CONNECTION

Texas Instruments

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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 provides the details you need on paper. Enclosed with this newspaper should be (1) a customized personal fact sheet which lists your benefit options and the 2014 prices, (2) the *2014 Update to the 2011 Retiree Health Benefits Guide* and (3) important information about dependent eligibility and the Automatic Bank Withdrawal service.

In an earlier mailing ...

In September you should have received an email or home mailing with a Creditable Coverage Notice related to Medicare Part D prescription drug coverage.

ANNUAL ENROLLMENT is the time each year you can adjust your TI benefits. This newspaper and the other materials in your enrollment kit provide the details you need. Once you've reviewed the information, use the following resources to register your choices.

By computer: Fidelity NetBenefits®

The NetBenefits website at **netbenefits.com/ti** will step you through the annual enrollment process choice by choice. If you haven't used the website before, follow the New User instructions on the first page to establish a customer ID and PIN. Then 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 2014. 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.

- **If you don't make any enrollment choices for 2014,** you'll stay in the same coverage options.
- **Outside of annual enrollment,** the only time you can make changes is within 30 days of a qualified status change, such as marriage, divorce or a birth/adoption.

Health care reform

What are public and private exchanges?

As mentioned in this summer's *Connection* newspaper, the **Affordable Care Act** is being implemented in stages from 2011 to 2020. In the news most recently is the opening of enrollment in the government-run public insurance exchanges, collectively termed the Health Insurance Marketplace.

It's important to know that:

- While pre-65 TI retirees are eligible to secure coverage through the public insurance exchanges (and receive federal tax credit upon satisfaction of income requirements), such insurance may or may not be comparable in terms of cost and benefits to what is available through TI. Pre-65 TI retirees will have the opportunity to compare the coverage available on the public insurance exchange with TI coverage to determine which is best suited to their needs.
- Some employers have decided to move post-65 retirees to private insurance exchanges. These exchanges are run by private businesses (consulting companies), while the public exchanges are run by federal and state governments. In some cases employers that take this approach provide a subsidy to their retirees for use toward purchasing coverage on the private exchange.

What you need to know for 2014

TI will offer the same health coverage options to TI retirees as those available in 2013.

Pre-Medicare participants

You can choose from the following offerings.

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

Medicare-eligible participants

You can choose from the following offerings.

- **Medical:**
  - Blue Cross Blue Shield (BCBS) PPO, which is available nationwide.
  - UHC MedicareAdvantage HMO, where available in Texas and Rhode Island.
- **Dental:**
  - MetLife Dental Basic or MetLife Dental Plus, which are both available nationwide.
  - Aetna DMO, if available in your area.

For a customized list of options, refer to the personal fact sheet enclosed with this newspaper. Or go to **netbenefits.com/ti**.

Changes for 2014

- **Medical premiums** will increase for most pre-Medicare retirees and Medicare-eligible participants. Premiums for dental insurance are also increasing slightly.
- **Blue Cross Blue Shield options** will include the deductible in the annual out-of-pocket maximum for medical/behavioral health care. Also, the nutrition therapy network will be expanded, providing a larger number of professional nutrition therapists from which to receive covered services.
- **Employee Assistance Program:** This benefit will be unavailable to retirees beginning in 2014.
- **HMO Blue New England:** An out-of-pocket maximum will cap participants' expenses at $6,350 for individual coverage and $12,700 for family coverage.

For details to the changes above, see the *2014 Update to the 2011 Retiree Health Benefits Guide* in this mailing.

Check the tables: Refer to pages 2 and 3 of this newspaper for plan comparisons.

2014 TI MEDICAL PLAN OPTIONS FOR PRE-MEDICARE PARTICIPANTS

More detailed information on all plans available at **netbenefits.com/ti**. **Deductible, copay and coinsurance reflect your part of the cost.**

