

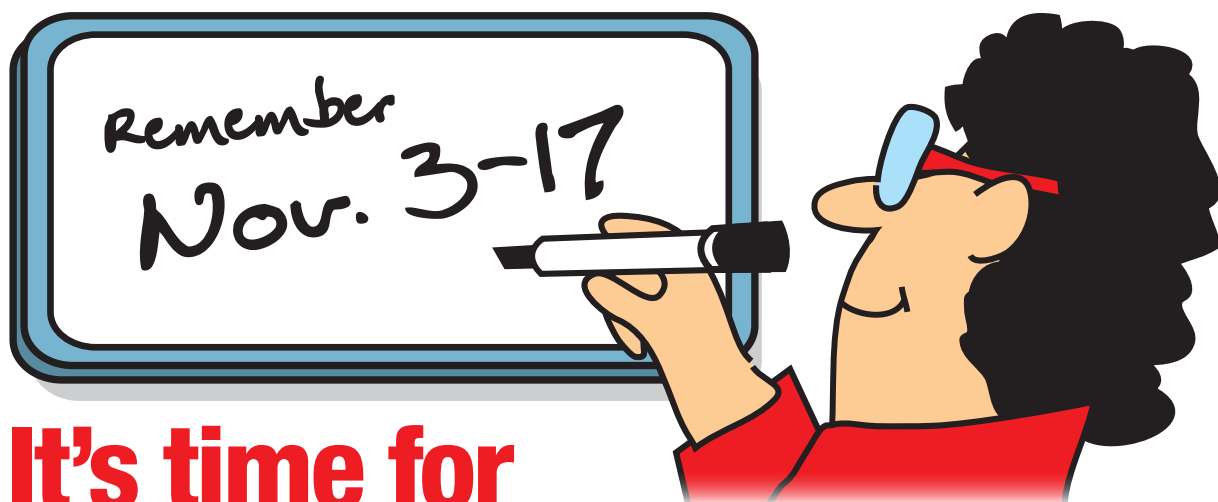
# CONNECTION



AUTUMN 2009

health benefits news for TI retirees

VOL. 3 • NO. 2



## It's time for annual enrollment

*Check your options, make your choices*



### Inside your envelope...

Besides the computer and phone resources for annual enrollment, TI has provided the details you need on paper. The enrollment packet you received with this newspaper should contain:

- A customized **personal fact sheet**, which lists your benefit options and the 2010 prices for each. It also includes important information about dependent eligibility and the Automatic Bank Withdrawal service.
- A booklet, the **Update to the 2006 Retiree Health Benefits Guide (2010 Summary of Material Modifications)**, which details changes effective in 2010 to each benefit program, including changes in contact information. (Read more below.)
- A notice containing important plan information.

#### About the yearly plan updates

In the past you should have received the 2006 Retiree Health Benefits Guide and updates for each year since. This year's update includes an index of changes since 2006. The index lists the changes by year, so you can know which update to reference for more details. You can see all of these documents online at [netbenefits.fidelity.com](http://netbenefits.fidelity.com) in the Reference Library, or you can request paper copies by calling the TI Benefits Center through TI HR Connect, **888-660-1411**, option 1.

**A**NUAL ENROLLMENT is the time each year you can adjust your TI benefits for changes in your life or needs. This newspaper and the other materials in your enrollment kit provide details to evaluate your options and make appropriate choices for 2010. Once you've reviewed the information, use the following resources to register your choices.

#### By computer: Fidelity NetBenefits®

The NetBenefits Web site at [netbenefits.fidelity.com](http://netbenefits.fidelity.com) is designed to step you through the annual enrollment process choice by choice. If you haven't used the Web site before, follow the New User instructions on the first page to establish a customer ID and PIN. Once that's done, you'll see personalized information about your benefit choices.

Throughout the year, NetBenefits is available as the primary online resource for managing your TI benefits.

#### By phone: TI HR Connect

Call the toll-free TI HR Connect number, **888-660-1411**, and select the first option to be connected with the TI Benefits Center. A representative will speak with you and step you through your benefit options for 2010. Representatives are available Monday through Friday, 8:30 a.m. to 8:30 p.m. Eastern time, except for New York Stock Exchange holidays. Throughout the year, TI HR Connect is your one-call connection to all TI benefit programs.

