Texas Instruments

2018 Retiree Health Benefits Guide

With updates as of June 2018
(indicated by dark blue text)

Original version: September 2017

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IMPORTANT PHONE NUMBERS

CONTACT:	FOR INFORMATION ABOUT…	PHONE NUMBER/ WEB ADDRESS:
TI HR Connect	**One number to access benefit providers and obtain guidance from the TI Benefits Center**	**888-660-1411**
• Blue Cross Blue Shield (BCBS) HDHP and PPO A & B	Medical benefits and claim status	888-660-1411
• BCBS HDHP and PPO Pharmacy Network Administrator (CVS Caremark)	Pharmacy benefits and claim status	888-660-1411
• Cigna Copay Plan	Area Served - TX, NC, AZ, and Bryan, Love and Marshall counties of OK	888-660-1411
• MetLife Dental Basic/Dental Plus	Dental benefits and claim status	888-660-1411
• TI Benefits Center	Billings and coverage status	888-660-1411
Dental Health Maintenance Organization		
Aetna DMO	Dental benefits and claim status	800-772-1416
Medicare	Medicare benefits and claim status	800-633-4227
Social Security	Social Security benefits	800-772-1213
TI Alumni Association website	Retiree benefits	tialumni.org
Fidelity NetBenefits® website (TI Benefits website)	Access health information online	netbenefits.com/ti

CONTACT:	FOR INFORMATION ABOUT…	PHONE NUMBER/ WEB ADDRESS:
Via Benefits (formerly OneExchange)* – for participants age 65 or over	Individual medical and/or prescription drug insurance policies you can purchase	844-638-4642 My.ViaBenefits.com/TI
* Via Benefits customer service representatives are available Monday through Friday, from 8:00 a.m. to 9:00 p.m. Eastern time		
Regional Health Maintenance Organization (HMO)	**(AREA SERVED)**	**PHONE NUMBERS:**
Kaiser HMO	(Northern California)	800-278-3296

INTRODUCTION

This guide is the Summary Plan Description of Texas Instruments Incorporated's (TI's) Extended Health Benefits, offered through the TI Retiree Health Benefit Plan, as of January 1, 2018. Such coverage is available for (i) qualified TI retirees and their eligible dependents, (ii) qualified dependents of deceased TI retirees and (iii) qualified TI retirees formerly employed by National Semiconductor Corporation (NSC).

The Summary Plan Description is written in plain language to help you understand how the plan works. If there is a conflict between the information in this guide and the plan document (or insurance policy or contract for fully-insured benefits), the plan document will govern for self-insured benefits; and if applicable, the insurance policy or contract will govern for fully-insured benefits.

The guide has a summary of each benefit option that should answer many of your questions. It will explain:

- Who is eligible
- When coverage can start
- When coverage ends
- What is not covered
- How to file claims
- Who to contact for more information

The TI Retiree Health Benefit Plan is designed to provide a bridge to Medicare for employees who terminate employment before age 65.

LIFE EVENTS AND SPECIAL CIRCUMSTANCES SUMMARY

This summary outlines the steps you need to take and some things you should think about when events occur that could affect your coverage.

EVENT	ACTION REQUIRED	REMINDERS
An early retired TI employee (with coverage under a TI group retiree medical option) or enrolled spouse (or domestic partner) reaches age 65.	You or your spouse (or domestic partner) should contact Social Security three months before either of you reach age 65 to enroll in Medicare. Be sure to enroll in Medicare Parts A and B. You or your spouse (or domestic partner) can purchase an individual medical and/or prescription drug insurance policy through Via Benefits (formerly OneExchange). You or your eligible dependent must be enrolled in Medicare Parts A and B and maintain a permanent U.S. address, which cannot be in Puerto Rico, Guam or U.S. Virgin Islands.	You or your spouse's (or domestic partner's) coverage will no longer be provided directly through TI's group retiree coverage.

EVENT	ACTION REQUIRED	REMINDERS
A disabled retiree or dependent (with coverage under a TI group retiree medical option) under the age of 65 becomes eligible for Medicare.	You or your dependent will automatically be enrolled in the Medicare-eligible BCBS PPO option. Be sure to enroll in Medicare Parts A and B. Once you or your dependent have enrolled in Medicare Parts A and B and have received your Medicare card, contact Fidelity and if covered through the Blue Cross Blue Shield (BCBS) PPO, you will need to call and tell them that you want to verify that they have your, or your dependent's, Medicare information in their system. At that time, they will ask you for your, or your dependent's, Medicare number (which Medicare calls the Medicare Claim Number) located on your, or your dependent's, Medicare card. They will also ask for the Medicare effective date.	Once you or your dependent have enrolled in Medicare, all your medical claims must be filed with Medicare first. No claim under the BCBS PPO will be accepted until your Medicare claim has been processed. If you or your dependent does not enroll in Medicare Part B, the BCBS PPO will continue to pay second and BCBS will estimate the portion that would have been paid by Medicare when determining what part of the claim has not been paid to determine what the Plan pays. If you or your dependent previously declined enrollment in Medicare Part B you should consider enrolling in Medicare Part B immediately to minimize Medicare's late enrollment penalty and your share of medical costs when this Plan pays its benefits.

EVENT	ACTION REQUIRED	REMINDERS
You die while enrolled in TI group retiree medical or dental coverage.	The survivor should contact the TI Benefits Center through TI HR Connect	Your surviving spouse and any eligible dependents may be able to continue coverage. However, if your surviving spouse remarries, your surviving spouse's coverage WILL END and the surviving spouse WILL NOT be eligible to continue coverage under COBRA.
You become divorced while enrolled in TI group retiree medical or dental coverage.	Contact TI Benefits Center through TI HR Connect Your former spouse's coverage stops on the date of the divorce — see the COBRA section.	If you remarry, you may enroll your new spouse in TI group retiree medical or dental within 30 calendar days of your marriage.
You move.	Contact TI Benefits Center through TI HR Connect	If you are covered by a regional HMO and move out of that HMO's service area, you may enroll in the Blue Cross Blue Shield PPO or HDHP, Cigna Copay Plan (if available in your area) or a regional HMO (if available in your area). In such cases, you must contact TI Benefits Center through TI HR Connect within 30 calendar days of your move.
You have a question about your TI Retiree Health Benefit Plan bill.	Contact TI Benefits Center through TI HR Connect.	TI Benefits Center sends out all TI group retiree medical and dental coverage bills.

ELIGIBILITY

TI Extended Health Benefits provides access to TI group retiree medical and/or dental coverage after leaving TI for those under age 65. Via Benefits (formerly OneExchange), a private exchange, provides access to purchase an individual medical, prescription drug and/or dental insurance policy after leaving TI for those ages 65 or over. When you terminate employment from TI, you may be eligible for TI Extended Health Benefits or Via Benefits. TI Extended Health Benefits are offered through the TI Retiree Health Benefit Plan for those under age 65. Via Benefits offers individual insurance policies for those ages 65 or over. For more information on Via Benefits, see section beginning on page 180.

Eligibility for TI Extended Health Benefits or Via Benefits

If you were hired into TI or acquired by TI prior to January 1, 2018, you must meet one of the following requirements upon termination of employment to be eligible for TI Extended Health Benefits:

- 20 years of service
- At least age 55 and have ten years of service
- At least age 65

If you were employed by National Semiconductor Corporation (NSC) on September 23, 2011, and you were at least age 52 and had completed at least two years of service as of such date**,** you must meet one of the following requirements upon termination of employment to be eligible for TI Extended Health Benefits:

- 20 years of service
- At least age 55 and have five years of service
- At least age 65

If you were hired into TI or acquired by TI on or after January 1, 2018, you must meet one of the following requirements upon termination of employment to be eligible for TI Extended Health Benefits:

- At least age 55 and have ten years of service
- At least age 65

Your service date is the date used to determine your eligibility for TI Extended Health Benefits.

A ***year of service*** is defined as each year that you are employed as an employee of TI from your date of employment to the following year's anniversary of the date of employment. If you were employed by NSC on September 23, 2011, your years of service at NSC count toward your years of service with TI.

If you have any questions about your eligibility, you should contact the TI Benefits Center via TI HR Connect.

IMPORTANT NOTES:

- For those under age 65, if you meet the above requirements to be eligible for TI Extended Health Benefits, you must enroll within 30 calendar days of the date you terminate employment or forego eligibility in the future. Your active TI coverage ends on your termination date.
- For those ages 65 or over, or eligible for split-family coverage, if you meet the above requirements to be eligible for TI Extended Health Benefits, you must be eligible for and purchase an individual medical and/or prescription drug insurance policy through Via Benefits within 60 calendar days of the date on which you terminate employment. Enrollment within this 60-calendar-day period is also required for TI to contribute annually to a Retiree Reimbursement Account (RRA) for those eligible to receive such a contribution. Your active TI coverage ends the last calendar day of the month, following the month of your termination. This extension of your active TI coverage allows you to enroll in Medicare benefits and purchase an individual policy through Via Benefits. For more information on Via Benefits, see section beginning on page 180.

Re-employment After Termination of Employment and Enrollment in TI Extended Health Benefits

For those rehired on or after January 1, 2018: If you are rehired and you were enrolled in TI Extended Health Benefits at the time of rehire, your coverage under TI Extended Health Benefits terminates and you may be eligible for active health benefits. When you terminate employment again, **you may no longer have access to coverage** under TI Extended Health Benefits or Via Benefits. In order to have access to such coverage, you must be at least age 65 or at least age 55 with ten years of service (service is counted from your date of rehire) when you terminate employment again.

For those rehired prior to January 1, 2018: If you are rehired as an employee eligible for active benefits after you terminated employment and elected TI Extended Health Benefits, you will no longer be eligible for TI Extended Health Benefits, effective immediately upon the date of your rehire. You may be eligible

for TI Extended Health Benefits or Via Benefits when you terminate employment again. The retirement eligibility status in effect at the date of your original termination of employment will apply to your subsequent termination of employment. You may qualify for additional years of service.

For more information about your coverage after your subsequent termination of employment, contact the TI Benefits Center.

Other Important Information

Eligibility and plan rules for TI Extended Health Benefits under the TI Retiree Health Benefit Plan may differ from the eligibility and plan rules for pension benefits under the TI Employees Pension Plan. Therefore, satisfaction of the eligibility requirements under the TI Employees Pension Plan will not automatically provide eligibility for TI Extended Health Benefits offered through the TI Retiree Health Benefit Plan. TI Extended Health Benefits medical and/or dental coverage is not tied or related to benefits under the TI Employees Pension Plan and the coverage under the TI Retiree Health Benefit Plan may terminate or cease prior to payments ceasing under the TI Employees Pension Plan.

TI Extended Health Benefits offered through the TI Retiree Health Benefit Plan may be changed or discontinued in the future. See TI's Right to End or Change the Plans later in this section.

Eligible Dependents

For each eligible dependent, you must provide dependent's name, date of birth and U.S. Social Security Number (SSN) or an Internal Revenue Service Individual Taxpayer Identification Number (ITIN) to receive benefits. You may be required on an annual basis to provide a certification or other proof that your eligible dependents qualify as such under TI's Extended Health Benefits. The Plan Administrator reserves the right to determine the documentation that is necessary to support or prove eligibility.

The types of persons who may be your eligible dependents include the following, but the requirements may vary by benefit:

- **Spouse:** Your "spouse" as recognized under U.S. federal tax law, or
- **Domestic Partner:** Your domestic partner of the same or opposite gender who meets the following criteria:
    - At least 18 years or older,
    - Unmarried,
    - Not be related by blood,

    - Financially interdependent or your domestic partner is primarily dependent on you for care and financial support,
    - Share a common residence for at least one year and intend to do so indefinitely,
    - Affirm you are in a committed relationship and intend to remain so, and
    - Not in a relationship to solely attain benefits.
- **Children:** Your children who meet one of the following requirements:
    - Your biological children including those who do not live with you, but for whom you have parental rights,
    - Legally adopted children or children for whom adoption papers were filed,
    - Stepchildren who live with you in a parent-child relationship at least 50% of the time and for whom you have financial responsibility as determined by U.S. federal tax law,
    - Children of your domestic partner living with you in a parent-child relationship and for whom you have assumed legal responsibility,
    - A child for whom you are legal guardian or managing conservator,
    - A foster child, placed in your care by a court,
    - A child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice, or
    - Your grandchildren who live with you and are claimed by you as dependents on IRS tax filings.

Domestic Partner

TI retirees can enroll their eligible domestic partners in TI group retiree medical and/or dental benefits. The retiree, however, must be enrolled in a TI group retiree medical and/or dental option for the domestic partner coverage to be effective.

If you choose to cover a domestic partner, under any benefits, who is not your dependent for tax purposes and/or their dependents, the value of the company's cost in providing such coverage will be imputed to you as income and reported to the IRS.

If you and your domestic partner get married, you must notify TI Benefits Center within 30 calendar days of your marriage to avoid having income unnecessarily imputed to you and reported to the IRS, increasing your U.S. federal income taxes.

Children - Eligibility for Extended Medical and/or Dental Benefits

Your eligible dependent children for purposes of participation in extended medical and/or dental benefits under the TI Retiree Health Benefit Plan include your son or daughter (including your biological child, stepchild, adopted or foster child, child of your domestic partner, or other child as defined above) who is under age 26.

Extended Medical and/or Dental Benefits If Your Dependent Child is Disabled

Dependent children 26 years of age or older who are physically or mentally disabled may continue to be covered under the TI Retiree Health Benefit Plan after the child otherwise ceases to meet the definition of an eligible dependent child, provided they were covered as dependents on the calendar day before their 26th birthday and if the disability occurred before the time that their status as a dependent child would otherwise end. Coverage is subject to approval. Contact the TI Benefits Center to find out how to apply for coverage.

Qualified Status Change Events

You can only make appropriate changes in your TI group retiree medical and/or dental coverage, or add dependents, as follows:

- Within 30 calendar days of your termination of employment
- Within 30 calendar days of a qualified status change, which includes:
    - Changes in legal marital status (marriage, judgment, decree or order resulting from a divorce, legal separation or annulment)
    - Changes in number of dependents (excluding birth or adoption)
    - Changes in employment status (yours, spouse's or domestic partner's)
    - Changes in dependent eligibility (meets or fails to meet eligibility requirements)
    - Significant changes in cost of health coverage
    - Loss of other health plan coverage, including reaching a plan's lifetime limit on all benefits (yours, spouse's, domestic partner's or dependents)
    - Changes in residence of the retiree, spouse or domestic partner, or dependent (move out of an HMO's coverage area)
    - Entitlement to Medicare or Medicaid by the retiree, spouse or domestic partner, or dependent
    - Significant curtailment of TI group retiree health coverage

    - Loss of coverage under a governmental plan or educational institution plan, excluding the State child health insurance program (CHIP) or Medicaid program
    - Changes in legal custody that require health coverage for a child (including a Qualified Medical Child Support Order or a National Medical Support Notice)
    - Death of a spouse or domestic partner/dependent
    - Spouse or domestic partner, or dependent goes on or returns from a strike or lockout
    - Exhaustion of all available COBRA coverage for a spouse or domestic partner/dependent
    - Change made by spouse or domestic partner/dependent during annual enrollment for plan of the spouse or domestic partner/dependent
- Within 60 calendar days of a qualified status change, which includes:
    - Loss of coverage or become eligible to participate in a premium assistance program under Medicaid or a State child health insurance program
    - Adding a newborn or adopted child (qualified status change begins on the date of birth, date of adoption or date adoption papers were filed)

    Note: Changes in coverage must be consistent with the change in status and may only be effective consistent with the requirements imposed by the IRS.
- Each year during annual enrollment

You may make appropriate changes to coverage, which are effective retroactive to the date of the qualified status change, by processing the Life Event change on the Fidelity NetBenefits® website at netbenefits.com/ti or by contacting the TI Benefits Center. After you have made the appropriate changes, you should print your “Confirmation of Benefit Election” page for your records, as this will serve as your confirmation. You can drop dependents at any time, however you can only re-enroll eligible dependents during any annual enrollment period or by notifying the TI Benefits Center through TI HR Connect within 30 or 60 calendar days depending on the type of qualified status change, as long as you remain enrolled in the TI plan. Your dropped dependents will only be eligible for COBRA continuation coverage if they meet certain requirements. For more information, see the COBRA Qualifying Events section beginning on page 195.

Approaching age 65

Prior to your 65th birthday, Via Benefits will send you – or your spouse (or domestic partner) – information about enrolling in individual insurance policies that are available to those who are age 65 or over. The information contains instructions for purchasing the individual medical and/or prescription drug insurance policy of your choice through Via Benefits. For more information on Via Benefits, see section beginning on page 180.

Split-family coverage

A “split-family” occurs when one family member is age 65 or over and the other is under age 65.

After you reach age 65, your eligible dependents under age 65 may be covered under the TI Retiree Health Benefit Plan as long as you continuously purchase an individual medical or prescription drug policy through Via Benefits.

If you are under age 65, but your eligible spouse (or domestic partner) is age 65 or over, he/she is eligible to purchase an individual medical, prescription drug or dental insurance policy through Via Benefits, as long as he/she continues to be eligible for dependent coverage.

For more information on Via Benefits, see section beginning on page 180.

IMPORTANT NOTES: If your TI group retiree medical and dental coverage is dropped for any reason, you and your eligible dependents under the age of 65 will permanently lose TI group retiree medical and dental coverage and you and your eligible dependents WILL NOT be eligible to enroll again at any time in the future.

If your individual medical and prescription drug insurance policy at Via Benefits is dropped for any reason (e.g., you decide to not pay the premium or you purchase a medical and/or prescription drug policy outside of Via Benefits), your eligible dependents under the age of 65 will permanently lose their TI group retiree medical and dental coverage and they WILL NOT be eligible to enroll again at any time in the future.