Region in the U.S.	Nationwide		Texas, Arizona, North Carolina
Specific insurance plan	**Blue Cross Blue Shield PPO A[5]**	**Blue Cross Blue Shield PPO B[5]**	**CIGNA Copay Plan**
Medical expenses			
Annual deductible[1] Individual/family	$300/$600	$500/$1,000	$0/$0
Annual out-of-pocket maximum[1] Individual/family	**In Network:** $3,000/$6,000 **Out of Network:** $4,500/$9,000	**In Network:** $5,000/$10,000 **Out of Network:** $7,500/$15,000	$0/$0
Preventive exams and screenings	100% covered	100% covered	$0 copay
Doctor office visit copay or coinsurance[1]	**In Network:** 10% coinsurance **Out of Network:** 50% coinsurance		$20 copay PCP; $40 copay specialist
Hospital copay and/or hospital coinsurance[1]	**In Network:** 30% coinsurance **Out of Network:** $300 annual copay, 50% coinsurance		$500 copay/admission; 0% coinsurance after hospital copay
Emergency room copay or coinsurance (not followed by admission)	**In Network:** 30% coinsurance **Out of Network:** 50% coinsurance		$100
Physical therapy	**In Network:** 10% coinsurance; $2,000 max/calendar year **Out of Network:** 50% coinsurance; $2,000 max/calendar year (max combined with In Network)		$40 copay; no limit
Prescription drug expenses			
Retail: Generic/formulary brand/ non-formulary brand copay or coinsurance: 30-day supply, except when noted	**In Network[4]:** 35%[3] coinsurance **Out of Network[4]:** 50%[3] coinsurance		$15/$30/$50
Mail order[2]: Generic/formulary brand/ non-formulary brand copay or coinsurance: Up to 90-day supply, except when noted	30%[3, 4] coinsurance		$40/$85/$145

1 Applies to both in-network and out-of-network medical and behavioral health care expenses. The deductible is included in the out-of-pocket maximum.
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.

2014 TI MEDICAL PLAN OPTIONS FOR MEDICARE-ELIGIBLE PARTICIPANTS

More detailed information on all plans available at **netbenefits.com/ti**. **Deductible, copay and coinsurance reflect your part of the cost.**

Region in the U.S.	Nationwide	Texas (available in most areas of the state)	Rhode Island
Specific insurance plan	**Blue Cross Blue Shield PPO[6]**	**UHC MedicareAdvantage HMO – TX[5]**	**UHC MedicareAdvantage HMO – RI[5]**
Medical expenses			
Annual deductible[1] Individual/family	$500/$1,000	$0/$0	$0/$0
Annual out-of-pocket maximum Individual/family	**In Network:** $5,000/$10,000[1] **Out of Network:** $7,500/$15,000[1] There is a separate out-of-pocket maximum for pharmacy: $5,000/$10,000	$6,700 per person	$3,500 per person
Doctor office visit copay or coinsurance	**In Network:** 10% coinsurance[1] **Out of Network:** 50% coinsurance[1]	$10	$15
Hospital copay and/or hospital coinsurance	**In Network:** 30% coinsurance[1] **Out of Network:** $300 copay/year, 50% coinsurance[1]	0% coinsurance	0% coinsurance after $225 inpatient hospital per day 1-16; $0 thereafter
Emergency room copay or coinsurance (not followed by admission)	**In Network:** 30% coinsurance **Out of Network:** 50% coinsurance	$50	$50
Physical therapy	**In Network:** 10% coinsurance; $2,000 max/calendar year **Out of Network**: 50% coinsurance, $2,000 max/calendar year (max combined with In Network)	$10 copay	10% coinsurance
Prescription drug expenses			
Retail: Generic/formulary brand/ non-formulary brand copay or coinsurance 30-day supply, except when noted	**In Network:** 35%[3] coinsurance **Out of Network:** 50%[3] coinsurance	$10/$20/$40	$4/$28/$55[4] (31-day supply)
Mail order[2]: Generic/formulary brand/ non-formulary brand copay or coinsurance Up to 90-day supply, except when noted	30%[3] coinsurance	$20/$40/$80	$8/$74/$155[4]

1 Applies to both in-network and out-of-network medical and behavioral health care expenses. The deductible is included in the out-of-pocket maximum.
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.

TOBACCO SURCHARGE: If you and/or your covered spouse or 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. This applies to any legal use (other than religious or ceremonial) of any tobacco product on average of four or more times per week within the last six months or less. (Does not apply to residents of Kentucky.) You can avoid paying the surcharge if you can attest that you completed a formal tobacco cessation program. For free help, go to www.smokefree.gov or call the National Cancer Institute phone line at 1-877-44U-QUIT (1-877-448-7848). To change your tobacco user status, contact the TI Benefits Center toll-free through TI HR Connect at 888-660-1411, option 1.