Read on to learn about changes to TI benefits for 2010 and how they might affect you. Then register your choices by computer or by phone so that you'll have what you need for the coming year.

■ **If you don't make any enrollment choices for 2010**, you'll stay in the same coverage options as you have currently.

## What you need to know for 2010

For 2010, TI offers the same coverage options that were available in 2009:

#### Pre-Medicare participants

- **Medical:** Blue Cross Blue Shield (BCBS) PPO A or PPO B nationwide, or an HMO if available in your geographic area.
- **Dental:** MetLife Dental Basic or MetLife Dental Plus, or the Aetna DMO if available in your area.

#### Medicare-eligible participants

- **Medical:** Blue Cross Blue Shield (BCBS) PPO nationwide or the Secure Horizons HMO for participants in the Dallas-Fort Worth area, San Antonio area or Rhode Island.
- **Dental:** MetLife Dental Basic or MetLife Dental Plus, or the Aetna DMO if available in your area.

For a listing of options available to you, refer to your personal fact sheet in the materials that came with this newspaper.

#### Premiums higher

Premiums for 2010 are going up across all types of retiree coverage (medical and dental), with HMO coverage increasing most significantly. These increases reflect the national health care cost environment. TI is expecting the company's total cost for the retiree medical program to increase in line with national averages. TI leaders continue to take actions to keep health care expenses as low as possible and limit the effect on participants, such as negotiating rates with suppliers and adjusting program features.

#### Coverage changes in BCBS PPO

- The list of preventive expenses covered at 100 percent has been expanded.
- The limit for physical therapy has been increased from \$1,500 to \$2,000.
- Changes to behavioral health care have been made to eliminate limitations and align costs to ensure that medical and behavioral health care benefits are comparable.
- Coverage has been extended for 12 months for dependent children on leave of absence from college due to medical illness.

#### Check the tables

Pages 2 and 3 in this newspaper provide details to help with your 2010 health benefit decisions. Understand the changes, evaluate your options and use annual enrollment this year to make the most of your TI benefits.

## You have options

Pre-Medicare participants enrolled in TI Extended Health Benefits Coverage have two to three options for medical care:

- **BCBS PPO A** – Higher monthly premium, lower deductible.
- **BCBS PPO B** – Lower monthly premium, higher deductible.
- **An HMO** – For many areas of the country there is an HMO option available; cost varies widely based on regional cost and competitive factors.



A **PPO** (preferred provider organization) offers service from a network of doctors. You choose which doctors you'd like to see and pay a negotiated price for services. You will pay a percentage of the service fees and you or your doctor will need to file a claim to be reimbursed. You'll also need to satisfy an annual deductible. You can also use an out-of-network provider, but the amount you pay will be higher.

In an **HMO** (health maintenance organization) you designate a primary care physician who oversees your care and makes referrals when necessary, within the HMO. You pay a fixed copay for services rather than a percentage, with no deductible or claim filing. Usually the only out-of-network care covered is for emergencies.

## 2010 TI MEDICAL PLAN OPTIONS FOR PRE-MEDICARE PARTICIPANTS

More detailed information on all plans is available on the Fidelity NetBenefits® Web site.