Please see page 182 for additional information regarding Retiree Reimbursement Account (RRA) eligibility and contributions.

Eligibility Claim Appeal Information

You may designate a representative or provider to act on your behalf only to pursue a claim for a benefit. You must pursue any claim for any other right you have under ERISA, including a claim related to your eligibility, on your own. This means you cannot assign to a health care provider your right to receive any penalty related to any delay or failure to provide plan documents or any claim related to a breach of fiduciary duty or to enforce ERISA. Your designation of a representative must be in writing. For more information about how to designate a representative, you may call the Claims Administrator through TI HR Connect at 888-660-1411.

This Summary Plan Description does not address the treatment of claims for eligibility involving an HMO, as these claims are administered solely by the HMO Claims Administrator. Details about such eligibility claim procedures can be obtained directly from the HMO.

Claims for Eligibility

Claims for eligibility relate to whether you, your spouse, your domestic partner or one of your dependents (or your domestic partner's dependents) is enrolled in or covered under TI group retiree medical and/or dental benefits. Examples of claims for eligibility include claims regarding whether you are enrolled in the correct benefit option and claims related to whether you properly and timely enrolled any new dependent. Claims for eligibility do not address whether a particular treatment or benefit is covered under a benefit plan.

How to Appeal an Eligibility Claim Denial

First Level of Appeal of Eligibility Claim Denial

If you believe you or your dependent was incorrectly denied eligibility for TI group retiree medical and/or dental benefits, you may request your claim be reviewed. To appeal, you will need to provide in writing the reasons why you do not agree with the determination within 180 calendar days after you receive notice of the denial based on eligibility. Send your appeal to:

TI Benefits Center
P.O. Box 770003
Cincinnati, OH 45277-1060

You may ask to review your file and any relevant documents and may submit written issues, comments and additional information.

Notice of an Adverse Benefit Determination - If a First Level Appeal for Eligibility Claim Is Denied

You may receive an Adverse Benefit Determination from the Plan Administrator on your first level appeal. An "**Adverse Benefit Determination**" means a denial, reduction, or termination of a benefit that is based on eligibility for coverage or covered benefit status.

This determination will be provided within 60 calendar days of receipt of your first level appeal. If this occurs, you will receive a written notice from the Plan Administrator with the following information:

- The reasons for determination;
- A reference to the plan provisions on which the determination is based, or the contractual or administrative guidance relied upon for the determination;
- A description of additional information which may be necessary and an explanation of why such material is necessary (if applicable);
- An explanation of the internal review/appeals process (and how to initiate a review/appeal) and a statement of your right, if any, to bring a civil action under Section 502(a) of ERISA following a final denial on internal review/appeal;
- The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim for eligibility;
- Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such documentation will be provided free of charge upon request; and
- In the case of a denial of an eligibility claim related to an individual needing urgent care or an expedited clinical claim, a description of the expedited review procedure applicable to such claims.

Second Level of Appeal of Eligibility Claim Denial

If you believe the Plan Administrator incorrectly made an Adverse Benefit Determination on your, or your dependent's, eligibility, you may request your claim be reviewed for a second time. To appeal, you will need to provide in writing within 90 calendar days after you receive notice of the Adverse Benefit Determination on eligibility the reasons why you do not agree with the determination and any issues, comments and additional information related to your appeal.

The Administration Committee is the appointed Plan Administrator for purposes of second level claim appeals related to eligibility. Send your appeal to:

TI Benefits Center
P.O. Box 770003
Cincinnati, OH 45277-1060

You may ask to review your file and any relevant documents.

Notice of Final Adverse Benefit Determination - If a Second Level Appeal for Eligibility Claim Is Denied

A representative of the Administration Committee will provide you with written notice of the final determination. This determination will be provided within 60 calendar days of receipt of your second level appeal.

You may receive a Final Adverse Benefit Determination on behalf of the Administration Committee. If this occurs, the notice of Final Adverse Benefit Determination will contain the information (if applicable) described in the Notice of an Adverse Benefit Determination - If a First Level Appeal for Eligibility Claim Is Denied section above.

External review is not available for eligibility claims.

If You Need Assistance

If you need assistance with the eligibility claim review processes, you may call the Texas Instruments eligibility claims and appeals unit managed by Fidelity at 877-208-0936, Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 a.m. and 8:30 p.m. Eastern time.

Legal Action under U.S. Federal Laws

If your eligibility claim is denied after you have used all of your required appeal rights under the benefit plan, you have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, in federal court.

Any civil action must be brought within the earlier of three (3) years from the date on which the eligibility claim was made (for example, when coverage of the service, the supply or prescription was denied due to eligibility), or within one (1)

year of the date such claim was denied in the final level of the appeal process outlined above. You may not file a civil action after the expiration of this deadline.

Other Important Information

ERISA Information

In addition to your rights and obligations under this retiree health plan, you also have certain rights under the Employee Retirement Income Security Act of 1974 (ERISA). These rights are explained in the ERISA section. Plans governed by ERISA will be designated as such.

TI's Right to End or Change the Plans

This plan has been established with the intention of being maintained for an indefinite period. However, TI, as the Plan Sponsor, has the right to cancel or change the plan or provisions.

Plan Interpretation

TI reserves the right to interpret any ERISA-governed benefit plan and its benefit options (excepting only decisions on benefit coverage in the fully-insured benefits), including the plan document and/or contracts. In some of the benefit options, the right to interpret the terms of the option will be exercised by an entity other than TI. Nevertheless, such discretionary interpretations of the benefit plan (including any policies or procedures under which it is operated) will be final and binding.

In no event may any representations by any person change the terms of the benefit plan. If you are in doubt about benefit provisions, contact the designated Plan or Claims Administrator.

MEDICAL — Blue Cross Blue Shield High Deductible Health Plan and PPOs, Cigna Copay (Open Access Plus In-Network) Plan and Regional HMOs for Participants under age 65

ERISA PLAN, offered through the TI Retiree Health Benefit Plan

A Quick Look

Pre-Medicare Blue Cross Blue Shield (BCBS) PPOs

You may choose from two BCBS Preferred Provider Organization (PPO) options: PPO A or PPO B. The difference between these options is the deductible amounts, out-of-pocket maximums and the cost for coverage. See page 37 for more details. If a non-network hospital is used, a hospital copay of $300 applies to an individual once each calendar year for inpatient medical/surgical expenses. The hospital copay is in addition to your deductible and coinsurance.

Pre-Medicare Blue Cross Blue Shield (BCBS) HDHP

The individual medical deductible is $1,500 per calendar year. The family deductible is $3,000. The TI group retiree HDHP option offers different medical benefits than the TI group active HDHP option. See page 39 for more details.

A Health Savings Account (HSA) is a tax advantaged account that you can put money into to save for future medical expenses. TI does not make any contributions on behalf of a retiree to an HSA. If an individual established an HSA with Fidelity HSA Services while employed by TI, such individual may continue to contribute to this account. An individual may also establish an HSA by working directly with any financial institution offering this product. To be eligible for an HSA, an individual must be covered by an HDHP, must not be covered by other health insurance (does not apply to specific injury insurance and accident, disability, dental care, vision care, long-term care), must not be eligible for Medicare and cannot be claimed as a dependent on someone else's U.S. federal income tax return.

Pre-Medicare Cigna Copay Plan

Key features of the Cigna Copay Plan are highlighted below. You will find more detailed information on the following pages.

- Network name: Cigna Open Access Plus In-Network (OAPIN)
- Offered to participants residing in TX, NC, AZ and in Bryan, Love and Marshall counties of OK
- You do not have to designate a Primary Care Physician, but you still have to access treatment from a network provider and out-of-network treatment is only covered in the event of an emergency

- Dependents living in another city may access treatment from a Cigna OAPIN contracted provider without having to establish “guesting” arrangements
- Most services are available after payment of a set dollar copay
- No out-of-pocket maximum required

Pre-Medicare Regional HMOs

- Key features of the regional HMOs (if available in your area) can be viewed during enrollment on the Fidelity NetBenefits® website at netbenefits.com/ti. You can also call the regional HMO directly.
- The list of available regional HMOs and contact information can be found in the Important Phone Numbers chart, at the beginning of this guide.

Medicare-Eligible Blue Cross Blue Shield PPO

- There is an individual $500 per person calendar year deductible for medical coverage. The family deductible is $1,000.
- If a non-network hospital is used, a hospital copay of $300 applies to an individual once each calendar year for inpatient medical/surgical expenses. The hospital copay is in addition to your deductible and coinsurance.

Pre-Existing Conditions

The plan does not impose any limitations or exclusions based on pre-existing conditions.

Enrollment and Maintaining Your Coverage

If you are eligible for TI Extended Health Benefits, you and your eligible dependents can obtain TI group retiree medical coverage through the BCBS HDHP (if you and your dependents are pre-Medicare), BCBS PPOs, Cigna Copay Plan (if available in your area) or a TI-sponsored regional HMO (if available in your area) on the first calendar day following your termination of employment. To cover yourself and your eligible dependents, you must make an election on the Fidelity NetBenefits® website at netbenefits.com/ti or contact the TI Benefits Center through TI HR Connect within 30 calendar days of your termination of employment date.

To have TI group retiree medical coverage offered through the TI Retiree Health Benefit Plan, you must elect TI Extended Health Benefits within 30 calendar days from the date you terminate employment or forego eligibility in the future. You may not opt in and out of TI Extended Health Benefits; once you elect it, you must continue paying costs without lapse in order to maintain coverage. If you don't enroll in TI group retiree dental coverage through TI Extended Health

Benefits within 30 calendar days from the date you terminated employment, you'll be eligible to enroll for TI group retiree dental coverage later (during annual enrollment or in the event of an appropriate qualified status change) as long as you're enrolled in TI group retiree medical coverage through TI Extended Health Benefits.

If you elect coverage, you may also enroll your eligible dependents, unless they are eligible for coverage under another health plan. In this case, you may not cover your dependents under this plan. If a dependent loses eligibility for coverage at a later date, it will be considered a qualified status change, and you may enroll the dependent at that time, as long as you remain enrolled in TI Extended Health Benefits. You may also add an eligible dependent during any annual enrollment period.

If You Do Not Enroll

If you do not make an election within 30 calendar days of your first eligibility for the TI Retiree Health Benefit Plan, you WILL NOT be eligible to enroll in the TI Retiree Health Benefit Plan again and your eligibility will be permanently lost.

If you do not make an election during annual enrollment, you will automatically be enrolled in the coverage you had the previous calendar year. If you elect no coverage, your eligibility will be permanently lost.

If your TI group retiree medical option is no longer available for the new calendar year and you do not make an election, you will automatically be enrolled in the BCBS PPO B option at the level of coverage (for example, you + family) you had the previous calendar year. The design is shown in detail on page 37 for medical and page 76 for prescription drugs.

If you want to drop coverage, you must contact TI Benefits Center through TI HR Connect.

IMPORTANT NOTE: If you elect to drop TI group retiree medical coverage at any time for yourself, you WILL NOT be eligible to re-enroll in TI group retiree medical coverage at any time. If you drop coverage for your eligible dependents you will be able to re-enroll them during any annual enrollment period or within 30 calendar days of an appropriate qualified status change, as long as you remain enrolled in TI group retiree medical coverage offered through TI Extended Health Benefits.

NOTE: *If you are hospitalized at the end of a calendar year and your hospital stay continues or will continue into the next calendar year, you should contact*

your medical HDHP/PPO/regional HMO insurance carrier to understand what process you should follow to be sure your medical expenses will be covered.

When You Can Change to a Different Coverage

You may change to a different coverage only during annual enrollment or when you move away from the geographic area served by the regional HMO or the area served by the Cigna Copay Plan.

When You Can Make Changes

During the annual enrollment period or within 30 or 60 calendar days depending on the type of qualified status change, you may make changes in TI group retiree medical coverage. Please see the Eligibility section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement.

Effective Date of Coverage

Retiree

Coverage for you, provided you enroll within the first 30 calendar days of your termination of employment, takes effect retroactive to your termination of employment date.

Dependents

Coverage for your dependent(s), provided you enroll them within the first 30 calendar days of your termination of employment, takes effect retroactive to your termination of employment date.

If adding coverage subject to an appropriate qualified status change, provided you enroll your eligible dependent within 30 or 60 calendar days depending on the type of qualified status change, coverage takes effect retroactive to the date of the qualified status change. Please see the Eligibility section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement. The next opportunity to add coverage, absent a change in coverage consistent with a qualified status change, will be during annual enrollment. Changes made during annual enrollment are effective on the first calendar day of the calendar year following annual enrollment.

If terminating coverage due to an appropriate qualified status change, coverage is terminated retroactive to the date of the qualified status change, provided you

notify the TI Benefits Center within 30 or 60 calendar days depending on the type of qualified status change. Please see the Eligibility section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement.

Newborn or Adopted Children

To add coverage for a newborn or adopted child, coverage must be elected within 60 calendar days from the date of birth, date of adoption or date adoption papers were filed. You must enroll your child on the Fidelity NetBenefits® website at netbenefits.com/ti or contact the TI Benefits Center. The next opportunity to add coverage, absent a change in coverage consistent with a qualified status change, will be during annual enrollment. Changes made during annual enrollment are effective on the first calendar day of the calendar year following annual enrollment.

Cost — Who Pays

If you terminated employment on or before January 4, 1993 – TI pays part of the cost for TIers who terminated employment on or before January 4, 1993 with five or more years of service and 50 percent of the cost for their covered dependents. Retirees who terminated employment with TI on or before January 4, 1993 with less than five years of service must pay the entire cost for themselves and their dependents. You will also be responsible for deductibles, copays and coinsurance payments and any expenses above the Allowable Amount for a Non-Network provider.

If you terminated employment after January 4, 1993 and were hired before January 1, 2001 – If you have less than 15 years of service at the time you terminated employment, you must pay the entire cost for TI Extended Health Benefits. If you have 15 or more years of service, you will receive a TI contribution toward your medical cost. This TI contribution increases with each year of service. TIers who terminated employment with 30 years of service or more will receive the largest TI contribution. Covered dependents must pay the entire cost. You will also be responsible for deductibles, copays and coinsurance payments and any expenses above the Allowable Amount for a Non-Network provider.

If you were hired on or after January 1, 2001 and prior to January 1, 2018 – If you were hired on or after January 1, 2001 and prior to January 1, 2018 you will have access to TI Extended Health Benefits if you meet one of the following requirements upon termination:

- 20 years of service
- At least age 55 and have ten years of service
- At least age 65

You must pay the entire cost for your coverage and coverage for your eligible dependents. TI will not make any financial contribution toward plan costs. You will also be responsible for deductibles, copays and coinsurance payments and any expenses above the Allowable Amount for a Non-Network provider.

If you were hired on or after January 1, 2018 – If you were hired on or after January 1, 2018 you will have access to TI Extended Health Benefits if you meet one of the following requirements upon termination:

- At least age 55 and have ten years of service
- At least age 65

You must pay the entire cost for your coverage and coverage for your eligible dependents. TI will not make any financial contribution toward plan costs. You will also be responsible for deductibles, copays and coinsurance payments and any expenses above the Allowable Amount for a Non-Network provider.

If you were employed by NSC on September 23, 2011, and you are eligible for and elect TI Extended Health Benefits, you will have access to coverage for you and your eligible dependents. You must pay the entire cost for your coverage and the coverage for your eligible dependents. TI will not make any financial contribution toward plan costs. You will also be responsible for deductibles, copays and coinsurance payments and any expenses above the Allowable Amount for a Non-Network provider.

For the above to apply, you must be eligible for and elect TI Extended Health Benefits, as discussed in the Enrollment and Maintaining Your Coverage section above.

This cost-sharing policy may change at any time.

A ***year of service*** is defined as each year that you are employed as an employee of TI from your date of employment to the following year's anniversary

of the date of employment. If you were employed by NSC on September 23, 2011, your years of service at NSC count toward your years of service with TI.

IMPORTANT NOTE*:* If you fail to submit monthly payments within 30 calendar days of the due date, your coverage will end retroactive to the last calendar day of the last month for which payment was received.
If your coverage is dropped because of non-payment, you WILL NOT BE ELIGIBLE to re-enroll in a TI health option at any time.

Use of Tobacco Products

Retirees, covered spouses or domestic partners who use tobacco products pay an additional health care cost. There will be an additional charge of $30 per month for each covered adult tobacco user, with a maximum of $60 per month. You are considered a user of tobacco products if you use cigarettes, e-cigarettes, cigars, pipes or smokeless tobacco (snuff). Tobacco use is defined as any legal use of any tobacco product on average four or more times per week within the last six months (this does not include religious or ceremonial use). You must be tobacco-free for six months before you are considered a non-user. If it is unreasonably difficult due to a health factor for you, your covered spouse or domestic partner to meet the requirement to be tobacco-free for six months (or if it is medically inadvisable for you to attempt to stop using tobacco products), you must complete a formal tobacco cessation program (or request an alternative standard from the Plan Administrator) to avoid this additional cost.

Retirees that would like help with tobacco cessation can access help online or over the phone.

Online:

Free step-by-step “Quit Guide” can be accessed at smokefree.gov

Telephone:

For help from the National Cancer Institute: 1-877-44U-QUIT (1-877-448-7848)

The National Cancer Institute’s trained counselors are available to provide information and help with quitting in English or Spanish, Monday through Friday, 8:00 a.m. to 8:00 p.m. Eastern time.

For help from your state quit line: 1-800-QUIT-NOW (1-800-784-8669).