We want to hear from you! Your feedback helps us understand your medical plan needs and priorities. **To take a short survey, go to surveymonkey/s/TIretiree.**

Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island	Northern California	Maryland, Washington, D.C., Virginia, Delaware, West Virginia
HMO Blue New England	**Kaiser HMO**	**Optimum Choice HMO**
$0/$0	$0/$0	$0/$0
$6,350/$12,700	$1,500/$3,000	$750/$1,500
$0 copay	$0 copay	$0 copay
$20 copay PCP; $25 copay specialist	$20 copay	$20 copay PCP; $30 copay specialist
$500 copay/admission; 0% coinsurance after hospital copay	$500 copay/admission; 0% coinsurance after hospital copay	$300 copay/admission; 0% coinsurance after hospital copay
$100 copay	$100 copay	$75 copay
$25 copay	$20 copay; limitations apply	$30 copay; 60 visits max combined for PT, OT, speech
$15/$30/$50	$15/$30/$30 Some restrictions may apply.	$10/$30[3]/$50[3] (31-day supply)
$30/$60/$100	$45/$90/$90 (100-day supply) Some restrictions may apply.	$25/$75[3]/$125[3]

TOBACCO SURCHARGE: If you and/or your covered spouse or 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. This applies to any legal use (other than religious or ceremonial) of any tobacco product on average of four or more times per week within the last six months or less. (Does not apply to residents of Kentucky.) You can avoid paying the surcharge if you can attest that you completed a formal tobacco cessation program. For free help, go to **www.smokefree.gov** or call the National Cancer Institute phone line at 1-877-44U-QUIT (1-877-448-7848). To change your tobacco user status, contact the TI Benefits Center toll-free through TI HR Connect at 888-660-1411, option 1.

WHAT IT MEANS

- **Coinsurance:** The percentage you pay.
- **Copayment:** The dollar amount you pay.
- **Deductible:** The dollar amount you pay before coinsurance applies.

2014 TI DENTAL PLAN OPTIONS

More detailed information on all plans available at **netbenefits.com/ti**. **Deductible, copay and coinsurance reflect your part of the cost.**

Region in the U.S.	Nationwide	Nationwide	Availability based on location
	MetLife Dental Basic	**MetLife Dental Plus**	**Aetna DMO**
General dental expenses			
Annual deductible Individual/family	$50 per person (applies to basic and major services only)	$50 per person (applies to basic and major services only)	$0/$0
Annual maximums	$1,000	$2,000	N/A
Notes	You may receive treatment from any dentist. However, dentists in the MetLife Network must negotiate their rates, resulting in lower fees.[1]	You may receive treatment from any dentist. However, dentists in the MetLife Network must negotiate their rates, resulting in lower fees.[1]	$10 office visit copay applies for all treatment. Limitations and exclusions may apply to services.
Preventive care			
Primary covered services	Oral exam, preventive X-rays, cleanings	Oral exam, preventive X-rays, cleanings	Oral exam, preventive X-rays, cleanings
Preventive care benefits	0% coinsurance	0% coinsurance	0% coinsurance after $10 office visit copay
Basic services			
Fillings[2]	50% coinsurance	20% coinsurance	0% coinsurance after $10 office visit copay
Major services			
Crowns, dentures, bridges	50% coinsurance	40% coinsurance	40% coinsurance after $10 office visit copay
Endodontics	50% coinsurance	40% coinsurance	0% coinsurance after $10 office visit copay. Applies to anterior and bicuspid teeth. Molar teeth 40% coinsurance after $10 office visit copay.
Orthodontia services			
Benefits (adult/child)	50% coinsurance up to lifetime maximum of $1,000	50% coinsurance up to lifetime maximum of $1,500	50% coinsurance after $10 office visit copay

1 Limitations and exclusions may apply to services. Reasonable and customary (R&C) limits apply if you don't use a network provider.
2 The plan provides the alternate benefit of an amalgam filling for composite fillings performed on molar teeth.

Enroll online...

Go to **netbenefits.com/ti**. 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.

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More information about TI Extended Health Benefits Coverage is available in the *2014 Retiree Health Benefits Guide,* which you can order 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.

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More info for Medicare-eligible participants

Coordination of benefits – BCBS

If you have coverage under Medicare or another group health plan, the Blue Cross Blue Shield (BCBS) 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 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 *2014 Retiree Health Benefits Guide*, which you can view online at **netbenefits.com/ti** or request a copy by calling the TI Benefits Center.