Region in the U.S.	Nationwide		Arizona	Texas: Houston and Austin	North Carolina	North Texas: Dallas/ Fort Worth, Sherman
Specific insurance plan	Blue Cross Blue Shield PPO A <sup>5</sup>	Blue Cross Blue Shield PPO B <sup>5</sup>	CIGNA HMO	CIGNA HMO	CIGNA HMO	CIGNA HMO
<b>Medical expenses</b>						
<b>Annual deductible<sup>1</sup> Individual/family</b>	\$300/\$600	\$500/\$1,000	\$0/\$0	\$0/\$0	\$0/\$0	\$0/\$0
<b>Annual out-of-pocket maximum<sup>1</sup> Individual/family</b>	<b>In Network:</b> \$3,000/\$6,000 <b>Out of Network:</b> \$4,500/\$9,000	<b>In Network:</b> \$5,000/\$10,000 <b>Out of Network:</b> \$7,500/\$15,000	\$1,500/\$3,000	\$1,500/\$3,000	\$1,500/\$3,000	\$1,500/\$3,000
<b>Doctor office visit copay or coinsurance<sup>1</sup></b>	<b>In Network:</b> 90% covered <b>Out of Network:</b> 50% covered		\$20 copay PCP; \$40 copay specialist	\$20 copay PCP; \$40 copay specialist	\$20 copay PCP; \$40 copay specialist	\$20 copay PCP; \$40 copay specialist
<b>Hospital copay and/or hospital coinsurance<sup>1</sup></b>	<b>In Network:</b> 70% covered <b>Out of Network:</b> \$300 annual copay, 50% covered		\$250 copay/ admission; 100% covered after hospital copay	\$250 copay/ admission; 100% covered after hospital copay	\$250 copay/ admission; 100% covered after hospital copay	\$250 copay/ admission; 100% covered after hospital copay
<b>Emergency room copay or coinsurance (not followed by admission)</b>	<b>In Network:</b> 70% covered <b>Out of Network:</b> 50% covered		\$100	\$100	\$100	\$100
<b>Physical therapy</b>	<b>In Network:</b> 90% covered; \$2,000 max/calendar year <b>Out of Network:</b> 50% covered; \$2,000 max/ calendar year (max combined with In Network)		\$40 copay; 20 visits max combined for PT, OT, speech	\$40 copay; no limit	\$40 copay; 60 visits max combined for PT, OT, speech	\$40 copay; no limit
<b>Prescription drug expenses</b>						
<b>Retail: Generic/formulary brand/non-formulary brand copay or coinsurance</b> 30-day supply, except when noted	<b>In Network<sup>4</sup>:</b> 55% <sup>3</sup> covered <b>Out of Network<sup>4</sup>:</b> 50% <sup>3</sup> covered		\$15/\$30/\$50	\$15/\$30/\$50	\$15/\$30/\$50	\$15/\$30/\$50
<b>Mail order<sup>2</sup>: Generic/formulary brand/non-formulary brand copay or coinsurance</b> Up to 90-day supply, except when noted	60% <sup>3, 4</sup> covered		\$40/\$85/\$145	\$40/\$85/\$145	\$40/\$85/\$145	\$40/\$85/\$145

1 Applies to both in-network and out-of-network medical and behavioral health care expenses.

2 Mail order is not available out of network.

3 If a generic drug is available and a brand-name drug is purchased instead, you'll pay the coinsurance for the brand-name drug cost plus the cost difference between the brand-name and generic drug.

4 There is a separate out-of-pocket maximum for prescription drug expenses of \$5,000 individual/\$10,000 family.

5 The Blue Cross Blue Shield PPO is an option for pre-Medicare retirees and dependents. It is not an option for Medex participants.

## 2010 TI MEDICAL PLAN OPTIONS FOR MEDICARE-ELIGIBLE PARTICIPANTS

More detailed information on all plans is available on the Fidelity NetBenefits® Web site.