Calling this toll-free number will connect you directly to your state quit line. All states have quit lines in place with trained coaches who provide

information and help with quitting. Specific services and hours of operation vary from state to state.

You can avoid paying the tobacco surcharge if you can attest that you have completed a formal tobacco cessation program, regardless of whether you actually stop using tobacco products. To change your tobacco user status, contact the TI Benefits Center.

Women's Health and Cancer Rights Act (WHCRA)

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- All stages of reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Treatment of physical complications of the mastectomy, including lymphedema.

These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this plan.

If you would like more information on WHCRA benefits, call your Plan Administrator through TI HR Connect at 888-660-1411.

Extended Medical - Blue Cross Blue Shield HDHP and PPOs

The following explanations pertain to coverage in both the Blue Cross Blue Shield (BCBS) HDHP and PPO options. When coverage is different, it will be noted in a chart format.

Deductibles and Coinsurance

A deductible is the amount you must pay for eligible expenses each calendar year before most benefits begin. Coinsurance is the percentage that you must pay for your eligible medical expenses after you meet your deductible (unless otherwise noted). Any costs not covered by the coinsurance are your responsibility, and you must pay this amount. Coinsurance amounts will depend on how, where and the kind of treatment provided. For an explanation of out-of-pocket expenses for medical or surgical treatment and for out-of-pocket expenses for behavioral health care treatment, call BCBS through TI HR Connect at 888-660-1411. Your out-of-pocket expenses will be less if you use network providers.

The out-of-pocket maximum is the annual limit you will pay for most eligible expenses after the deductible is met. Some additional expenses are not applied toward the deductible or out-of-pocket maximum. For additional information, please see the footnotes included on pages 37-38 and 41-42 in the chart "Deductibles, Copays and Coinsurances in the BCBS PPOs" and on pages 39-40 in the chart "Deductibles, Copays and Coinsurances in the BCBS HDHP".

	HDHP	PPOs
Deductible accumulation	You Only coverage has an individual deductible. If family coverage is elected, the family deductible may be satisfied by one participant or a combination of two or more participants. The family deductible must be satisfied before any copays or coinsurance are applied for the remainder of that calendar year.	You Only coverage has an individual deductible. If family coverage is elected, no individual will contribute more than the individual deductible. The individual deductible must be satisfied before any copays or coinsurance are applied for the remainder of that calendar year. When the family deductible is reached, no further individual deductible will have to be satisfied for the remainder of that calendar year.

	HDHP	PPOs
Out-of-pocket accumulation	You Only coverage has an individual out-of-pocket maximum. If family coverage is elected, the family out-of-pocket may be satisfied by one participant or a combination of two or more participants. The family out-of-pocket must be satisfied before any charges are payable at 100% for the remainder of that calendar year.	You Only coverage has an individual out-of-pocket maximum. If family coverage is elected, no individual will contribute more than the individual out-of-pocket. The individual out-of-pocket must be satisfied before any charges are payable at 100% for the remainder of that calendar year. When the family out-of-pocket is reached, no further individual out-of-pocket will have to be satisfied for the remainder of that calendar year.
Application of deductible to out-of-pocket maximum	Deductibles apply to the out-of-pocket maximum	Deductibles apply to the out-of-pocket maximum
Pharmacy expenses applied to deductible	Applied to combined medical/behavioral health/pharmacy deductible	No deductible
Pharmacy expenses applied to out-of-pocket maximum	Applied to combined medical/behavioral health/pharmacy out-of-pocket maximum	Separate out-of-pocket maximums for medical/behavioral health and for pharmacy

Networks

BCBS network providers offer care to retirees and covered family members at negotiated rates. Network providers have agreed to a negotiated rate, which results in lower fees. By having negotiated rates, you and TI pay less for health care.

Network Provider Verification

There are several ways to access or verify network health care providers:

- Call BCBS through TI HR Connect at 888-660-1411 or by logging on to bcbstx.com
    - If you contact BCBS, you may need to specify the Blue Choice PPO network. This applies to both the HDHP and PPO options.
- Contact the provider directly by phone or through their website which may be located by using bcbstx.com
- View the listing of network providers (including doctors, hospitals, and pharmacies) which can be found on the Fidelity NetBenefits® website at netbenefits.com/ti. You can search for a provider based on defined criteria or by the provider name.

Network providers/locations are subject to change without notice.

Network/Non-Network

If you live in or receive care in a location with a network, your benefits will be paid based on your selection of a network or non-network provider. This applies to all non-emergency inpatient, outpatient or pharmacy services. However, if non-network labs or radiology services are used, when in connection with services requested by a network provider, your benefits will be reimbursed at the in-network benefit level.

When you travel, you must use a network provider for non-emergency care in order to receive network reimbursement. If you use non-network providers, your benefits will be reimbursed at the non-network level (See section on Emergency Care for information on using non-network providers in an emergency situation).

Network providers have agreed to file the claim and accept a negotiated rate, which results in lower fees for you and TI. The listing of Network providers can be found on bcbstx.com.

Notes:

- "Provider" is defined as anyone who is licensed and provides medical services within the scope of their license — hospitals, doctors, and outpatient care centers.
- Network or negotiated rates apply to expenses that are covered under the BCBS HDHP and PPOs. Network or negotiated rates do not apply to non-covered expenses.

Your Benefits

What is Covered under the BCBS HDHP and PPO Options

These options cover only those services for medical, surgical and behavioral health care that meet the following conditions:

- The service rendered is medically necessary for the treatment of your injury, disease or pregnancy
- The service rendered is delivered by an eligible provider (for medical this is a licensed physician acting within the scope of his license, not a resident physician or intern; for behavioral health this is a licensed physician, Ph.D. psychologist, licensed professional counselor, licensed marriage and family therapist, or masters of social work)
- The service rendered is covered under the plan

Medically necessary expenses are those services, supplies and procedures which are necessary for the diagnosis, care or treatment of an illness and which are determined to be widely accepted professionally in the U.S. as effective, appropriate, and essential, based on recognized standards of the health care specialty involved. You or your provider can contact BCBS to confirm whether an expense is eligible for coverage.

Billed Amounts – Network Doctor

The amount the provider charges for the service is referred to as the billed amount. This amount does not take into account any discounts negotiated with BCBS. The Allowable Amount is the amount covered by this option, as agreed to by the participating provider. You or your provider can contact BCBS to confirm whether an expense is eligible for coverage.

Case Management

Case Management, which is a collaborative process provided as a service to you and your family to facilitate the communication and coordination of care options, may also be available to you. You or your provider can contact BCBS's Case Management Department for assistance with determining available resources and coordination of care options. Case management can be of assistance for catastrophic injuries (such as head, spinal cord, burns, amputations, crush injuries) and catastrophic illnesses (such as strokes, cancer, HIV/AIDS, transplant, aneurism, muscular dystrophy, multiple sclerosis, organ transplants). You can contact BCBS's Case Management Department by calling BCBS through TI HR Connect at 888-660-1411.

Allowable Amount

The Allowable Amount is the maximum amount of benefits the Claims Administrator will pay for eligible expenses that you incur under the BCBS HDHP and PPO options. The Claims Administrator has established an Allowable Amount based on the contracted rate for medically necessary services, supplies, and/or procedures provided by providers that have contracted with the Claims Administrator (also referred to as network doctors). For providers who have not contracted with the Claims Administrator (also referred to as non-network doctors), the Plan's payment of benefits is based on the Allowable Amount determined by the Claims Administrator. Allowable Amounts are updated on a periodic basis by the Claims Administrator.

When you choose to receive medically necessary services, supplies, and/or procedures from a provider that does not contract with the Claims Administrator, a non-network provider, the Allowable Amount may not equal the provider's billed charges, and you will be responsible for any difference between the Allowable Amount and the billed charges by the non-network provider. This difference may be considerable. Additionally, you will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable deductibles and coinsurance amounts. If the non-network provider waives your obligation to pay the amounts you are responsible for paying under the Plan, the Plan may not pay any amount on the claim by the non-network provider.

ParPlan

When you consult with a physician or other licensed medical professional who does not participate in the Network, you should inquire if he or she participates in the Claims Administrator's *ParPlan* - a simple direct−payment arrangement. If the physician or other licensed medical professional participates in the *ParPlan,* he or she agrees to:

- File all claims for you,
- Accept BCBS's Allowable Amount determination as payment for medically necessary services, and
- Not bill you for services over the Allowable Amount determination.

The care you will receive will be treated as out-of-network benefits, and you will be responsible for:

- Any deductibles,
- Coinsurance amounts, and

- Services that are not covered under the benefit option or that are in excess of the benefit option limits.

Allowable Amount for Out-of-Network Providers Located Outside of Texas

If you seek treatment from an out-of-network provider located outside of Texas, you will be responsible for paying the amounts that exceed the Allowable Amount which is determined using the regional out-of-network reimbursement limit. The regional out-of-network reimbursement limit is approximately 300% of the Medicare rate in a geographic area (3 x Medicare). For example, this means that if the Medicare rate for a particular procedure in an area outside of Texas is equal to or less than $900, then $2,700 (300% of $900) would be the most that would be reimbursed for that procedure, or the allowable amount. Here, you would be responsible for charges over $2,700, in addition to your deductible and coinsurance.

Allowable Amount for Out-of-Network Providers Located in Texas

In general, if you seek treatment from an out-of-network provider located in Texas, the Allowable Amount is determined using base reimbursement schedules multiplied by a predetermined factor. The base reimbursement schedule is either (a) the base Medicare participating reimbursements excluding any Medicare adjustments based on the information on the claim or (b) the Blue Cross Blue Shield (BCBS) of Texas base non-contracting schedule for the service. For the base Medicare participating reimbursement schedule, the predetermined factor shall not be less than 75% of Medicare. For BCBS of Texas non-contracting base schedules, the predetermined factor shall not be less than 75% of the average network contract rate of the schedule.

How to Estimate Out-of-Pocket Expenses for Non-Network Doctor's Fees

If you choose a non-network doctor, you can estimate your out-of-pocket expenses. Here's how:

1) Call your doctor's office and ask for
    - The CPT Code of each procedure (including the office visit)
    - Your doctor's fee for each procedure
    - The zip code of your doctor's office
2) Call BCBS
    - Give the doctor's zip code and each CPT Code and fee to the BCBS Benefits Representative
    - You will be told if the fees are within the reimbursement limits. If they are more than the Allowable Amount, you will be given an estimate of the additional amount you would pay.

What You Will Pay

If you have access to a network provider and you choose a non-network provider who charges more than the Allowable Amount, you will be responsible for the difference between the Allowable Amount and billed charges.

Expenses that are Not Covered

Expenses for treatment provided which are not covered:

- Charges for services considered not medically necessary
- Charges for procedures or services not covered by the plan
- Charges that are more than the Allowable Amount
- Charges for procedures or services delivered by an ineligible provider

Proof of Previous TI Insurance Coverage

If you lose TI group retiree medical coverage and are required by another employer or Medicare to provide proof of your previous TI insurance coverage, contact the TI Benefits Center. You will need to maintain records of your TI coverage to prove you were covered. This proof may be required to offset any pre-existing condition exclusion or limitation in another employer's retiree only plan or to prove you had creditable coverage* to the Medicare program.

* You can find the Creditable Prescription Drug Coverage Notice on page 157.

Pre-Medicare Participants – Deductibles, Copays and Coinsurances in the BCBS PPOs

Retirees share the cost of coverage through deductibles, copays and coinsurance; the following chart highlights the coverage amounts. The coinsurance rates below represent the amounts paid by the participant.

Your Cost	Network	Non-Network
Deductibles and Copays		
Annual Deductible — Medical/Behavioral Health Care [1]	PPO A option: $300 individual / $600 family PPO B option: $500 individual / $1,000 family	
Annual Deductible — Pharmacy	No deductible	
Annual Hospital Copay	$0	$300
Benefit	**Coinsurance Paid by Participant**	
Doctor [2]	10%	50%
Professional Services [7]	10%	50%
Hospital/Facilities (inpatient & outpatient) [5]	30%	50%
Nutrition Network	10%	N/A
Behavioral Health Care (doctor)	10% [4]	50% [3,4]
Behavioral Health Care (facility/outpatient) [5]	30% [4]	50% [3,4]
Behavioral Health Care (hospital/inpatient) [5]	30% [4]	50% [3,4]
Annual Out-of-Pocket Maximum for Medical/Behavioral Health Care [1]	PPO A option: $3,000 ind/$6,000 family PPO B option: $5,000 ind/$10,000 family	PPO A option: $4,500 ind/$9,000 family PPO B option: $7,500 ind/$15,000 family
Annual Out-of-Pocket Maximum for Pharmacy [6]	$5,000 individual / $10,000 family	

[1] The annual deductible and annual out-of-pocket maximum for medical/behavioral health care does not include your non-network annual hospital copays, charges not covered by the plan or exceeding the Allowable Amount or other plan limits, or any pharmacy costs.

[2] If a lead network surgeon is used and services are performed at a network facility and the assistant surgeon is non-network, the claims for the assistant surgeon's services would be reimbursed at the in-network level. If the lead surgeon and the assistant surgeon are both non-network providers, claims for their services would be reimbursed at the non-network level.

[3] Non-network behavioral health care reimbursement amounts are set at the average network negotiated rates for inpatient care and the Allowable Amount for outpatient covered expenses.

[4] Behavioral health care must be provided by a licensed M.D., Ph.D. psychologist, licensed professional counselor, licensed marriage and family therapist or masters of social work.

[5] Facilities include, but are not limited to, hospitals, emergency rooms, skilled nursing facilities and hospice.

[6] The annual out-of-pocket maximum for pharmacy does not include the cost difference you pay if a brand-name drug is received when a generic is available.

[7] Professional services include(s), but are not limited to, surgeons, radiologists, anesthesiologists, physical therapists and home health care providers.

Pre-Medicare Participants – Deductibles, Copays and Coinsurances in the BCBS HDHP

Retirees share the cost of coverage through deductibles, copays and coinsurance; the following chart highlights the coverage amounts. The coinsurance rates below represent the amounts paid by the participant.

Your Cost	**Network**	**Non-Network**
	Deductibles and Copays	
Annual Deductible – Medical/Behavioral Health Care (and Pharmacy) [7]	$1,500 individual $3,000 family [1]	
Annual Deductible – Pharmacy	Included in above	
Annual Hospital Copay	$0	
Benefit	**Coinsurance Paid by Participant**	
Doctor [2]	10%	50%
Professional Services [3]	10%	50%
Hospital/Facilities [4] (inpatient & outpatient)	20%	50%
Nutrition Network	10%	N/A
Behavioral Health Care (doctor)	10% [6]	50% [5, 6]
Behavioral Health Care (facility/outpatient) [4]	20% [6]	50% [5, 6]
Behavioral Health Care (hospital/inpatient) [4]	20% [6]	50% [5, 6]
Annual Out-of-Pocket Maximum for Medical/Behavioral Health Care (and Pharmacy) [7]	$3,000 individual $6,000 family [1]	$6,000 individual $12,000 family [1]
Annual Out-of-Pocket Maximum for Pharmacy	Included in above	

[1] The HDHP family annual deductible and annual out-of-pocket maximums apply to you + spouse, you + child and you + family coverage and are met when all medical and pharmacy claims add up to the family deductible and/or maximum out-of-pocket amount.

[2] If a lead network surgeon is used and services are performed at a network facility and the assistant surgeon is non-network, the claims for the assistant surgeon's services would be reimbursed at the in-network level. If the lead surgeon and the assistant surgeon are both non-network providers, claims for their services would be reimbursed at the non-network level.

[3] Professional services include(s), but are not limited to, surgeons, radiologists, anesthesiologists, physical therapists and home health care providers.

[4] Facilities include, but are not limited to, hospitals, emergency rooms, skilled nursing facilities and hospice.

[5] Non-network behavioral health care reimbursement amounts are set at the average network negotiated rates for inpatient care and the Allowable Amount for outpatient covered expenses.

[6] Behavioral health care must be provided by a licensed M.D., Ph.D. psychologist, licensed professional counselor, licensed marriage and family therapist or masters of social work.

[7] The HDHP annual deductible and annual out-of-pocket maximum for medical/behavioral health care does not include charges not covered by the plan or exceeding the Allowable Amount or other plan limits, or the difference in cost between a generic and brand-name drug when a generic is available but a brand-name drug is purchased.

Medicare-Eligible Participants – Deductibles, Copays and Coinsurances in the BCBS PPO

Retirees share the cost of coverage through deductibles, copays and coinsurance, the following chart highlights the coverage amounts. The coinsurance rates below represent the amounts paid by the participant.

Your Cost	Network	Non-Network
Deductibles and Copays		
Annual Deductible — Medical/Behavioral Health Care [1]	$500 individual / $1,000 family	
Annual Deductible — Pharmacy	No deductible	
Annual Hospital Copay	$0	$300
Benefit	**Coinsurance Paid by Participant**	
Doctor [2]	10%	50%
Professional Services [7]	10%	50%
Hospital/Facilities (inpatient & outpatient) [5]	30%	50%
Nutrition Network	10%	N/A
Behavioral Health Care (doctor)	10% [4]	50% [3,4]
Behavioral Health Care (facility/outpatient) [5]	30% [4]	50% [3,4]
Behavioral Health Care (hospital/inpatient) [5]	30% [4]	50% [3,4]
Annual Out-of-Pocket Maximum for Medical/Behavioral Health Care [1]	$5,000 individual $10,000 family	$7,500 individual $15,000 family
Annual Out-of-Pocket Maximum for Pharmacy [6]	$5,000 individual / $10,000 family	

[1] The annual deductible and annual out-of-pocket maximum for medical/behavioral health care does not include your non-network annual hospital copays, charges not covered by the plan or exceeding the Allowable Amount or other plan limits, or any pharmacy costs.

