does an HSA work?

Is an HSA right for you? Here are answers to some frequently asked questions about choosing and using an HSA:

Who can open an HSA?

To be eligible for an HSA, you must meet the following requirements:

- Must be covered by a qualified HDHP. The CDHP option will be the only TVA medical plan that will qualify as an HDHP.
- 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)

How do I use my HSA to pay for healthcare services?

Until you meet your deductible, you will usually pay for services when you receive them. You can withdraw HSA funds from an ATM, or pay at the point of service using an HSA debit card or checks. Essentially, an HSA works just like a regular checking account.

Will the CDHP cover anything before I meet my deductible?

Yes. The CDHP will continue to have the preventive care benefit for you and each of your covered dependents.

Who monitors how I use the funds in my HSA, and who determines what qualifies as an eligible medical expense?

The IRS specifies which medical expenses qualify for tax-free HSA distributions. See Publication 502 on the IRS web site at www.irs.gov for a comprehensive list. You do not have to obtain pre-approval for HSA distributions; however, it is important to keep track of all receipts as proof of payment for qualified medical expenses.

If I pay for a qualified medical expense out-of-pocket, can I reimburse myself later using funds from my HSA?

Yes. You can pay for expenses out-of-pocket and reimburse yourself later; either by using your HSA debit card to withdraw cash from an ATM, or by writing yourself a check. Regardless of how you pay for qualified medical expenses, be sure to retain your receipts as proof of payment.

Can I get an HSA for my family?

HSAs are individually owned, so there is no such thing as a "family" account. However, you can use HSA funds to pay for the medical expenses of your spouse or dependent children, even if they are not covered under the CDHP. If your family is covered under the CDHP, you also benefit from higher HSA contribution limits.

What happens to my HSA when I retire?

Funds in an HSA are yours for life, and can be used throughout retirement. After age 65, HSA funds can be withdrawn penalty-free for non-medical expenses. You will pay only ordinary income tax on nonqualified distributions.

Stay tuned

In the following months, watch for more details in these sources: *Inside TVA*, tva.com, eBenefits on TVA's InsideNet, and *TVA Today*. You can also learn more about HSAs at www.treasury.gov.