Region in the U.S.	Nationwide	Texas: Dallas/Fort Worth and San Antonio areas	Rhode Island
Specific insurance plan	Blue Cross Blue Shield PPO <sup>6</sup>	SecureHorizons TX HMO <sup>5</sup>	SecureHorizons RI HMO <sup>5</sup>
<b>Medical expenses</b>			
<b>Annual deductible<sup>1</sup> Individual/family</b>	\$500/\$1,000	\$0/\$0	\$0/\$0
<b>Annual out-of-pocket maximum Individual/family</b>	<b>In Network:</b> \$5,000/\$10,000 <sup>1</sup> <b>Out of Network:</b> \$7,500/\$15,000 <sup>1</sup> There is a separate out-of-pocket maximum for pharmacy: \$5,000/\$10,000	N/A	\$3,500 per person
<b>Doctor office visit copay or coinsurance</b>	<b>In Network:</b> 90% covered <sup>1</sup> <b>Out of Network:</b> 50% covered <sup>1</sup>	\$10	\$15
<b>Hospital copay and/or hospital coinsurance</b>	<b>In Network:</b> 70% covered <sup>1</sup> <b>Out of Network:</b> \$300 copay/year, 50% covered <sup>1</sup>	100% covered	100% covered after \$225 inpatient hospital per day 1-16; \$0 thereafter
<b>Emergency room copay or coinsurance (not followed by admission)</b>	<b>In Network:</b> 70% covered <b>Out of Network:</b> 50% covered	\$50	\$50
<b>Physical therapy</b>	<b>In Network:</b> 90% covered; \$2,000 max/calendar year <b>Out of Network:</b> 50% covered; \$2,000 max/calendar year (max combined with In Network)	\$10 copay	90% covered
<b>Prescription drug expenses</b>			
<b>Retail: Generic/formulary brand/ non-formulary brand copay or coinsurance</b> 30-day supply, except when noted	<b>In Network:</b> 55% <sup>3</sup> covered <b>Out of Network:</b> 50% <sup>3</sup> covered	\$10/\$20/\$40	\$4/\$28/\$55 <sup>4</sup> (31-day supply)
<b>Mail order<sup>2</sup>: Generic/formulary brand/ non-formulary brand copay or coinsurance</b> Up to 90-day supply, except when noted	60% <sup>3</sup> covered	\$20/\$40/\$80	\$8/\$74/\$155 <sup>4</sup>

1 Applies to both in-network and out-of-network medical and behavioral health care expenses.

2 Mail order is not available out of network.

3 If a generic drug is available and a brand-name drug is purchased instead, you'll pay the coinsurance for the brand-name drug cost plus the cost difference between the brand-name and generic drug.

4 After you reach \$2,400 annually in total drug cost, other limitations apply.

5 This plan's benefits may change after the print date of this newspaper pending approval by the Centers for Medicare and Medicaid Services (CMS).

6 The Blue Cross Blue Shield PPO is an option for Medicare-eligible retirees and dependents. It is not an option for Medex participants.

If you, your covered spouse or same-gender domestic partner uses tobacco products, there will be an additional charge of \$30 per month for each covered adult tobacco user, with a maximum of \$60 per month. You can avoid paying the additional cost for as long as you participate in the LivingFree Program, regardless of whether you actually stop using tobacco products. The additional cost does not apply to residents of Kentucky.

Connecticut, Massachusetts, New Hampshire, Rhode Island	Illinois	California – Northern and Southern	California	Maryland, Washington, D.C., Virginia, Delaware, West Virginia
HMO Blue New England	HMO Illinois	Kaiser HMO	PacifiCare HMO	Optimum Choice HMO
\$0/\$0	\$0/\$0	\$0/\$0	\$0/\$0	\$0/\$0
N/A	\$1,500/\$3,000	\$1,500/\$3,000	\$3,000/\$9,000	\$750/\$1,500
\$20 copay PCP; \$25 copay specialist	\$20 copay PCP; \$30 copay specialist	\$20	\$20 copay PCP; \$40 copay specialist	\$20 copay PCP; \$30 copay specialist
\$250 copay/admission; 100% covered after hospital copay	\$250 copay/admission; 100% covered after hospital copay	\$250 copay/admission; 100% covered after hospital copay	\$250 admission; 100% covered after hospital copay	\$300 copay/admission; 100% covered after hospital copay
\$100	\$100	\$100	\$100	\$75
\$20 copay	\$20 copay; 60 visits max combined for PT, OT, speech	\$20 copay; limitations apply	\$40 copay	\$30 copay; 60 visits max combined for PT, OT, speech
\$15/\$30/\$50	\$15/\$30/\$50 (34-day supply)	\$15/\$30/\$30 Some restrictions may apply.	\$15/\$30/\$50	\$10/\$30 <sup>3</sup> /\$50 <sup>3</sup> (31-day supply)
\$30/\$60/\$100	\$30/\$60/\$100	\$30/\$60/\$60 (100-day supply) Refills only. Some restrictions may apply.	\$30/\$60/\$100	\$25/\$75 <sup>3</sup> /\$125 <sup>3</sup>

If you and/or your covered spouse or same-gender domestic partner use tobacco products, you'll have an additional charge of \$30 per month for each covered adult tobacco user, with a maximum of \$60 per month. You can avoid paying the additional cost for as long as you participate in the LivingFree Program, regardless of whether you actually stop using tobacco products. The additional cost does not apply to residents of Kentucky. For details about LivingFree, call the toll-free support line at 877-719-9860 or go to the TI Alumni Association Web site at [tialumni.org](http://tialumni.org). (Click on TI Health Plans, then Smoking Cessation.)