[2] If a lead network surgeon is used and services are performed at a network facility and the assistant surgeon is non-network, the claims for the assistant surgeon's services would be reimbursed at the in-network level. If the lead surgeon and the assistant surgeon are both non-network providers, claims for their services would be reimbursed at the non-network level.

[3] Non-network behavioral health care reimbursement amounts are set at the average network negotiated rates for inpatient care and the Allowable Amount for outpatient covered expenses.

[4] Behavioral health care must be provided by a licensed M.D., Ph.D. psychologist, licensed professional counselor, licensed marriage and family therapist or masters of social work.

[5] Facilities include, but are not limited to, hospitals, emergency rooms, skilled nursing facilities and hospice.

[6] The annual out-of-pocket maximum for pharmacy does not include the cost difference you pay if a brand-name drug is received when a generic is available.

[7] Professional services include(s), but are not limited to, surgeons, radiologists, anesthesiologists, physical therapists and home health care providers.

Lifetime Dollar Limits

Below are the amounts that will be payable under the BCBS HDHP and PPOs, per covered individual.

Benefit	**HDHP and PPOs Lifetime Limit**
Behavioral Health Care – Inpatient – Outpatient [1]	Included in Medical Limit
Medical [2]	$2,000,000 network $1,000,000 non-network

[1] Covered expenses include network and non-network expenses. Medication checks will be reimbursed under the BCBS medical benefit.

[2] The medical lifetime limit of $1,000,000 non-network, applies to the total $2,000,000 network medical lifetime limit.

Adult Preventive Health Care – BCBS HDHP and PPO Participants

Preventive health care is designed to help retirees take an active role in managing their health and well-being. Targeted preventive care services help detect risks and health problems early when they are easiest to treat.

The periodic preventive health office visit, screening tests and immunizations recommended for your age and gender are covered at 100%.

No copay, coinsurance or deductibles apply. Diagnosis must be routine; if billed as diagnostic will be subject to deductible/coinsurance. Preventive services by non-network providers are covered at 100% of the Allowable Amount. Preventive services and the recommended frequency are specified in the following chart. Services must be billed with a primary diagnosis of preventive, screening or wellness. If you have questions regarding diagnosis and procedure codes associated with these services, please call BCBS.

The preventive care covered under the TI group retiree HDHP and PPO options differs from that provided under the TI group active HDHP and PPO options. You should verify whether the preventive care you are seeking is a covered service described in the charts below.

Preventive Services Covered by the BCBS HDHP and PPOs				
Preventive Health Office Visit	**Ages Covered**	**Recommended Frequency**	**Gender**	
			M	**F**
Health History & Lifestyle Counseling	18 and older	Annually	X	X
Blood Pressure Check	18 and older	Annually	X	X
Cancer Screen Exams (visual and/or Palpation)				
- Digital Rectal	40 and older	Annually	X	X
- Testicular	18 and older	Annually	X	
- Vaginal and Cervical	18 and older	Annually		X
Screening Tests	**Ages Covered**	**Recommended Frequency**	**Gender**	
			M	**F**
Breast Cancer Screen (screening mammogram)	35 and older	Annually		X
Genetic Risk Assessment and BRCA Testing for Breast and Ovarian Cancer	Any women with increased family history risk	Once only		X
Bone Density Screening for Osteoporosis	65 and older or 60 and older if at increased risk	Annually Every 2 years		X
Colonoscopy	50 and older	Every 10 years	X	X
EKG	35 and older	Once only	X	X

Screening Tests (continued)	Ages Covered	Recommended Frequency	Gender	
			M	F
Screening for Abdominal Aortic Aneurysm	65 to 75 who ever smoked	Once only	X	
Fasting Glucose	18 and older	Annually	X	X
Flexible Sigmoidoscopy	50 and older	Every 5 years	X	X
Screening for Type 2 Diabetes for those with high blood pressure	18 and older	Annually	X	X
Papanicolaou (Pap) Test (including ThinPrep™ and HPV testing)	18 and older	Annually		X
Prostate Specific Antigen (PSA)	50 and older	Annually	X	
Testing for Chlamydia, Gonorrhea and Syphilis	18 and older, and sexually active	Annually	X	X
Screening for HIV	18 and older for those at increased risk	At least annually	X	X
Colorectal cancer screening - Stool Blood Test	50 and older	Annually	X	X
Blood Count	18 and older	Annually	X	X
Lipid Panel (tests for Total, HDL and LDL Cholesterol and Triglycerides)	18 and older	Annually	X	X
Urinalysis	18 and older	Annually	X	X
Screening for Alcohol Misuse	18 and older	Annually	X	X
Screening for Depression	18 and older	Annually	X	X
Screening for Obesity	18 and older	Annually	X	X
Pregnancy Screenings		**Recommended Frequency**	**Gender**	
			M	**F**
Hepatitis B Screening		1st prenatal visit		X
- Urine Culture		12 to 16 weeks gestation or at the 1st prenatal visit, if later		X
- Anemia screening for iron deficiency		During pregnancy		X

Pregnancy Screenings (continued)		Recommended Frequency	Gender	
			M	F
- Rh (D) Incompatibility		1st prenatal visit, repeated for any unsensitized Rh (D) negative at 24 to 28 weeks' gestation		X
- Syphilis Screening		During pregnancy		X
- Tobacco cessation counseling		During pregnancy		X
Immunizations*	**Ages Covered**	**Recommended Frequency**	**Gender**	
			M	**F**
Flu Vaccine	18 and older**	Annually	X	X
Human Papillomavirus (HPV) vaccine (Gardasil®, for example)	18 to 26	One series	X	X
Hepatitis A	18 and older	One series	X	X
Hepatitis B	18 and older	One series	X	X
Measles/Mumps/Rubella (MMR)	18 and older	One series	X	X
Meningococcal	18 and older	One series	X	X
Pneumococcal	65 and older	One series	X	X
Rubella	18 and older	Once only	X	X
Shingles vaccine (Zostavax®, for example)	60 and older	Once only	X	X
Diphtheria/Tetanus/Pertussis	18 and older	Every 10 years	X	X
Herpes Zoster	18 and older	One series	X	X
Varicella Zoster (Chicken Pox)	18 and older	One series for those not previously immunized	X	X

* Immunizations can also be obtained at no cost through CVS Caremark's in-network pharmacies (subject to availability).

Certain immunizations, through any pharmacy may require a physician's prescription.

** Flu vaccine provided for dependents ages 0 to 18 under the Well-Baby, Well-Child Care benefits.

Flu Vaccinations

Flu vaccinations for you, your eligible spouse (or domestic partner) and dependent children are covered at 100%. You, your spouse (or domestic partner) and dependent children can receive your annual flu vaccination at your doctor's

office, or at CVS Caremark's in-network pharmacies. Flu vaccinations at CVS Caremark's in-network pharmacies are subject to availability by location and for dependent children, the age protocols established by the states. If a non-network BCBS provider provides the vaccination, services are covered at the Allowable Amount. You, your eligible spouse (or domestic partner) and dependent children participating in the Cigna Copay Plan or in an HMO should contact the health insurance carrier to obtain a flu vaccination under the health insurance carrier guidelines.

Well-Baby, Well-Child Care – BCBS HDHP and PPO Participants

Preventive Health Care for Infants and Children (0 Months-18 Years)
Well-Baby, Well-Child care provides coverage for recommended immunizations and the office visit at the time of the immunization. The immunization schedule is based on the recommendations of the American Academy of Pediatrics, the American Academy of Family Practice Physicians and the U.S. Task Force for Preventive Services. The plan also covers a Phenylketonuria (PKU) lab test performed at birth and a well-baby office visit with a PKU lab test two to three weeks following birth.

The following immunization schedule is a guide and represents the maximum number and type of immunizations and lab tests that are covered by the BCBS HDHP and PPOs. Your physician may prescribe an actual interval for immunizations and PKU lab tests consisting of approximately eight well-baby checkups for the baby's first year.

Well-Baby, Well-Child Care
Immunizations and Lab Tests Covered by the BCBS HDHP and PPOs

Immunizations*	Ages Covered	Recommended Frequency
Diphtheria/Tetanus/Pertussis (DTP)**	0 to 18	One series
Flu vaccine (inactivated and live attenuated)	0 to 18	Annually
Human Papillomavirus (HPV) vaccine (Gardasil®, for example)	9 to 18	One series
H. influenza type B (Hib)*	0 to 18	One series
Hepatitis A	0 to 18	One series
Hepatitis B	0 to 18	One series
Measles/Mumps/Rubella (MMR)	0 to 18	One series
Meningococcal (conjugate and polysaccharide)	0 to 18	One series
Pneumococcal (conjugate and polysaccharide)	0 to 18	One series
Polio (inactivated)	0 to 18	One series
Prevnar	0 to 18	One series
Rotavirus	0 to 18	One series
Tuberculosis Test (TB)	0 to 18	Once only
Varicella Zoster (Chicken Pox)	0 to 18	One series for those not previously immunized

Office Visit	Ages Covered	Recommended Frequency
Physical Development Assessment	0 to 18	Annually
Screening for Autism	At 18 and 24 months	At 18 and 24 months
Alcohol and Drug Use Assessments	Adolescents	Annually
Developmental Screening	0 to 18	Annually
Behavioral Assessments	0 to 18	Annually
Blood Pressure Screening	0 to 18	Annually
Fluoride treatment (for children whose primary water sources is deficient in fluoride)	6 months to 6 years	Annually
Hearing Loss Screening	Newborns	Once only
Height, Weight And Body Mass Index	0 to 18	Annually
Iron supplements for those at risk for anemia	6 to 12 months	As needed
Gonorrhea Prevention Medication for the eyes	Newborns	Once only
Oral Health Risk Assessment	0 to 10 years	Annually
Sexually Transmitted Infection (STI) prevention counseling	Those sexually active	Annually
Screening for Depression	12 to 18	Annually
Screening and Counseling for Obesity	6 and older	Annually
Vision Acuity Screening	By age 5 years	Once only
Lab Tests	**Ages Covered**	**Recommended Frequency**
Cholesterol	0 to 18	Once only
Papanicolaou (Pap) Test (including ThinPrep™ and HPV testing)	Those sexually active	Every 3 to 5 years for females
HIV Screening	Those sexually active	At least annually
Testing for Chlamydia, Gonorrhea and Syphilis	Those sexually active	Annually
Hematocrit	0 to 18	Annually
Hemoglobin	0 to 18	Annually
Urinalysis	0 to 18	Annually
Lead Screening	0 to 6	Once only
Test for Iron Deficiency Anemia for children at increased risk	6 to 12 months	Once only

Lab Tests (continued)	Ages Covered	Recommended Frequency
Phenylketonuria (PKU)	Newborns to age 1	At birth and 2 -3 weeks after birth
Dyslipidemia Screening	0 to 18	Annually
Hypothyroidism Screening	Newborns	Once
Sickle Cell Disease Screening	Newborns	Once

* Immunizations can also be obtained at no cost through CVS Caremark's in-network pharmacies (subject to availability).

Certain immunizations, through any pharmacy may require a physician's prescription.

** If your doctor chooses, Tetramune can be given instead of DTP and Hib

Reminder: To add coverage for a newborn child or newly adopted child (adopted or placement for adoption), coverage must be elected within 60 calendar days from the date of birth, date of adoption or date adoption papers were filed.

Well-Baby, Well-Child Check-ups

One physical development assessment office visit per calendar year will be covered

Under both the BCBS HDHP and PPO options, expenses for recommended immunizations and lab tests are covered at 100%. No copay, coinsurance or deductibles apply. Services by non-network providers are covered at 100% of the Allowable Amount.

Additional Healthy Pregnancy Benefits

The following screenings/services are covered at 100% if billed as preventive by your provider:

- Urine culture at 12 to 16 weeks gestation or at the first prenatal visits, if later
- Hepatitis B screening at first prenatal visit
- HIV screening during pregnancy, with consent
- Syphilis screening
- Anemia screening for iron deficient anemia in asymptomatic pregnant women
- Primary care interventions to promote breastfeeding during pregnancy and after birth
- Rh (D) incompatibility during first prenatal visit, repeated testing for any unsensitized Rh (D) negative women at 24 – 28 weeks gestation

Inpatient Maternity Admissions

For mothers and their new babies, the BCBS HDHP and PPOs provides up to 48 hours of hospitalization following a vaginal delivery and up to 96 hours of hospitalization following a Cesarean-section delivery. However, with the consent of their physicians, mothers and/or their new babies may be released from the hospital sooner if they wish.

Emergency Care

Emergency care is defined as an emergency illness or injury requiring immediate care. The need for immediate care is evidenced by acute symptoms of sufficient severity so that a prudent layperson, with average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention would place the individual's health in serious jeopardy, or seriously impair bodily functions, bodily organs or parts.

Emergency illness or injury requiring immediate care should be treated at the nearest provider (facility or doctor) that is able to provide the necessary care, regardless of whether that provider is in the network. For emergency/accident care received outside the network, eligible charges will be reimbursed at the Allowable Amount for in-network benefits. You may be held responsible for charges in excess of the BCBS Allowable Amount for emergency services. If you are billed for such charges, you may wish to contact a BCBS representative at 866-866-2300 to review the bill and determine your share of the responsibility, if any. You may not assign the right to request a review to any other person or entity.

If hospitalization is required — once stable, transfer to a network hospital (if available) to receive the highest benefit coverage levels may be necessary.

Behavioral Health Care

Behavioral health care covers a wide range of issues and illnesses. For example:

- Psychological problems
- Prescription drug abuse
- Alcohol abuse and addiction
- Mental illness
- Family/relationship concerns
- Parenting issues/concerns
- Stress, depression or anxiety
- Illegal drug abuse or addiction
- Elder Care issues/concerns
- Eating disorders

Behavioral Health Care Options	
Network Benefits	**Non-Network Benefits**
In the HDHP - Coinsurance for doctor services is 10% and for hospital care is 20% of covered expenses, after the medical deductible (up to plan limits). In the PPOs - Coinsurance for doctor services is 10% and for hospital care is 30% of covered expenses, after the medical deductible (up to plan limits).	Select your own behavioral health care provider — licensed M.D., Ph.D. psychologist, licensed professional counselor, licensed marriage and family therapist or masters of social work. Coinsurance is 50% of average network negotiated rates for inpatient care and 50% of the Allowable Amount for outpatient care. Coinsurance is applied to covered expenses, after the medical deductible (up to plan limits).

Additional Behavioral Counseling Benefits

The following preventive behavioral counseling services are covered at 100% if billed as preventive by your network provider, under the BCBS HDHP and PPO options:

- Counseling to prevent sexually transmitted infections
- Counseling intervention in primary care to reduce alcohol misuse
- Counseling to prevent tobacco use and tobacco-caused disease
- Counseling in primary care to promote a healthy diet
- Counseling and behavioral interventions for obesity
- Counseling for HIV for sexually active women
- Counseling on aspirin use to prevent cardiovascular disease for men age 45 to 79 and women age 55 to 79

Behavioral Health Care Services Not Covered under the BCBS HDHP and PPOs

Services are not covered under the BCBS HDHP and PPOs for the following:

- Stammering or stuttering
- Specific delays in mental development
- Mental retardation
- Education, training, recreation (therapeutic or otherwise), or services and supplies not regularly a part of institutional care
- Missed appointments, telephone consultations or personal comfort items

You should call BCBS through TI HR Connect at 888-660-1411 if you have any questions about treatment covered under the plan.

Second Surgical Opinion (Optional)

How a Second Opinion is Handled

Retirees have the option of obtaining a second opinion for any surgical procedure. The plan pays 100% of the Allowable Amount for the examination and second opinion. Charges by a non-network doctor are subject to the Allowable Amount that may not equal the provider's billed charges. This benefit is not subject to coinsurance.

	HDHP	PPO
Second and Third Surgical Opinions	Subject to Annual Medical Deductible	Not subject to Annual Medical Deductible

A surgical opinion covers:

- A physical exam of the individual
- X-ray and laboratory work
- A written report by the physician

The surgical opinion must

- Be performed by a physician who is certified by the American Board of Surgery or other specialty board
- Take place before the date the surgery is scheduled to be performed
- Take place within 120 calendar days of the first opinion

The plan also pays 100% of the covered charges made for a third surgical opinion by a doctor if the second surgical opinion does not confirm the recommendation of the first physician who will perform the surgery.

> **Note:** Please ask your provider to clearly indicate that your service is for a second or third surgical opinion.

Second and third surgical opinion benefits are not payable if the opinion provided is from a physician who is associated or in practice with the first physician who recommended the surgery.

Other Covered Expenses — BCBS HDHP and PPOs

Other covered expenses under the BCBS HDHP and PPOs include:

- Room and board at the semiprivate room rate and other medically necessary services and supplies the hospital furnishes to the patient
- Room and board at the private room rate is only covered if isolation is medically required, the illness is imminently terminal or if no semiprivate rooms are available
- Outpatient charges
- Charges made by an RN or a nursing agency for skilled nursing care if approved in advance
- Drugs and medicines that by law require a physician's prescription
- Diagnostic laboratory and X-ray examinations, radium and radioactive isotope therapy
- Anesthesia and oxygen
- Rental or purchase of durable medical or surgical equipment necessary for the medical or surgical treatment of a covered disease or injury
- Medically necessary local ambulance or air ambulance service to the nearest facility offering medically required services
- Artificial limbs and artificial eyes when part of an approved treatment plan
- Up to 48 hours of hospitalization following a vaginal delivery and 96 hours following a Cesarean-section delivery
- Blood transfusions
- Birth control pills, injections or devices that are medically prescribed and not considered experimental or investigational (See Exclusions and Limitations)
- Physical therapy that is prescribed as to type, frequency and duration by the attending medical doctor and from which there is the reasonable expectation of functional improvement. See below for coverage limits.
- Reconstructive breast surgery following mastectomy, including reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications of all stages of mastectomy, including swelling associated with the removal of lymph nodes
- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:

- the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
- the orthognathic surgery is medically necessary as a result of tumor, trauma, disease; or
- the orthognathic surgery is required as a result of severe congenital facial deformity or congenital condition.

Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review physician.

- Cognitive rehabilitation provided to treat an Acquired Brain Injury, which is brain damage caused by events after birth, rather than as part of a genetic or congenital disorder such as birth defects, fetal alcohol syndrome, perinatal illness or perinatal hypoxia, provided:
  - the cognitive therapy is used to restore mental skills or functions to at or near the pre-accident/disease state;
  - the cognitive therapy is prescribed by a licensed Physician and is rendered by a qualified licensed professional acting within the scope of his/her license (an individual with a professional license who is qualified by training to treat acquired brain injury);
  - medical records indicate that you or your covered dependent has sufficient cognitive function to understand and participate in the rehabilitative cognitive therapy program, adequate language expression and comprehension (i.e., no severe aphasia) and a likely expectation of achieving measurable improvement in a predictable period of time; and
  - you or your covered dependent receiving the rehabilitative cognitive therapy must demonstrate continued objective improvement in function as a result of cognitive therapy measured by objective rehabilitative cognitive therapy effectiveness tests, including but not limited to: Functional Cortical Mappings, Electroencephalography (EEGs), Electromyography (EMGs), biofeedback and psychological evaluations.

  Rehabilitative cognitive therapy services involving non-medically necessary care including, but not limited to, services and treatments of dementia, Alzheimer's disease, Huntington's Chorea, and AIDS are not covered by the Plan.

Allergy Testing and Treatment

Benefits for allergy testing and treatment:

- Pre-Medicare participants - Network coinsurance is 10%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met
- Maximum benefit is up to $1,000 per person per calendar year (combined network and non-network)

Chiropractic Services

To be covered, visits must be for the treatment of:

- Misalignment or dislocation of the spine
- Strained muscles or ligaments related to spinal disorders or the extremities

Benefits for chiropractic services:

- Pre-Medicare participants - Network coinsurance is 10%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

	HDHP	PPOs
Maximum benefit per person per calendar year	35 visits (combined network and non-network)	$1,000 (combined network and non-network)

Durable Medical Equipment

If you require durable medical equipment, the following applies:

- Pre-Medicare participants - Network coinsurance is 10%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Durable medical equipment will only be eligible for coverage if it is considered medically necessary. Contact BCBS to determine what durable medical equipment is covered under the plan.

Home Health Care

If you or your covered dependents have been seriously ill or hospitalized and require continued care after release, you may be able to receive nursing care, medical supplies and/or therapy services at home.

Conditions to Meet for Home Health Care Coverage

To receive network benefits, you or your covered dependents must meet three conditions:

- Be confined at home while receiving care
- Receive care through a network home health agency
- Have the physician establish and periodically review the home health program

Benefits for Home Health Care Services

The benefits include:

- Part-time or intermittent home nursing care by an RN, APN or LVN
- Part-time or intermittent home health-aide services that consist primarily of caring for the individual
- Physical, occupational, respiratory and speech therapy
- Medical supplies, drugs and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital. This is only to the extent that they would have been covered under this plan if the individual had remained in the hospital.
- Services for orthotics (see Exclusions and Limitations section for limitations on foot orthotics) or prosthetic devices are covered by the plan
- Pre-Medicare participants - Network coinsurance is 10%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

The maximum number of home health care visits is 120 visits per person per calendar year (combined network and non-network). Each visit of up to four hours by an RN, APN, LVN, aide or therapist will be considered as one visit. If there are two visits (of up to four hours) in one calendar day, then only one visit would be deducted from the calendar year visit maximum. Care must require skilled nursing interventions.

Services Not Covered by the Home Health Care Coverage

Home health care expenses not covered:

- Services, treatments, or supplies not covered under your home health program
- Services of a person who ordinarily resides in your home or is a member of your family or your spouse's or domestic partner's family
- Services of a social worker
- Transportation services

Hearing Therapy and Treatment for Hearing Loss

Benefits include medically necessary care and treatment of loss or impairment of hearing. Hearing services include testing, evaluation, screening and rehabilitation; also includes bone conduction and semi-implantable hearing devices.

	HDHP	PPOs
Network coinsurance for pre-Medicare and Medicare-eligible participants	10%, after the deductible is met	Not covered
Non-network coinsurance	50%, after the deductible is met	Not covered
Maximum hearing aid benefit per person	1 set of hearing aids every 3 years	Not covered

Hospice Care Program

If you or any of your covered dependents should become terminally ill (that is, diagnosed with six months or less to live), you may be eligible for a variety of hospice services and supplies. Contact BCBS for additional information.

Benefits for hospice care:

- Pre-Medicare participants - Network coinsurance is:

	HDHP	PPOs
Network coinsurance	20%, after the deductible is met	30%, after the deductible is met

- Medicare-eligible participants - Network coinsurance is 30%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

	HDHP	PPOs
Annual or lifetime maximum inpatient and outpatient hospice benefit	None*	$20,000 (combined network and non-network)

* Applied towards the medical lifetime limit of $2,000,000 network and $1,000,000 non-network. The medical lifetime limit of $1,000,000 non-network, applies to the total $2,000,000 network medical lifetime limit.

Benefits for Hospice Care Services

Benefits include:

- Room and board and other necessary services and supplies furnished to an individual while full-time inpatient is limited to up to 30 calendar days per person per calendar year (if you are in the PPO)

	HDHP	PPOs
Maximum benefit per person per calendar year	None*	Up to 30 calendar days (combined network and non-network)

* Applied towards the medical lifetime limit of $2,000,000 network and $1,000,000 non-network. The medical lifetime limit of $1,000,000 non-network, applies to the total $2,000,000 network medical lifetime limit.

- Part-time or intermittent outpatient nursing care by an RN, APN or LVN

Services Not Covered under Hospice Care

Services not included under hospice care:

- Bereavement counseling

- Funeral arrangements
- Pastoral counseling
- Financial or legal counseling - this includes estate planning and the drafting of a will
- Homemaker or caretaker services (including sitter or companion services for either the individual who is ill or other members of the family), transportation, house cleaning and maintenance of the house
- Respite care, which is care furnished during a period of time when the individual's family or usual caretaker cannot or will not attend to the individual's needs

Injuries to Teeth

Services available to you and your covered dependents include the correction of damage caused solely by external violent accidental injury to healthy natural teeth and supporting tissues. An injury sustained as a result of biting or chewing is not considered to be an accidental injury.

Medical Nutrition Therapy

Under both the HDHP and PPOs, medical nutrition therapy, provided by a qualified network dietitian, is available to you and your covered dependents in certain cases where a change in eating habits may significantly improve your health. The sessions feature interactive and individualized education and counseling.

Who is Eligible for Nutrition Benefits

For you or your covered family members to be eligible, you must be a BCBS HDHP or PPO participant and have a diagnosis such as (but not limited to):

- Cancer (e.g., breast, colon, lung or stomach)
- Cardiovascular Disease
    - Congestive heart failure, chronic
    - Coronary artery disease
    - Hypercholesterolemia (high cholesterol)
    - Hyperlipidemia (abnormal blood fats)
    - Hypertension (chronic high blood pressure)
    - Hypertension in pregnancy
- Diabetes/endocrine disorders
    - Diabetes, insulin-dependent
    - Diabetes, noninsulin-dependent
    - Diabetes, gestational (during pregnancy)

    - Hypoglycemia, reactive (low blood sugar)
- Gastrointestinal disorders
- HIV infection with HIV-related complications
- Food allergy that causes abnormal weight loss or acute asthma
- Failure to thrive/malnutrition/eating disorders
- Obesity
- Renal/kidney disease

You may have up to four visits in a calendar year for an eligible medical problem. If a new problem requiring medical nutrition therapy develops in the same calendar year, you may be eligible for an additional four visits.

During your initial visit, your provider will assess your food preferences and eating patterns. The provider will also help you understand how your food and lifestyle choices affect your medical condition and will assist you in setting goals to meet your individual needs. Follow-up visits will include checking to see if your diet plan is still right for you, a review of progress toward goals and additional education. After each visit, your provider will send your doctor a brief report.

Cost

Pre-Medicare participants - The coinsurance is 10% of the cost after the deductible is met for benefits in the Nutrition Network.

Medicare-eligible participants - The coinsurance is 10% of the cost after the deductible is met for benefits in the Nutrition Network.

Dietitian visits outside the network are not covered.

Outpatient Physical Therapy Benefits

Benefits for outpatient physical therapy (services provided in the doctor/therapist's office or in an outpatient facility):

- Pre-Medicare participants - Network coinsurance is 10%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met
- Maximum benefit is 50 visits per person per calendar year (combined network and non-network)

Skilled Nursing Facility

Benefits for a skilled nursing facility (care must be non-custodial):

- Pre-Medicare participants - Network coinsurance is:

	HDHP	PPOs
Network coinsurance	20%, after the deductible is met	30%, after the deductible is met

- Medicare-eligible participants - Network coinsurance is 30%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

	HDHP	PPOs
Annual Hospital Copay	None	$300 annual hospital copay for non-network admissions

- Maximum benefit is 100 calendar days per person per calendar year (combined network and non-network)

Skilled nursing facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services, and which is 1) licensed in accordance with state law (where the state law provides for licensing of such facility); or 2) Medicare or Medicaid eligible as a supplier of skilled nursing care.

Human Organ or Tissue Transplants

Certain organ and tissue transplants are covered including heart, heart/lung, bone marrow (autologous/allogeneic), liver and simultaneous pancreas kidney. Not all organ or tissue transplants are covered and certain limitations apply. Call BCBS for additional information.

Transplant Network

The Transplant Network is a subset of the BCBS HDHP and PPO network and consists of health care providers that have entered into an agreement with the plan to provide services or care related to organ and tissue transplants at pre-established rates.

If you live in an area where a Transplant Network is available, you should use network providers in order to receive the highest level of reimbursement.

Patients who reside outside of the Transplant Network geographic area may be eligible for coverage of pre-approved travel expenses. Contact BCBS to determine whether you reside in a Transplant Network geographic area.

Network and non-network coinsurance, after the deductible is met, is as follows:

	HDHP and PPOs	
	Network	**Non-Network**
Doctor [1]	10%	50%
Professional Services [2]	10%	50%
Hospital/Facilities [3] **(inpatient & outpatient)**	20% in HDHP 30% in PPOs	50%

[1] If a lead network surgeon is used and services are performed at a network facility and the assistant surgeon is non-network, the claims for the assistant surgeon's services would be reimbursed at the in-network level. If the lead surgeon and the assistant surgeon are both non-network providers, claims for their services would be reimbursed at the non-network level.

[2] Professional services include(s), but are not limited to, surgeons, radiologists, anesthesiologists, physical therapists and home health care providers.

[3] Facilities include, but are not limited to, hospitals, emergency rooms, skilled nursing facilities and hospice.

Non-network services (for human organ or tissue transplants) reimbursement maximum:

	HDHP	**PPOs**
Non-network services reimbursement maximum	None*	$10,000

* Applied towards the medical lifetime limit of $1,000,000 non-network and towards the medical lifetime limit of $2,000,000 network

Treatment for Loss or Impairment of Speech

Speech therapy services are eligible for coverage when all the following criteria are met:

- Used in the treatment of communication or swallowing impairment
- Prescribed by a licensed physician and rendered by a licensed/certified speech therapist
- Used to achieve a specific diagnosis-related or therapeutic goal
- Medical records must indicate the patient has a likely expectation of achieving measurable improvement in a predictable period of time

Benefits for outpatient treatment for loss or impairment of speech:

- Pre-Medicare participants - Network coinsurance is 10%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met
- Maximum benefit is $2,000 per person per calendar year (combined network and non-network)

Exclusions and Limitations

Services that are Not Covered under the Plan

The plan does not cover:

- Treatment not prescribed by a licensed physician or dentist
- Experimental or investigational treatment
    - Experimental or investigational treatment includes procedures, treatments, care, services and supplies which do not represent a commonly accepted form of treatment; are not generally accepted by the medical community in the United States as effective, appropriate and essential for the treatment of a diagnosed condition; or are not proven effective in the treatment of an illness
    - A drug, device, procedure, service, or treatment is experimental or investigational if it is, or it includes, a drug, device, procedure, service or treatment:
        (1) that cannot be lawfully marketed for the proposed use without approval of the U.S. Food and Drug Administration and which has not been so approved for marketing at the time the drug or device is furnished or which was not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;
        (2) which was reviewed and approved (or which is required by U.S. federal laws to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure which is used with a patient informed consent document which was reviewed and approved (or which is required by U.S. federal laws to be reviewed and approved) by the treating

facility's Institutional Review Board or other body serving a similar function;

(3) which Reliable Evidence shows is the subject of an on-going Phase I, II or III clinical trial or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;

(4) which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;

(5) that is less effective than conventional treatment methods;

(6) for which a review of the number of patients who have received indicates that the patients who have received the treatment or procedure, received it during Phase I, II or III of the clinical trial of the development of the treatment or procedure;

(7) that is currently undergoing review by the Institutional Review Board (or similar body) for the treating health care facility; or

(8) for which language appearing in the consent form or in the treating Hospital's or Physician's protocol for treatment indicates that the Hospital or the Physician regards the treatment or procedure as experimental.

"Reliable Evidence" means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the written informed consent form used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure with respect to the condition of the covered person in question.

The Claims Administrator, in its judgment, may deem an experimental service to be covered under this Plan for treating a life threatening sickness or condition if it is determined by the Claims Administrator that the experimental service at the time of the determination: (i) is proven to be safe with promising efficacy; and (ii) is provided in a clinically controlled research setting; and (iii) uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. For purposes of this

section, “life threatening” is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.

- Cosmetic surgery or treatment, except for:
  - correcting damage caused by accidental injury when the surgery is performed within a one-year period following the date of the accident that causes the injury or as soon thereafter as medically advisable
  - reconstructive breast surgery following mastectomy as described in the Other Covered Expenses section
- Occupational illness or injuries
- Exercise programs or vitamins
- Routine health checkups and tests not specified in preventive care (See the Adult Preventive Health Care and Well-Baby, Well-Child Care sections for information about preventive health care.)
- Fitting or cost of eyeglasses, except when needed because of an injury to the eye
- Hearing aids and exams to the extent not covered

	HDHP	PPOs
Maximum hearing aid benefit per person	1 set of hearing aids every 3 years	Not covered

- Eye exams made for or in connection with treating or diagnosing astigmatism, myopia or hyperopia
- Dental work and dental X-rays, except for accidental injury
- Charges for services of a resident physician or intern
- Charges for services for which a covered individual is not legally obligated to pay, for which a covered individual is not billed or for which a covered individual would not have been billed except that they were covered under this plan
- Charges for education, special education or job training
- Non-network doctor fees above the Allowable Amount
- Sonograms during pregnancy, unless medically necessary
- Charges for, or related to hormonal and surgical sex reassignment or treatment of gender dysphoria
- Charges for, or associated with, artificial insemination, in-vitro fertilization, embryo transfer procedures, sexual dysfunction, promotion of fertility through extra-coital reproductive technologies or reversal of sterilization
- Charges for fertility and/or infertility medications

- Birth control devices which are experimental/investigational or which are purchased without a prescription
- Providers not covered include, but are not limited to, massage therapists, exercise physiotherapists and acupuncturists. Acupuncture is only covered when used in lieu of anesthesia for surgery.
- Speech therapy is not covered for any of the following reasons:
    - Speech dysfunctions that are self-correcting
    - Services which maintain function that are neither diagnostic or therapeutic
    - Any procedure which may be carried out by someone other than a licensed/certified speech therapist
    - Psychoneurotic or psychotic conditions
    - Developmental delay that is not related to a medical condition, including, but not limited to:
        - Psychosocial speech delay
        - Behavioral problems
        - Attention disorders
        - Conceptual handicap
        - Mental retardation
        - Reduced cognitive function
    - Stammering or stuttering that is not related to an underlying medical condition
- Applied Behavioral Analysis encompasses behavior modification training techniques, therapies and programs, including, but not limited to:
    - Early Intensive Behavioral Intervention (EIBI)
    - Lovaas Therapy
    - Discrete Trial Training
    - Learning Experiences and Alternative Programs (LEAP)
    - Treatment and Education of Autistic and Related Communication of Handicapped Children (TEACCH)
    - Denver Program
    - Rutgers Program
    - Psycho Educational Profile
    - Any similar program or therapy related to behavior modification training
- Foot orthotics are not covered, unless prescribed for diabetes
- **Select** Specialty Medications (including self-administered and physician administered injectables, along with certain oral medications) are covered exclusively under the Pharmacy Network administered by CVS Caremark.

These select Specialty Medications are not eligible for coverage by BCBS. For more information, refer to the Specialty Medications part of the Pharmacy Network section.

- Rehabilitative cognitive therapy services involving non-medically necessary care including, but not limited to, services and treatments of dementia, Alzheimer's disease, Huntington's Chorea, and AIDS are not covered by the Plan.
- Custodial care

The Plan may impose further limitations and exclusions on certain procedures according to accepted standards of medical practice. *These additional limitations and exclusions may not be included in the list*. If you have any questions about coverage, contact BCBS.