UHC MedicareAdvantage HMO

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

- **For information about coverage,** contact UHC directly at 800-950-9355 for the Dallas-Fort Worth area or 888-867-5548 for Rhode Island. **For information about enrollment, premiums or payment,** contact the TI Benefits Center. Note: To enroll in the UHC MedicareAdvantage HMO you must call the TI Benefits Center at 888-660-1411, option 1. Enrollment cannot be completed online on NetBenefits. This is the only way you can enroll in UHC MedicareAdvantage offered through TI.
- **UHC MedicareAdvantage HMO** includes a Medicare prescription drug plan (Medicare Part D) for its prescriptions.
- **Centers for Medicare and Medicaid Services (CMS)** will not allow you to enroll in more than one Medicare Part D plan. If you enroll in the UHC MedicareAdvantage HMO through TI and another Medicare Part D plan, you could lose the UHC MedicareAdvantage coverage offered through TI. Depending on when you retired, you may not be able to re-enroll for TI coverage.
- **Since the UHC MedicareAdvantage HMO** is a plan governed by Medicare, it only permits coverage to start at the beginning of the month. If you enroll during annual enrollment, your coverage will begin Jan. 1, 2014. If you enroll outside of annual enrollment or make a permitted change in coverage, your new coverage will begin the first day of the month you become eligible for Medicare.

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.

Medicare Prescription Drug Program

Q: Can I be in TI's retiree medical coverage and also have Medicare Part D (Medicare Prescription Drug Program)?

A: No, this is not allowed.

Q: If I choose Medicare Part D, can my spouse or dependent who is not Medicare-eligible remain in TI's retiree medical coverage?

A: No. To maintain TI coverage for them, you also must remain in the TI plan.

Q. What happens if I accidentally enroll in both TI's medical coverage and Medicare Part D?

A: You will be dropped from TI retiree medical coverage. You may or may not be able to re-enroll based on these guidelines:

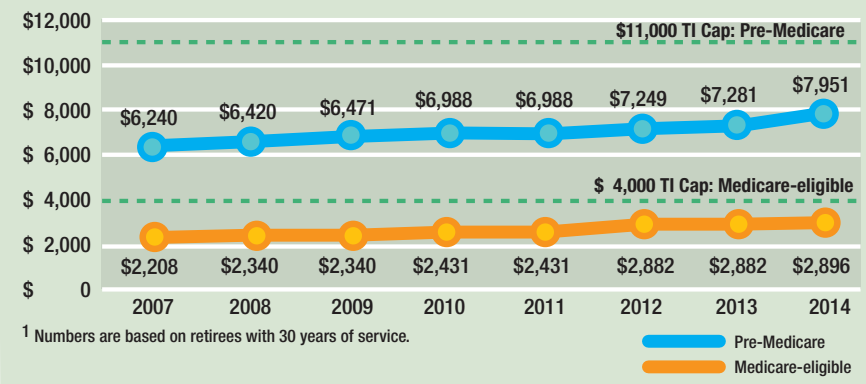
- If you terminated prior to Jan. 1, 1998, you will lose medical benefits for the remainder of the year, but will be eligible to re-enroll in TI coverage during any annual enrollment or within 30 days of an appropriate qualified status change.
- If you terminated on or after Jan. 1, 1998 you will not be able to re-enroll in TI coverage at any time.

For more information, refer to the *2014 Retiree Health Benefits Guide,* which you can view online at **netbenefits.com/ti** or request a copy by calling the TI Benefits Center.

2014 UPDATE

TI maintains maximum contribution levels

Rising health care costs are a significant challenge for TI as well as a financial issue for retirees. TI has set an annual maximum it will spend on retiree premiums, sometimes 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.



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 retirees with 30 or more years of service who retired after Dec. 31, 1992, the cap is currently $11,000 for pre-Medicare retirees and $4,000 for 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 the cap is reached, retirees will pay 100 percent of the costs above the 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.

The chart above illustrates TI's annual contribution to retiree medical premiums from 2007 through 2014, and differentiates between pre-Medicare and Medicare-eligible individuals.

For additional details on the cap, please go to the TI Alumni Association website at **tialumni.org.** At the top under Benefits, click "TI Health Plans." On the next page, click the last link, "TI Bulletin – Retiree Medical Cap."

Pay the easy way

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 website 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 the *2014 Retiree Health Benefits Guide,* which you can view online at **netbenefits.com/ti** or request a copy by calling the TI Benefits Center.

Q: How can I confirm my 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® website.

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 2014 in the coverage you had in 2013. If you have no coverage in 2013, you will be assigned no coverage in 2014.

Q: What if I'm currently in treatment?

A: If you change medical plans for 2014 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. Don't forget you can cover dependents up to age 26, regardless of marital or student status.

Q: Will I get new insurance ID cards?

A: Generally, you will receive new ID cards if you change insurance carriers. Carriers will mail new ID cards if needed in late December. If you have questions, contact your carrier toll-free through TI HR Connect at 888-660-1411, option 1.

Don't miss a monthly payment!

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 may not be eligible to re-enroll in a TI-sponsored health plan at any time.**