## 2010 TI DENTAL PLAN OPTIONS

More detailed information on all plans is available on the Fidelity NetBenefits® Web site.

Region in the U.S.	Nationwide	Nationwide	Availability based on location
	MetLife Dental Basic	MetLife Dental Plus	Aetna DMO
<b>General dental expenses</b>			
<b>Annual deductible Individual/family</b>	\$50 per person (applies to basic and major services only)	\$50 per person (applies to basic and major services only)	\$0/\$0
<b>Annual maximums</b>	\$1,000	\$1,500	N/A
<b>Notes</b>	You may receive treatment from any dentist. However, dentists in the MetLife Network must negotiate their rates, resulting in lower fees. <sup>1</sup>	You may receive treatment from any dentist. However, dentists in the MetLife Network must negotiate their rates, resulting in lower fees. <sup>1</sup>	\$10 office visit copay applies for all treatment. Limitations and exclusions may apply to services.
<b>Preventive care</b>			
<b>Primary covered services</b>	Oral exam, preventive X-rays, cleanings, fluoride treatments	Oral exam, preventive X-rays, cleanings, fluoride treatments	Oral exam, preventive X-rays, cleanings, fluoride treatments
<b>Preventive care benefits</b>	100% covered	100% covered	100% covered after \$10 office visit copay
<b>Basic services</b>			
<b>Fillings</b>	50% covered	80% covered	100% covered after \$10 office visit copay
<b>Endodontics (root canal therapy)</b>	50% covered	60% covered	100% covered after \$10 office visit copay. Applies to anterior and bicuspid teeth. Molar teeth 60% covered after \$10 office visit copay.
<b>Major services</b>			
<b>Crowns</b>	50% covered	60% covered	60% covered after \$10 office visit copay
<b>Dentures</b>	50% covered	60% covered	60% covered after \$10 office visit copay
<b>Bridges</b>	50% covered	60% covered	60% covered after \$10 office visit copay
<b>Orthodontia services</b>			
<b>Benefits (adult/child)</b>	50% covered up to lifetime maximum of \$1,000	50% covered up to lifetime maximum of \$1,500	50% covered after \$10 office visit copay

<sup>1</sup> Limitations and exclusions may apply to services. Reasonable and customary (R&C) limits apply if you don't use a network provider.

### Enroll online!

Go to [netbenefits.fidelity.com](http://netbenefits.fidelity.com). If this is your first time to use NetBenefits, click "New User Registration" and follow the process to set up a customer ID and PIN.

### Or by phone

Call TI HR Connect

**888-660-1411**

Select the first option.

If you set up your Fidelity account online, the customer ID and PIN you select will also be used when you phone the TI Benefits Center at Fidelity.

**CONNECTION** More information about TI's Extended Health Benefits Coverage is available in the 2006 Retiree Health Benefits Guide and its updates, the 2007 Summary of Material Modifications (SMM), the 2008 SMM, the 2009 SMM and the 2010 SMM. These documents provide detailed information on the plans. You can order a copy by calling the TI Benefits Center through TI HR Connect, 888-660-1411, option 1.

TI, as the plan sponsor, has the right to cancel or change any of the plans, programs or provisions without notice. The platform bar is a trademark of Texas Instruments. All trademarks are the properties of their respective owners. © 2009 Texas Instruments Incorporated. Printed in the USA.