Know Your Benefits

To get the most from your benefits:

- Call BCBS before care is received or to verify medical necessity
- Use a network provider

Claiming Medical/Behavioral Health Care Benefits

When You Must File Your Claims

All medical/behavioral health care expense claims must be postmarked to BCBS **no later than June 30** following the end of the calendar year in which the expenses were incurred; claims submitted after this deadline will be denied as untimely. It is your responsibility to ensure that your claims are filed before the June 30 deadline.

Payment of Hospital Expenses

BCBS *usually pays the hospital directly*. Have the admitting clerk call BCBS if you are hospitalized so the hospital will submit bills directly to BCBS.

If you want to pay the hospital yourself and then be reimbursed, you must send a copy of the paid hospital receipt along with your claim form to BCBS. Call BCBS through TI HR Connect at 888-660-1411 if you have any questions concerning your claim.

Payment of Doctor Expenses

Network — When you use a network doctor, the network doctor has the option to collect part of the fee at the time of service or to file the claim with BCBS. You will receive an Explanation of Benefits (EOB), showing the amount paid by the BCBS HDHP or PPO and the balance you owe, if any.

Non-network — For doctor services received outside the network, it may be necessary for you to file a medical claim form before you or your health care provider can be reimbursed.

BCBS HDHP and PPO claim forms can be found on the Fidelity NetBenefits® website at netbenefits.com/ti. You can also obtain a claim form by contacting BCBS through TI HR Connect at 888-660-1411 or you can go to the bcbstx.com website. Fill in the patient information section on the claim form. The completed form should be submitted directly to BCBS, along with your itemized bills, for reimbursement.

If you want BCBS to pay the provider directly, indicate this on the claim form by signing the "Authorization to Pay Provider Directly" portion.

ParPlan – For physician or other licensed medical professional services received outside the network from a *ParPlan* provider, you receive coverage based on out-of-network benefits. You are not required to file claim forms in most cases. *ParPlan* providers will usually file claims for you. You are not balance billed. *ParPlan* providers will not bill for costs exceeding the Claims Administrator's Allowable Amount for covered services. In most cases, *ParPlan* providers will preauthorize necessary services.

If You Need Help Filing a Claim

If you have any questions concerning your claim or need help filing your claim, call BCBS, the Claims Administrator, through TI HR Connect at 888-660-1411.

Claims should be sent to:

Blue Cross Blue Shield
P.O. Box 660044
Dallas, TX 75266-0044

You also may write to BCBS at the following address:

Blue Cross Blue Shield
P.O. Box 655488
Dallas, TX 75265-5488

Additional Information

The Blue Cross Blue Shield HDHP and PPO claims are administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association. Blue Cross and Blue Shield of Texas provides claims payment services only and does not assume any financial risk or obligation with respect to claims.

Other Important Information

Right to Recovery

By accepting the payment and/or reimbursement of benefits made by the plan, the retiree or other covered individual agrees that payments made by the plan are made on the condition and understanding that the plan will be fully reimbursed to the extent of benefits paid by the plan to or for the benefit of the retiree or other covered individual, subject to reduction for the plan's pro rata share of legal expenses the TI Retiree or other covered person incurred to obtain such recovery.

In the event of injury or illness caused by a third party, if that responsible party or their insurer has not made payments to a retiree or other covered individual, or his or her estate, the plan has a right to collect health care-related expenses from the applicable third party, subject to reduction for the plan's pro rata share of legal expenses the TI Retiree or other covered person incurred to obtain such recovery. If payment has been made to the retiree or other covered individual, such covered individual shall hold such amounts in a constructive trust for benefit of the plan. The plan has the right to collect any amount paid by the responsible third party or that responsible party's insurer to the retiree or other covered individual, subject to reduction for the plan's pro rata share of legal expenses the TI Retiree or other covered person incurred to obtain such recovery. The plan shall have an equitable lien on such funds. This is the case, regardless of whether the retiree or other covered individual has been fully compensated or made whole, and regardless of the fault of the retiree or other covered individual.

You will be notified by BCBS if your claim appears to be one where the right to recovery applies. If you have any questions, contact BCBS.

Coordination of Benefits (does not apply to Pharmacy Network benefits)

If You Have Other Medical Insurance

If you have coverage under Medicare or another group medical plan, your coverage under the BCBS HDHP or PPOs will be coordinated. This means that one of your plans is considered primary and the other secondary. The primary plan pays your expenses first.

Benefits are coordinated for participants in the BCBS HDHP or PPOs using a method referred to as Maintenance of Benefits. Under this method, when the TI medical plan is secondary, the plan will pay the difference between what it would have paid as the primary plan and the amount paid by the other group medical plan. The TI plan will use the lowest eligible amount of the primary or secondary plan due to the provider in this calculation. **If the primary plan pays the same or more than TI's plan, the TI plan WILL NOT pay on the claim – the TI plan will only pay if its benefits are higher than the primary plan.**

Even if BCBS does not make a payment on eligible charges, BCBS adjusts the member's account. This means that the member's deductible, out-of-pocket maximum and lifetime maximum will be reduced regardless of whether a payment by BCBS is made or not. However, the annual limits for specific benefits (such as physical therapy, speech therapy, etc.) will only be reduced if BCBS makes a payment on the claim.

If You Have Other Private Medical Insurance

The BCBS HDHP or PPOs will not coordinate with other private medical insurance policies such as those available through individual insurance purchased on your own. If you carry insurance, other than Medicare or another group plan, the BCBS HDHP or PPOs will ignore the private policy.

Birthday Rule

When dependents are covered by two group plans which have the birthday rule, the plan of the parent whose birthday occurs first in the year is primary. When one plan does not have the birthday rule, the father's plan is primary.

Termination of Coverage

Your TI group retiree medical coverage will end the earlier of the following:

- When you reach age 65, your medical coverage ends effective the last calendar day of the month prior to your eligibility for Medicare
- For those under age 65, who are eligible for Medicare due to disability - when you reach age 65, your medical coverage ends effective the last calendar day of the month prior to your 65th birthday
- Date you die
- The date the plan is discontinued or amended to eliminate TI group retiree medical coverage under TI Extended Health Benefits
- Retroactive to the last calendar day of the last month for which payment was received, if you fail to submit monthly payments within 30 calendar days of the due date. See important note in the Cost – Who Pays section.

It is your responsibility to inform the TI Benefits Center that a dependent's coverage should end. Your dependent coverage will end the earlier of the following in most cases:

- Date a dependent becomes covered as a TIer
- Date the dependent does not meet the definition of an eligible dependent
- Date of their death
- Date your retiree coverage ends for reasons other than death
- Date dependent coverage is no longer offered under the plan
- Last date for which payment was made for dependent coverage
- Expiration of the period to which a Qualified Medical Child Support Order or a National Medical Support Notice applies

Death

If you die while an employee of TI and you were eligible for TI Extended Health Benefits under the TI Retiree Health Benefit Plan or were eligible for Via Benefits (formerly OneExchange) at the time of your death (service and age must satisfy the eligibility rules for TI Extended Health Benefits or Via Benefits), coverage for your eligible dependents may be elected under TI Extended Health Benefits or Via Benefits, as long as they continue to be eligible for dependent coverage. If your surviving spouse remarries, your surviving spouse's coverage WILL END and the surviving spouse WILL NOT be eligible to continue coverage under COBRA.

Coverage for TI Extended Health Benefits or Via Benefits must be elected within 30 calendar days of your death, by at least one survivor. If your survivors do not enroll in dental coverage through TI Extended Health Benefits within 30 calendar days of your death, they will only be eligible to enroll for dental coverage in the event of an appropriate qualified status change or during annual enrollment as long as they are enrolled in medical coverage through TI Extended Health Benefits. If none of your survivors enroll in medical coverage through TI Extended Health Benefits, or if they all opt out at a later date, none of the survivors will be eligible to enroll for medical or dental coverage through TI Extended Health Benefits in the future.

Pharmacy Network

CVS Caremark administers an extensive nationwide network to provide TI with network discounts for prescription medications. Your out-of-pocket expense will vary based on whether your prescription drug is filled in-network, out-of-network or through mail-order (CVS Caremark Home Delivery service) and whether you are enrolled in the BCBS HDHP or PPO options. You can also fill 90-calendar-day prescriptions at retail CVS pharmacies for the same price as mail-order.

The retail network includes both chain and independent pharmacies. The directory of nationwide participating pharmacies can be accessed on the caremark.com website.

You have the option to fill prescriptions at the following types of retail pharmacies:

- In-network – At a participating pharmacy
- Out-of-network – At a nonparticipating pharmacy

Contact CVS Caremark through TI HR Connect at 888-660-1411 with all pharmacy-related questions.

Immunizations can also be obtained at no cost through CVS Caremark's in-network pharmacies (subject to availability). Certain immunizations, through any pharmacy may require a physician's prescription.

Pre-Medicare BCBS Prescription Drug Benefits – HDHP

The pharmacy coinsurance rates below represent the amounts paid by the participant.

HDHP			
Type	**In-Network Coinsurance**	**Out-of-Network Coinsurance**	**Mail-Order Program* Coinsurance**
Generic Drugs	25% of the total drug cost, for up to a 30-calendar-day supply	45% of the total drug cost, for up to a 30-calendar-day supply	20% of the total drug cost, for up to a 90-calendar-day supply
Brand-name Drugs**	40% of the total drug cost, for up to a 30-calendar-day supply	60% of the total drug cost, for up to a 30-calendar-day supply	35% of the total drug cost, for up to a 90-calendar-day supply
Specialty Drugs**	10% of the total drug cost, for up to a 30-calendar-day supply Required to be filled through the CVS Caremark SpecialtyRx Pharmacy****	Not covered	Not covered
Annual pharmacy deductible	No separate pharmacy deductible; pharmacy claims are applied to the BCBS HDHP medical deductible		
Annual pharmacy out-of-pocket maximum***	No separate pharmacy out-of-pocket maximum; pharmacy claims are applied to the BCBS HDHP medical out-of-pocket maximum		

* You can also fill 90-calendar-day prescriptions at retail CVS pharmacies for the same price as mail-order.

** If a generic is available and a brand-name drug is purchased instead, you pay the appropriate coinsurance for the brand-name drug cost plus the cost difference between the brand-name and generic drug. The cost difference does not apply towards the annual medical out-of-pocket maximum — you must still pay the difference, even if your annual medical out-of-pocket maximum has been met.

*** The cost difference you pay if a brand-name drug is received when a generic is available does not apply to the HDHP annual medical out-of-pocket maximum.

**** For more information, see the Specialty Medications section on page 78.

Pre-Medicare and Medicare-Eligible BCBS Prescription Drug Benefits – PPO

The pharmacy coinsurance rates below represent the amounts paid by the participant.

PPO			
Type	**In-Network Coinsurance**	**Out-of-Network Coinsurance**	**Mail-Order Program* Coinsurance**
Generic Drugs	35% of the total drug cost, for up to a 30-calendar-day supply	50% of the total drug cost, for up to a 30-calendar-day supply	30% of the total drug cost, for up to a 90-calendar-day supply
Brand-name Drugs**	35% of the total drug cost, for up to a 30-calendar-day supply	50% of the total drug cost, for up to a 30-calendar-day supply	30% of the total drug cost, for up to a 90-calendar-day supply
Specialty Drugs**	10% of the total drug cost, for up to a 30-calendar-day supply Required to be filled through the CVS Caremark SpecialtyRx Pharmacy****	Not covered	Not covered
Annual pharmacy deductible	No deductible		
Annual pharmacy out-of-pocket maximum***	$5,000 individual / $10,000 family		

* You can also fill 90-calendar-day prescriptions at retail CVS pharmacies for the same price as mail-order.

** If a generic is available and a brand-name drug is purchased instead, you pay the appropriate coinsurance for the brand-name drug cost plus the cost difference between the brand-name and generic drug. The cost difference does not apply towards the pharmacy annual out-of-pocket maximum — you must still pay the difference, even if your annual out-of-pocket pharmacy maximum has been met.

*** The cost difference you pay if a brand-name drug is received when a generic is available does not apply to the PPO annual pharmacy out-of-pocket maximum.

**** For more information, see the Specialty Medications section on page 78.

You can receive the highest covered pharmacy benefit by doing the following:

- While at your doctor's office, talk with your doctor to determine whether brand-name drugs are medically necessary or if a generic substitute could be obtained.
- If a generic drug would be appropriate, ask your doctor to indicate “generic substitution permissible” on your prescription.
- If you are having your doctor call in the prescription to a pharmacy, remind your doctor that you save money using generics.
- If you are filling a prescription for a brand-name drug, ask the pharmacist to tell you if a generic alternative is available.

Quality Care

CVS Caremark Clinical Pharmacists may perform an evaluation of a participant's pharmaceutical therapies for the identification of potential reduced out-of-pocket expenses, simplified pharmaceutical therapy plan, prevention of side effects caused by unnecessary or inefficient prescribing, and the identification of over- or under-drug utilization. You may contact CVS Caremark Customer Care through TI HR Connect at 888-660-1411 for more information.

Lost or Stolen Medication

If medication received at a retail pharmacy or after you have received it through mail-order is lost or stolen, or otherwise destroyed, you are responsible for the entire cost of replacement medication.

Drugs Subject to Standard Formulary and Compound Exclusions

The Plan has adopted CVS Caremark’s standard formulary and compound exclusion list. Drugs determined as excluded and non-formulary, or compound ingredients excluded by CVS Caremark, are not covered by the Plan. Preferred and non-preferred drugs will continue to be paid accordingly. If you have questions about your prescription drug coverage, contact CVS Caremark Customer Care through TI HR Connect at 888-660-1411.

Covered Drugs Subject to Prior Authorization

Prior Authorization determines benefit coverage or the appropriateness of drug therapy for drugs that would otherwise not be covered by the Plan based on certain evidence-based medical or other criteria, including, but not limited to, strict FDA approval criteria, and the inclusion of the drug in one or more national compendia (which are summaries of drug information compiled by experts who

have reviewed clinical data on drugs). Your pharmacist will inform you at the point-of-sale if your drug requires Prior Authorization and instruct you to have your physician contact the CVS Caremark Prior Authorization Unit. You may contact CVS Caremark Customer Care through TI HR Connect at 888-660-1411 if you have questions regarding whether your drug requires prior authorization. If your Prior Authorization is not approved by CVS Caremark, you will be responsible for the entire cost of the drug.

Covered Drugs Subject to Dispensing Limitations

Some drugs covered by the plan are subject to Maximum Dispensing Limitations at either a retail pharmacy or through the mail order program. The Plan will pay for the specified dispensing quantity within the specified time period. You may contact CVS Caremark Customer Care through TI HR Connect at 888-660-1411 if you have questions regarding whether your drug is subject to quantity-dispensing limitations.

Specialty Medications

Specialty medications are subject to a program that manages utilization to ensure medications are being used for FDA approved indications. Your health care provider is required to answer a set of questions to determine whether you meet the criteria to obtain the specialty medication.

Specialty medications may be dispensed up to a 30-calendar-day supply quantity only. The coinsurance for specialty medications will be 10% of the discounted drug cost. If you choose a brand-name drug when there is a generic available, you will also pay the cost difference between the brand-name and generic drug. Additionally, specialty medications are required to be filled through the CVS Caremark SpecialtyRx Pharmacy. CVS Caremark SpecialtyRx is a complete source for specialty injectable drugs and supplies (excludes insulin). SpecialtyRx offers medications for many chronic conditions including multiple sclerosis, rheumatoid arthritis, hemophilia, Gaucher disease, cystic fibrosis, hepatitis C, respiratory syncytial virus, growth hormone deficiency, anemia, Crohn’s disease, neutropenia, pulmonary hypertension, and many others. If you are being treated for any chronic conditions such as these, you or your physician should contact CVS Caremark Specialty Customer Care at 800-237-2767.

Select Specialty Medications (including self-administered and physician administered injectables, along with certain oral medications) are covered exclusively under the Pharmacy Network administered by CVS Caremark. To transfer your specialty medication prescription to CVS Caremark, call CVS Caremark Specialty Customer Care at 800-237-2767. Representatives are available 6:30 a.m. to 8:00 p.m. Central Time Monday-Friday to assist you. A

CVS Caremark Specialty Customer Care representative will contact your physician to obtain a new prescription.

Claiming Pharmacy Benefits

When You Must File Your Pharmacy Claims

Retirees can use their BCBS/CVS Caremark ID card when obtaining prescriptions at network pharmacies. This card provides pharmacists with the ability to access pharmacy eligibility and the TI Retiree Health Benefit Plan coverage information. Your network discount will apply when your prescription is filled at network pharmacies.

When you have prescriptions filled by pharmacies that are not in the CVS Caremark network, you will need to submit a claim to CVS Caremark to receive reimbursement of covered pharmacy expenses.

> All pharmacy expense claims must be postmarked to CVS Caremark **no later than 365 calendar days from the date of service**; claims submitted after this deadline will be denied as untimely. It is your responsibility to ensure that your claims are filed before the deadline.

CVS Caremark claim forms can be found on the Fidelity NetBenefits® website at netbenefits.com/ti. You can also obtain a claim form by contacting CVS Caremark Customer Care through TI HR Connect at 888-660-1411 or you can go to the caremark.com website. The completed form should be submitted directly to CVS Caremark, along with your receipts, for reimbursement.

If You Need Help Filing a Claim

If you have any questions concerning your claim or need help filing your claim, call CVS Caremark Customer Care through TI HR Connect at 888-660-1411.

Claims should be sent to:

CVS Caremark
P. O. Box 52116
Phoenix, AZ 85072-2116

Plan Provisions that apply to BCBS (including CVS Caremark) and Cigna for Participants under age 65

The following plan provisions apply uniformly to BCBS (including CVS Caremark) and Cigna, except where noted.

If You are Entitled to Medicare and You are Not Currently Employed by TI (does not apply to CVS Caremark)

Medicare is the primary payer for retirees and/or their covered dependents who are younger than age 65, who are covered by Medicare because of disability. The TI Retiree Health Benefit Plan is the primary payer for participants entitled to Medicare benefits for end stage renal disease for the 30-month period following the diagnosis.

For additional information, see the Overview of Medicare section.

When You Have A Complaint

The Claims Administrator wants you to be satisfied with the care you receive. That is why they have established a process for addressing your concerns and solving your problems. If you have a complaint regarding a person, a service, the quality of care, or plan benefits not related to Medical Necessity or plan coverage you can call or write to the Claims Administrator and explain your concern. A complaint does not include: a misunderstanding or problem of misinformation that can be promptly resolved by the Claims Administrator by clearing up the misunderstanding or supplying the correct information to your satisfaction; or you or your provider's dissatisfaction or disagreement with an adverse determination. Please call us at the Customer Service Toll-Free Number that appears on your Benefit Identification card, explanation of benefits or claim form, or write to us at the following address:

Blue Cross Blue Shield (BCBS) HDHP or PPOs		**Cigna Copay Plan**
For Medical Complaints:	**For Pharmacy Complaints:**	**For Medical and Pharmacy Complaints:**
Claim Review Section Blue Cross and Blue Shield of Texas P. O. Box 660044 Dallas, TX 75266-0044	CVS Caremark P.O. Box 52084 Phoenix, AZ 85072-2084 Or faxed to 866-443-1172	Cigna PO Box 188011 Chattanooga, TN 37422

The Claims Administrator will do their best to resolve the matter on your initial contact. They will respond in writing with a decision 30 calendar days after they receive a complaint regarding services already provided.

Claim Filing and Appeals Procedures

Interpretation of Employer's Plan Provisions

The Plan Administrator has granted the Claims Administrator the final authority and discretion to interpret or construe the terms and conditions of the TI Retiree Health Benefit Plan and the discretion to interpret and determine benefit claims (excluding claims involving eligibility for coverage except for HMO coverage) in accordance with the plan's provisions.

The Plan Administrator has all powers, discretion and authority necessary or appropriate to control and manage the operation and administration of the plan including, but not limited to, a person's eligibility to be covered under the plan.

Any powers to be exercised by the Claims Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment of persons in similar circumstances.

Claim Dispute Resolution

You must exhaust all administrative remedies as described below prior to taking further action under the plan. The Claims Administrator is the final interpreter of the TI Retiree Health Benefit Plan and may correct any defect, supply any omission, or reconcile any inconsistency or ambiguity in such manner as it deems advisable in regards to claims administration. All final determinations and actions concerning the claims administration and interpretation of the plan's benefits shall be made by the Claims Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, you may dispute the final denial upon appeal by filing a suit under 502(a) of ERISA. You may not assign your right to pursue any claim for a violation of ERISA or to enforce a requirement under ERISA to any other person or entity.

Claim and Appeal Procedures

Claim Determinations

For the HDHP and PPO options, BCBS is the Claims Administrator for medical (including behavioral health care) claims and CVS Caremark is the Claims Administrator for pharmacy claims. For the Cigna Copay Plan, Cigna is the Claims Administrator. When the Claims Administrator receives a properly

submitted claim, it has final authority and discretion to interpret and determine benefits in accordance with the plan's provisions.

For the purposes of this section, any reference to "you" or "your" also refers to a representative or provider designated by you to act on your behalf with respect solely to pursuing a claim or appeal of a benefit. You must pursue any claim for any other right you have under ERISA, including a claim related to your eligibility, on your own. This means you cannot assign to a health care provider your right to request plan documents or to receive any penalty related to any delay or failure to provide documents or any claim related to a breach of fiduciary duty or to enforce ERISA. Your designation of a representative must be in writing. For more information about how to designate a representative, you may call the Claims Administrator through TI HR Connect at 888-660-1411.

The Claims Administrator will respond in writing with a decision 30 calendar days after they receive a claim for a post-service coverage determination. If more time or information is needed to make the determination, they will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

If you are not satisfied with the results of a coverage decision or the decision on a claim for benefits, you can start the appeals procedure.

Adverse Determination Appeals Procedure

To initiate an appeal of an adverse determination on a claim for benefits decision, you must submit a request for an appeal in writing to the following address:

BCBS HDHP or PPOs		**Cigna Copay Plan**
For Medical Claims:	**For Pharmacy Claims:**	**For Medical and Pharmacy Claims:**
Claim Review Section Blue Cross and Blue Shield of Texas P. O. Box 660044 Dallas, TX 75266-0044	CVS Caremark Prescription Claim Appeals P.O. Box 52084 Phoenix, AZ 85072-2084 Or faxed to 866-443-1172	Cigna National Appeals Organization (NAO) PO Box 188011 Chattanooga, TN 37422

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. For BCBS medical coverage, you may ask to register your appeal by telephone if you are unable or choose not to write. Call the BCBS toll-free number on your Benefit Identification card, explanation of benefits or claim form.

Your appeal request will be conducted by the Appeals Committee (the "Committee"). The Claims Administrator will acknowledge in writing that they have received your request within five business days after the business date they

receive your request for a Committee review. The Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, the Committee will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed to complete the review. In the event any new or additional information (evidence) or rationale is considered, relied upon or generated by the Claims Administrator in connection with the appeal, the Claims Administrator will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond.

You will be notified in writing of the Committee's decision within five business days after the Committee's decision, and within the Committee review time frames above if the Committee does not approve the requested coverage.

You may request, in writing or orally, that the claim review process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient hospital stay.

If you request that your claim's review be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

The Claims Administrator's physician reviewer, or your treating physician, will decide if an expedited appeal is necessary. When review of a claim is expedited, the Claims Administrator will respond orally with a decision within the earlier of: 72 hours; or one business day after the receipt of all information, followed up in writing within 3 calendar days.

When You Receive an Adverse Determination and Want to Appeal Such Determination

An Adverse Determination is a decision made by the Claims Administrator that the health care service(s) furnished or proposed to be furnished to you is (are) not Medically Necessary, clinically appropriate or covered by the plan, or is not covered in whole or in part. An Adverse Determination also includes a denial by the Claims Administrator of a request to cover a specific prescription drug prescribed by your physician or reimbursement of a claim at a level lower than what you believe the plan provides.

If you are not satisfied with the Adverse Determination, you may appeal the Adverse Determination in writing. Any such appeal must be submitted within 180 calendar days after you receive notice of the Adverse Determination. You should

state the reason why you feel your appeal should be approved and include any information supporting your appeal. The Claims Administrator will acknowledge the appeal in writing within five business days after they receive the Adverse Determination Appeal request.

Your appeal of an Adverse Determination will be reviewed and the decision made by a health care professional not involved in the initial decision. In the event any new or additional information (evidence) or rationale is considered, relied upon or generated by the Claims Administrator in connection with the appeal, the Claims Administrator will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. The Claims Administrator will respond in writing with a decision within 30 calendar days after receiving the Adverse Determination appeal request.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health or ability to regain maximum function or in the opinion of your physician would cause you severe pain which cannot be managed without the requested services; or (b) your appeal involves non-authorization of an admission or continuing inpatient hospital stay. If you request that your appeal be expedited based on (a) above, you may also ask for an expedited external Independent Review at the same time, if the time to complete an expedited level-one appeal would be detrimental to your medical condition.

The Claims Administrator's physician reviewer or your treating physician will decide if an expedited appeal is necessary. When an appeal is expedited, they will respond orally with a decision within the earlier of: 72 hours; or one business day after the receipt of all information, followed up in writing within three calendar days.

In addition, your treating physician may request in writing a specialty review, which will be conducted by a specialty reviewer. The specialty reviewer is a physician of the Claims Administrator experienced in the same or similar specialty as the care under consideration. This review is voluntary.

Under the BCBS HDHP or PPO options, the specialty review request must be made within 10 business days of an Adverse Determination. The specialty review will be completed and a response sent within 15 business days of the request. If the specialty reviewer upholds the initial Adverse Determination and you remain dissatisfied, you are still eligible to request a review by an Independent Review Organization. *The specialty review is not available for CVS Caremark pharmacy claims.*

Under the Cigna Copay Plan, the specialty review request must be made prior to initiating an appeal of an Adverse Determination. For more information on this process, please call Cigna.

External Independent Review Procedure

If you are not fully satisfied with the decision of the Claims Administrator's Adverse Determination appeal process or if you feel your condition is life-threatening, you may request that your appeal be referred to an external Independent Review Organization. Your request must be made within four months after your receipt of a decision on appeal of an Adverse Determination.

The Independent Review Organization (the “IRO”) is composed of persons who are not employed by the Claims Administrator or any of its affiliates. A decision to use this voluntary level of appeal will not affect the claimant's rights to any other benefits under the plan. There is no charge for you to initiate this independent review process. The Claims Administrator will abide by the decision of the IRO.

In order to request a referral to an IRO, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination by the Claims Administrator. Administrative, eligibility or benefit coverage limits or exclusions are not eligible for appeal under this process.

To request that your appeal be referred to an Independent Review Organization, you must submit a request in writing to the following address:

BCBS HDHP or PPOs		**Cigna Copay Plan**
For Medical Claims:	**For Pharmacy Claims:**	**For Medical and Pharmacy Claims:**
Claim Review Section Blue Cross and Blue Shield of Texas P. O. Box 660044 Dallas, TX 75266-0044	CVS Caremark Prescription Claim Appeals P.O. Box 52084 Phoenix, AZ 85072-2084 Or faxed to 866-443-1172	Cigna National Appeals Organization (NAO) PO Box 188011 Chattanooga, TN 37422

The Claims Administrator will perform a preliminary review within five calendar days of receipt of your request and will notify you within one business day after completion of the preliminary review of your eligibility for external Independent Review. If your claim is eligible for external Independent Review by an IRO, the Claims Administrator will assign the matter to an IRO.

The IRO will provide you with timely notice that states you may submit in writing within ten business days following receipt of the notice additional information that the IRO must consider when conducting the external Independent Review. You will receive written notice of the IRO decision within 45 calendar days after the IRO receives your request for external Independent Review. The notice of

Independent Review decision will contain: (a) a general description of the reason for the request for external Independent Review; (b) the date the assignment to conduct the external Independent Review was received and the date of the IRO decision; (c) reference to the evidence or documentation considered; (d) a discussion of the principal reason(s) for the decision; (e) a statement that the determination is binding; (f) a statement that judicial review may be available to you; and (g) information about any office of health insurance consumer assistance or ombudsman available to assist you.

If the IRO reverses the Adverse Benefit Determination, the Claims Administrator will immediately provide coverage or payment for the claim.

If you make a claim for expedited external Independent Review that is determined to be eligible for external Independent Review, the IRO will provide notice of the eternal review decision as expeditiously as your medical condition requires, and no later than 72 hours after receipt of the request from the Claims Administrator for expedited external Independent Review.

You May Contact the Department of Labor with Your Questions Regarding Your Appeal

You have the right to contact the Employee Benefit Security Administration at 866-444-EBSA (3272) or at askebsa.dol.gov.

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include: (a) information sufficient to identify the claim; (b) the specific reason or reasons for the denial decision; (c) reference to the specific plan provisions on which the decision is based; a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information as defined; (d) a statement describing any voluntary appeal procedures offered by the plan and the claimant's right to bring an action under ERISA section 502(a); (e) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your appeal, (f) an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (g) information about any office of health insurance consumer assistance or ombudsman available to assist you in the appeal process (h) a description of the expedited review procedure in the case of a denial of an expedited claim and (i) a statement in non-English language(s) that indicates how to access language services and written notices of claims denials in such non-English language(s) (if applicable). A final notice of adverse determination will include a discussion of the decision.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your Plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office. You may also contact the Plan Administrator.

Relevant Information

Relevant Information is any document, record, or other information which was (a) relied upon in making the benefit determination; (b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by U.S. federal laws in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit or the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action Under U.S. Federal Laws

If your Plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against the Claims Administrator until you have completed the Claim and Adverse Determination Appeal process. Generally, if the Plan did not provide access to reasonable claims procedures consistent with the regulations, there is no need to complete the Claim and Appeal process prior to bringing legal action.

Deadline for Bringing a Legal Action

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under Section 502(a) of ERISA if you file such complaint in a federal court within the earlier of three (3) years from the date on which the claim was incurred (for example, when the service was provided, or the supply or prescription was filled), or within one (1) year of the date such claim was denied in the final level of the appeal process outlined above.

Any claim or complaint filed in court after the expiration of the deadline above shall be barred and subject to dismissal for failing to file on a timely basis.

EXTENDED MEDICAL – Cigna Copay Plan

(Uses the Cigna Open Access Plus In-Network (OAPIN))

Important Information

This summary of the Cigna Copay Plan option has been provided by Cigna and modified, in part, by Texas Instruments Incorporated in accordance with information contained elsewhere in the 2018 Retiree Health Benefits Guide. This summary is intended to describe the benefits Texas Instruments Incorporated has made available to participants in the TI Retiree Health Benefit Plan under the Cigna Copay Plan option.

This is not an insured benefit plan. The benefits described in this section are self-insured by Texas Instruments Incorporated which is responsible for their payment. Cigna Health provides claim administration services to the plan, but Cigna Health does not insure the benefits described.

Offered to participants residing in TX, NC, AZ and in Bryan, Love and Marshall counties of OK.

Special Copay Plan Provisions

Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

Services Available In Conjunction with Your Copay Plan Option

The following several pages describe helpful services available in conjunction with your Copay Plan Option. You can access these services simply by calling the toll-free number shown on the back of your ID card.

Cigna's Toll-Free Care Line

Cigna's toll-free care line allows you to talk to a health care professional 24 hours a day, 7 days a week simply by calling the toll-free number shown on your ID card.

Cigna's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may consult your Physician Guide which lists the Participating Providers in your area

or call Cigna's toll-free number for assistance. If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through Cigna's Away-From-Home Care feature. Call Cigna's toll-free care line for the names of Participating Providers in other network areas. Whether you obtain the name of a Participating Provider from your Physician Guide or through the care line, it is recommended that prior to making an appointment you call the provider to confirm that he or she is a current participant in the Open Access Plus Program.

Case Management

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

1. You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, a claim office or a utilization review program can refer you to Case Management (see the Prior Authorization/Pre-Authorized section of your benefits summary for the Copay Plan option regarding referral of an individual for Case Management).

2. The Review Organization assesses each case to determine whether Case Management is appropriate.
3. You or your Dependent is contacted by an assigned Case Manager who explains in detail how the program works. Participation in the program is voluntary - no penalty or benefit reduction is imposed if you do not wish to participate in Case Management.
4. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.
5. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
6. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
7. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

Additional Programs

Cigna may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to you for the purpose of promoting your general health and well being. Cigna may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to you or your covered Dependents. Contact Cigna for details regarding any such arrangements.

Important Information About Your Medical Plan

Details of your medical benefits are described on the following pages.

Opportunity to Select a Primary Care Physician

Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by Cigna for yourself and your Dependents. If you choose to select a Primary Care Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first calendar day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

How To File Your Claim

In most cases the provider will file claims directly to Cigna on your behalf. If it is necessary to file a claim, remember the prompt filing of any required claim form will result in faster payment of your claim. You may get the required claim forms from the website listed on your identification card or by calling Member Services using the toll-free number on your identification card.

CLAIM REMINDERS

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT/GROUP NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
- YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.

- PROMPT FILING OF ANY REQUIRED CLAIM FORMS PROPERLY COMPLETED RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.
- PLEASE REMEMBER TO PRESENT YOUR BENEFIT ID CARD AT THE TIME OF SERVICE. THE CARD TELLS THE PROVIDER TO SEND ITS BILLS DIRECTLY TO CIGNA.
- IF NECESSARY TO FILE A CLAIM, REMEMBER TO SUBMIT ITEMIZED COPIES OF YOUR BILLS WITH THE CLAIM FORM.

Timely Filing of Out-of-Network Claims

Cigna will consider claims for coverage under our plans when proof of loss (a claim) is submitted within 180 calendar days for Out-of-Network benefits after services are rendered. If services are rendered on consecutive calendar days, such as for a Hospital Confinement, the limit will be counted from the last date of service. If claims are not submitted within 180 calendar days for Out-of-Network benefits, the claim will not be considered valid and will be denied.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Any person who intentionally makes a misrepresentation of a material fact regarding eligibility, claims for benefits, or any matter related to the Cigna Copay Plan option or who commits fraud on the Cigna Copay Plan option shall be subject to having their coverage retroactively rescinded. In the event you or your dependent’s coverage is rescinded, notice will be provided of the effective date of the rescission. You may submit an appeal of such decision to the Cigna Copay Plan.

Open Access Plus In-Network Medical Benefits
The Schedule

For You and Your Dependents

Open Access Plus In-Network Medical Benefits provide coverage for care In-Network. To receive Open Access Plus In-Network Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Coinsurance

The term Coinsurance means the percentage of charges to be paid by you or your Dependent for Covered Expenses that a covered person incurs.

Copayments

Copayments are expenses to be paid by you or your Dependent for covered services. Copayments are in addition to any Coinsurance.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Assistant Surgeon and Co-Surgeon Charges

Assistant Surgeon

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed a percentage of the surgeon's allowable charge as specified in Cigna Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)

Co-Surgeon

The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Cigna Reimbursement Policies.