## 2010 UPDATE

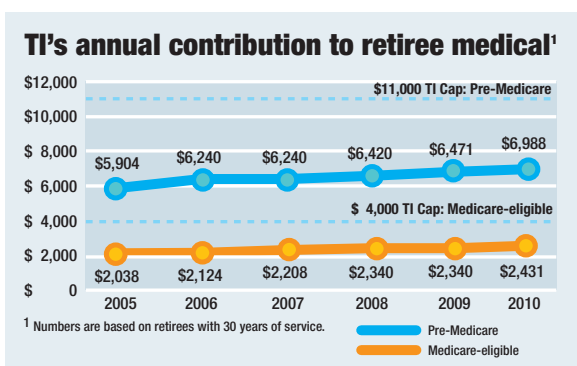
## TI maintains maximum contribution levels

Rising health care costs are a significant challenge for TI as well as a financial issue for retirees. In 2005, in an effort to help retirees manage these increasing costs, TI raised the annual maximum contribution that it will spend on retiree premiums. You may have heard this maximum contribution referred to as the retiree medical “cap.” This cap applies only to retirees who retired after Dec. 31, 1992. For those who retired prior to Jan. 1, 1993, there is no cap.

For retirees with 30 or more years of service who retired after Dec. 31, 1992, the cap increased from \$6,000 to \$11,000 for pre-Medicare retirees and from \$1,800 to \$4,000 for those retirees who are Medicare-eligible. TI’s maximum contribution is prorated for retirees with service levels between 15 and 30 years.

As long as TI’s annual contribution to retiree medical costs is below the cap, the company intends to continue sharing costs and cost increases with retirees. Once these new caps are reached, retirees will pay 100 percent of the costs above the new cap.

These maximums are strictly related to the premiums retirees pay each year. This doesn’t mean that the annual amount that TI pays on participants’ behalf for health care costs is limited to these caps. Participants have an annual maximum out-of-pocket expense in addition to premiums and deductibles. Once the maximum out-of-pocket expense is reached in a calendar year, TI pays 100 percent of any eligible



additional claim costs that year.

During the annual enrollment period in 2004, TI committed to keep retirees informed of the status of contributions relative to this new cap. The chart above illustrates TI’s annual contribution to retiree medical premiums from 2005 through 2010, and differentiates between pre-Medicare and Medicare-eligible individuals. This chart shows the gap between what TI currently pays and the per-person cap for retirees with 30 or more years of service (which applies only to those who retired after Dec. 31, 1992).

For additional details on the cap, please refer to the TI Retiree Health Benefits Bulletin dated October 2004. To view that bulletin, go to the TI Alumni Association Web site at [tialumni.org](http://tialumni.org). At the alumni Web site, use the search window on the upper right corner of the page to search for “October 2004 bulletin.” You will be taken to the PDF file.

### TI plans verified as “creditable coverage”

TI has determined that the prescription drug coverage options offered for 2010 are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. This is considered “creditable coverage” and is an important determination for anyone who later moves to Medicare prescription drug coverage.

### hot tip

### Pay the easy way

#### Set up ABW at Fidelity

Look for information in your annual enrollment kit for instructions on setting up the Automatic Bank Withdrawal (ABW) service to pay for your monthly coverage. Through ABW you pay your benefit premiums through automatic deductions from your bank account, eliminating the burden of mailing a check and ensuring your payments are on time. You can set up ABW at the NetBenefits Web site or by phone with a TI Benefits Center representative.

## Answers to common questions

For more information on any of these questions, call the TI Benefits Center or refer to your 2006 Retiree Health Benefits Guide and its updates.

### Q: How can I confirm my annual enrollment choices?

**A:** If you make a change during annual enrollment, you will receive a confirmation statement after annual enrollment ends, mailed to your home address. You should also print the online confirmation screen if you enroll on the NetBenefits® Web site.

### Q: Can I make changes after enrollment?

**A:** Only if you have an appropriate qualified status change, such as marriage, divorce, a birth/adoption or a change in employment status. Changes must be made within 30 days of a qualifying event and must be consistent with the change-in-status event.

### Q: What happens if I don’t enroll?

**A:** You will automatically be enrolled for 2010 in the coverage you had in 2009. If you have no coverage in 2009, you will be assigned no coverage in 2010.

### Q: What do I do if I’m currently in treatment?

**A:** If you change medical plans for 2010 and have an ongoing medical condition, check your new plan to see if your doctors are in the new network. If not, discuss the situation with your medical carrier immediately.

### Q: Do I need to verify that my dependents are still eligible for coverage?

**A:** Yes. You will be able to view, confirm and update your dependent data online through NetBenefits or by phone with the TI Benefits Center. There is also information about this in your enrollment kit.

### Q: Will I get new insurance ID cards?

**A:** Blue Cross Blue Shield (BCBS) PPO will issue new cards for anyone adding or making a change to their PPO coverage. The new cards will be mailed in late December. For HMOs, check with the specific carrier. You can contact your carrier through TI HR Connect.

### Q: Don’t miss a monthly payment!

**A:** Full payment should be received in the TI Benefits Center by the due date stated on your bill. If payment is not received by the due date, your coverage is subject to termination. It must be received no later than 30 days following the due date to avoid cancellation. **If your coverage is dropped because of nonpayment, you will not be eligible to re-enroll in a TI-sponsored health plan at any time.**

## Additional information for Medicare-eligible participants

### Medicare Part D enrollment coming

TI retirees who are eligible for Medicare have the opportunity to enroll in the Medicare Prescription Drug Program (Medicare Part D) each fall. Enrollment for 2010 benefits will be Nov. 15 to Dec. 31, 2009.

You may enroll in TI medical coverage or Medicare prescription drug coverage, but not both. If you decide to enroll in Medicare prescription drug coverage, be aware that **you as well as your covered dependent(s) will lose your TI medical coverage** and may not be able to re-enroll. As you consider your decision, note that your current coverage under the TI plan pays for other health expenses in addition to prescription drug coverage. For more information, refer to the 2010 Update to the 2006 Retiree Health Benefits Guide which was enclosed in the mailing with this newspaper.

**Where to go for help:** Your first stop for Medicare Part D information should be the Web site [medicare.gov](http://medicare.gov), particularly the link on the left side of the home page labeled “Prescription Drug Plan.” You can also call 800-MEDICARE (800-633-4227). The Medicare TTY phone number is 877-486-2048.

### Coordination of benefits

If you have coverage under Medicare or another group health plan, the Blue Cross Blue Shield PPO plan, like most medical plans, has a coordination of benefits provision. Under this provision, one of your plans is considered primary and the other secondary. The primary plan pays your expenses first. Medicare is primary for all Medicare-eligible participants, which includes all retirees age 65 and older.

If you retired on or after Jan. 1, 1988, or you became either age 65 or eligible for Medicare after this date, Maintenance of Benefits provisions are in effect. In this case, when the BCBS PPO is secondary, BCBS will compare the Medicare-allowed amount and the BCBS-allowed amount and use the lesser to determine the amount of secondary plan benefits covered. If the primary plan has paid the same or more than the covered amount of secondary plan benefits, the BCBS PPO will not pay on the claim. (Refer to the 2010 Update to the 2006 Retiree Health Benefits Guide which was enclosed in the mailing with this newspaper.)

### SecureHorizons update

If you are considering or are currently participating in the SecureHorizons HMO, keep these points in mind:

**Contact SecureHorizons** for information about their coverage; contact the TI Benefits Center about enrollment, dropping enrollment, monthly premiums or payments. (In order to enroll in SecureHorizons coverage you must call the TI Benefits Center at 888-660-1411, option 1. Enrollment cannot be completed online on NetBenefits.)

**SecureHorizons medical coverage** includes a Medicare prescription drug plan (Medicare Part D) for its prescriptions.

**If you or your dependent(s) enroll** in SecureHorizons and another plan which includes Medicare Part D (such as an individual SecureHorizons plan), be aware that since your new election takes the place of your coverage through TI, you and your covered dependent(s) will lose your TI medical coverage and may not be able to re-enroll. This is a Medicare requirement.

**Since SecureHorizons** is a plan governed by Medicare, it may only permit coverage to start at the beginning of the month. If you enroll during annual enrollment, your coverage will begin Jan. 1, 2010. If you enroll outside of annual enrollment or make a permitted change in coverage, your new coverage will not begin until the first day of the month following the month in which you make the change.

For more information, speak with a TI Benefits Center representative by calling TI HR Connect, 888-660-1411, and selecting option 1. Representatives are available 8:30 a.m. to 8:30 p.m. Eastern time, Monday through Friday, except for New York Stock Exchange holidays.