BENEFIT HIGHLIGHTS	IN-NETWORK
Lifetime Maximum	Unlimited
Coinsurance Level	0% coinsurance after applicable copay
Physician's Services	
Primary Care Physician's Office visit	No charge after $20 per office visit copay
Specialty Care Physician's Office Visits Consultant and Referral Physician's Services **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna.	No charge after $40 per office visit copay
Surgery Performed In the Physician's Office	No charge after the $20 PCP or $40 Specialist per office visit copay
Second Opinion Consultations (provided on a voluntary basis)	No charge after the $20 PCP or $40 Specialist per office visit copay
Allergy Treatment/Injections	No charge after either the $20 PCP or $40 Specialist per office visit copay or the actual charge, whichever is less
Allergy Serum (dispensed by the Physician in the office)	No charge
Preventive Care	
Routine Preventive Care for children through age 2 (including immunizations)	No charge
Immunizations	No charge
Routine Preventive Care for ages 3 and above **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna.	No charge
Immunizations	No charge

BENEFIT HIGHLIGHTS	IN-NETWORK
Mammograms, PSA, PAP Smear	
Preventive Care Related Services (i.e. “routine” services) Diagnostic Related Services (i.e. “non-routine” services)	No charge Subject to the plan’s x-ray & lab benefit; based on place of service **Note:** The associated wellness exam will be covered at no charge.
Inpatient Hospital - Facility Services Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	$500 per admission copay, then 0% coinsurance Limited to the semi-private negotiated rate Limited to the semi-private negotiated rate Limited to the negotiated rate
Outpatient Facility Services Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room **Note:** Non-surgical treatment procedures are not subject to the facility copay/deductible.	$125 per visit copay, then 0% coinsurance
Inpatient Hospital Physician’s Visits/Consultations	0% coinsurance
Inpatient Hospital Professional Services Surgeon Radiologist Pathologist Anesthesiologist	0% coinsurance
Outpatient Professional Services Surgeon Radiologist Pathologist Anesthesiologist	0% coinsurance

BENEFIT HIGHLIGHTS	IN-NETWORK
Emergency and Urgent Care Services	
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay
Hospital Emergency Room	No charge after $100 per visit copay* *waived if admitted
Outpatient Professional services (radiology, pathology and ER Physician)	No charge
Urgent Care Facility	No charge after $50 per visit copay* *waived if admitted
X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit	No charge
Independent x-ray and/or Lab Facility in conjunction with an ER visit	No charge
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)	No charge
Ambulance	0% coinsurance
Inpatient Services at Other Health Care Facilities Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities Calendar Year Maximum: Unlimited	0% coinsurance

BENEFIT HIGHLIGHTS	IN-NETWORK
Laboratory and Radiology Services (includes pre-admission testing)	
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay
Outpatient Hospital Facility	0% coinsurance
Independent X-ray and/or Lab Facility	0% coinsurance
Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)	
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay
Inpatient Facility	$500 per admission copay, then 0% coinsurance
Outpatient Facility	0% coinsurance
Outpatient Short-Term Rehabilitative Therapy Calendar Year Maximum: Unlimited Includes: Cardiac Rehab Physical Therapy Speech Therapy Occupational Therapy Pulmonary Rehab Cognitive Therapy	No charge after the $20 PCP or $40 Specialist per office visit copay **Note:** Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.
Chiropractic Care Calendar Year Maximum: 20 calendar days Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay

BENEFIT HIGHLIGHTS	IN-NETWORK
Home Health Care Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as medically necessary) Note: The maximum number of hours per calendar day is limited to 16 hours. Multiple visits can occur in one calendar day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per calendar day)	0% coinsurance
Hospice	
Inpatient Services	0% coinsurance
Outpatient Services (same coinsurance level as Home Health Care)	0% coinsurance
Bereavement Counseling	
Services Provided as part of Hospice Care	
Inpatient	0% coinsurance
Outpatient	0% coinsurance
Services Provided by Mental Health Professional	Covered under Mental Health benefit

BENEFIT HIGHLIGHTS	IN-NETWORK
Maternity Care Services	
Initial Visit to Confirm Pregnancy **Note:** OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with Cigna.	No charge after the $20 PCP or $40 Specialist per office visit copay
All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)	0% coinsurance
Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist	No charge after the $20 PCP or $40 Specialist per office visit copay
Delivery – Facility (Inpatient Hospital, Birthing Center)	$500 per admission copay, then 0% coinsurance
Abortion Includes elective and non-elective procedures	
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay
Inpatient Facility	$500 per admission copay, then 0% coinsurance
Outpatient Facility	$125 per visit copay, then 0% coinsurance
Physician's Services	0% coinsurance

BENEFIT HIGHLIGHTS	IN-NETWORK
Family Planning Services	
Office Visits, Lab and Radiology Tests and Counseling	No charge after the $20 PCP or $40 Specialist per office visit copay
Note: The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.	
Surgical Sterilization Procedure for Vasectomy/ Tubal Ligation (excludes reversals)	
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay
Inpatient Facility	$500 per admission copay, then 0% coinsurance
Outpatient Facility	$125 per visit copay, then 0% coinsurance
Physician's Services	0% coinsurance

BENEFIT HIGHLIGHTS	IN-NETWORK
Infertility Treatment Services Not Covered include: • Testing performed specifically to determine the cause of infertility. • Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition). • Artificial means of becoming pregnant (e.g. Artificial Insemination, In-vitro, GIFT, ZIFT, etc.). **Note:** Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.	Not covered
Organ Transplants Includes all medically appropriate, non-experimental transplants	
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay
Inpatient Facility	0% coinsurance at LifeSOURCE center after $500 per admission copay, otherwise 0% coinsurance after $500 per admission copay
Physician's Services	0% coinsurance
Lifetime Travel Maximum: $10,000 per transplant	No charge (only available when using LifeSOURCE facility)
Durable Medical Equipment	0% coinsurance
External Prosthetic Appliances	0% coinsurance

BENEFIT HIGHLIGHTS	IN-NETWORK
Nutritional Evaluation Calendar Year Maximum: 3 visits per person	
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay
Inpatient Facility	$500 per admission copay, then 0% coinsurance
Outpatient Facility	$125 per visit copay, then 0% coinsurance
Physician's Services	0% coinsurance
Dental Care Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.	
Physician's Office Visit	No charge after the $20 PCP or $40 Specialist per office visit copay
Inpatient Facility	$500 per admission copay, then 0% coinsurance
Outpatient Facility	$125 per visit copay, then 0% coinsurance
Physician's Services	0% coinsurance
Routine Foot Disorders	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
Mental Health	
Inpatient	$500 per admission copay, then 0% coinsurance
Outpatient (Includes Individual, Group and Intensive Outpatient)	
Physician's Office Visit and Outpatient Facility	No charge after the $20 per office visit copay

BENEFIT HIGHLIGHTS	IN-NETWORK
Substance Use Disorders	
Inpatient	$500 per admission copay, then 0% coinsurance
Outpatient (Includes Individual and Intensive Outpatient)	
Physician's Office Visit and Outpatient Facility	No charge after the $20 per office visit copay

Open Access Plus In-Network Medical Benefits

Prior Authorization/Pre-Authorized

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- non-emergency ambulance; or
- transplant services.

Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a Covered person for the charges listed below if they are incurred after he becomes covered for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by Cigna. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

Covered Expenses

- Charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any calendar day of Hospital

Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.

- Charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- Charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- Charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- Charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any calendar day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- Charges made for Emergency Services and Urgent Care.
- Charges made by a Physician or a Psychologist for professional services.
- Charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- Charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.
- Charges made for a mammogram for women ages 35 to 69, every year, or at any age for women at risk, when recommended by a Physician.
- Charges made for an annual Papanicolaou laboratory screening test.
- Charges made for an annual prostate-specific antigen test (PSA).
- Charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- Charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- Charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- Office visits, tests and counseling for Family Planning services.

- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
    - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
    - the orthognathic surgery is Medically Necessary as a result of tumor, trauma, disease; or
    - the orthognathic surgery is performed prior to age 19 and is required as a result of severe congenital facial deformity or congenital condition.

  Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review Physician.

Genetic Testing

- Charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
    - a person has symptoms or signs of a genetically-linked inheritable disease;
    - it has been determined that a person is at risk for carrier status as supported by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or
    - the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and post-genetic testing.

Nutritional Evaluation

- charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

Internal Prosthetic/Medical Appliances

- charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

Home Health Services

- Charges made for Home Health Services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility.

  Home Health Services are provided only if Cigna has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for non-skilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your non-skilled care and/or custodial services needs.

  Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per calendar day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

Hospice Care Services

- Charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
    - by a Hospice Facility for Bed and Board and Services and Supplies;
    - by a Hospice Facility for services provided on an outpatient basis;
    - by a Physician for professional services;
    - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
    - for pain relief treatment, including drugs, medicines and medical supplies;
    - by an Other Health Care Facility for:
        - part-time or intermittent nursing care by or under the supervision of a Nurse;
        - part-time or intermittent services of an Other Health Care Professional;
        - physical, occupational and speech therapy;
        - medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;

- for services or supplies that are primarily to aid you or your Dependent in daily living.

Mental Health and Substance Use Disorders Services

Mental Health Services are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health. Treatment of eating disorders constitutes mental health services.

Substance Use Disorder is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Use Disorders.

Inpatient Mental Health Services

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Mental Health Residential Treatment Services.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group, Partial Hospitalization or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a calendar day, totaling nine or more hours in a week.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Inpatient Substance Use Disorders Rehabilitation Services

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of use disorders or addiction to alcohol and/or drugs. Inpatient Substance Use Disorder Services include Residential Treatment services.

Substance Use Disorders Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Use Disorder conditions.

Substance Use Disorders Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Use Disorders; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Use Disorders Residential Treatment Center when she/he is a registered bed patient in a Substance Use Disorders Residential Treatment Center upon the recommendation of a Physician.

Outpatient Substance Use Disorders Rehabilitation Services

Services provided for the diagnosis and treatment of use disorders or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, Partial Hospitalization or a Substance Use Disorders Intensive Outpatient Therapy Program.

A Substance Use Disorders Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Use Disorders program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a calendar day, totaling nine, or more hours in a week.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Substance Use Disorders Detoxification Services

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

Exclusions

The following are specifically excluded from Mental Health and Substance Use Disorder Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement
- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders
- Counseling for activities of an educational nature

- Counseling for borderline intellectual functioning
- Counseling for occupational problems
- Counseling related to consciousness raising
- Vocational or religious counseling
- I.Q. testing
- Custodial care, including but not limited to geriatric day care
- Psychological testing on children requested by or for a school system
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline

Durable Medical Equipment

- Charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by Cigna for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

Durable Medical Equipment items that are not covered include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including non-power mattresses, custom mattresses and posturepedic mattresses
- **Bath Related Items:** bath lifts, non-portable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or

motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs

- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps
- **Car/Van Modifications**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines

External Prosthetic Appliances and Devices

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

Prostheses/Prosthetic Appliances and Devices

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

Orthoses and Orthotic Devices

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Non-foot orthoses – only the following non-foot orthoses are covered:
  - rigid and semi rigid custom fabricated orthoses,
  - semi rigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;
- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

Braces

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

Splints

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - No more than once every 24 months for persons 19 years of age and older and
  - No more than once every 12 months for persons 18 years of age and under.
  - Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

Infertility Services

Charges made for services related to the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness.

Short-Term Rehabilitative Therapy

Short-Term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

The following limitation applies to Short-term Rehabilitative Therapy:

- Occupational and cognitive therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-Term Rehabilitative Therapy services that are not covered include but are not limited to:

  - Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
  - Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury;
  - Maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient’s current status;
  - Services that are provided by a chiropractic Physician are not covered; and
  - Treatment of dementia, Alzheimer’s disease, cerebral palsy, attention deficit disorder, schizophrenia, pervasive developmental disorders/autism spectrum disorders, learning disabilities, developmental delay and mild traumatic brain injury, including concussion and post-concussion syndrome.

A separate Copayment will apply to the services provided by each provider.

Chiropractic Care Services

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

The following limitation applies to Chiropractic Care Services:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness;

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status; and
- vitamin therapy.

Transplant Services

- Charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered at 100% when received at Cigna LifeSOURCE Transplant Network® facilities. Cornea transplants are not covered at Cigna LifeSOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically

contracted with Cigna for those Transplant services, other than Cigna LifeSOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with Cigna for Transplant services, are not covered.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

Transplant Travel Services

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated Cigna LifeSOURCE Transplant Network® facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses:

- travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

Breast Reconstruction and Breast Prostheses

- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the non-diseased breast to produce symmetrical appearance; (c) post-operative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

Reconstructive Surgery

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b) reconstruction is required as a result of Medically Necessary, non-cosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

Prescription Drug Benefits
The Schedule

For You and Your Dependents

This option provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies for each 30-calendar-day supply at a retail pharmacy or each 90-calendar-day supply at a mail order pharmacy. That portion includes any applicable Copayment, Deductible and/or Coinsurance.

Copayments

Copayments are expenses to be paid by you or your Dependent for covered Prescription Drugs and Related Supplies. Copayments are in addition to any Coinsurance.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	NON-PARTICIPATING PHARMACY	MAIL-ORDER PHARMACY
Prescription Drugs			
Tier 1 Generic* drugs on the Prescription Drug List	No charge after $15 per prescription order or refill for up to a 30-calendar-day supply	In-network coverage only	No charge after $40 per prescription order or refill for up to a 90-calendar-day supply
Tier 2 Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after $30 per prescription order or refill for up to a 30-calendar-day supply	In-network coverage only	No charge after $85 per prescription order or refill for up to a 90-calendar-day supply
Tier 3 Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after $50 per prescription order or refill for up to a 30-calendar-day supply	In-network coverage only	No charge after $145 per prescription order or refill for up to a 90-calendar-day supply
Tier 4 Drugs designated as specialty on the Prescription Drug List	No charge after 10% coinsurance for up to a 30-calendar-day supply	In-network coverage only	No charge after 10% coinsurance for up to a 90-calendar-day supply
* Designated as per generally-accepted industry sources and adopted by Cigna			

Prescription Drug Benefits

For You and Your Dependents

Covered Expenses

If you or any one of your Dependents, while covered under the Copay Plan option for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, Cigna will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating Pharmacy, the prescription will be covered by Cigna, as if filled by a Participating Pharmacy.

Limitations

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-calendar-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging: or
- up to a consecutive 90-calendar-day supply at a mail-order Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to Cigna to request prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the P & T Committee clinically evaluates the Prescription Drug for a different designation.

Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

Your Payments

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule. Please refer to the Schedule for any required Copayments, Coinsurance, or Maximums if applicable.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for you, or your Dependent's convenience, a Copayment will apply to each Prescription Drug.

Exclusions

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by U.S. federal or state laws;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate;
- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- any fertility drug;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasmy, and decreased libido;
- prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products for treatment of children without fluoride in their water;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);

- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue.

Other limitations are shown in the Medical “Exclusions” section.

Reimbursement/Filing a Claim

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see your mail-order drug introductory kit for details, or contact member services for assistance.

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

Exclusions, Expenses Not Covered and General Limitations on Medical/Behavioral Health Benefits

Your plan **does not** provide coverage for the following except as required by law:

- Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training; vocational rehabilitation; behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy; employment counseling, back-to-school, return-to-work services, work hardening programs; driving safety and services; training; educational therapy; or other non-medical ancillary services for learning disabilities, developmental delays, autism or mental retardation.

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan. For example, if Cigna determines that a provider is or has waived, reduced, or forgiven any portion of its charges and/or any portion of copayment, deductible, and/or coinsurance amount(s) you are required to pay for a Covered Service (as shown on the Schedule) without Cigna's express consent, then Cigna in its sole discretion shall have the right to deny the payment of benefits in connection with the Covered Service, or reduce the benefits in proportion to the amount of the copayment, deductible, and/or coinsurance amounts waived, forgiven or reduced, regardless of whether the provider represents that you remain responsible for any amounts that your plan does not cover. In the exercise of that discretion, Cigna shall have the right to require you to provide proof sufficient to Cigna that you have made your required cost share payment(s) prior to the payment of any benefits by Cigna. This exclusion includes, but is not limited to, charges of a Non-Participating Provider who has agreed to charge you or charged you at an in-network benefits level or some other benefits level not otherwise applicable to the services received.
- charges arising out of or relating to any violation of a healthcare-related state or federal law or which themselves are a violation of a healthcare-related state or federal law.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

- for or in connection with experimental, investigational or unproven services.

  Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance use disorders or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

  - not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use (including bulk chemical ingredients which make up many compounded medications);
  - the subject of review or approval by an Institutional Review Board for the proposed use; or
  - the subject of an ongoing phase I, II or III clinical trial.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- regardless of clinical indication for macromastia or gynecomastia surgeries; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
- surgical or nonsurgical treatment of TMJ dysfunction.
- for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth (unless treatment was not medically advisable within such time period); (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.
- for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are the result of any surgery performed for the management of obesity or clinically

severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- gender reassignment surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- infertility services including infertility drugs, surgical or medical treatment programs for infertility, including in-vitro fertilization, artificial insemination, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the “Home Health Services” or “Breast Reconstruction and Breast Prostheses” sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the **Home Health Services** provision.
- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.

- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- treatment by acupuncture.
- all non-injectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.
- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician’s opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.

- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no insurance.
- for medical plan expenses that exceed the Maximum Reimbursable Charge applicable to care, if any (for example, emergency care).
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- rehabilitative cognitive therapy services involving non-medically necessary care including, but not limited to, services and treatments of dementia, Alzheimer's disease, Huntington's Chorea, and AIDS.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

Coordination of Benefits

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

Definitions

For the purposes of this section, the following terms have the meanings set forth below:

Plan

Any of the following that provides benefits or services for medical care or treatment:

(1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
(2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
(3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

Closed Panel Plan

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

Primary Plan

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

Secondary Plan

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

Allowable Expense

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any

Plan covering you. When a Plan provides benefits in the form of services, the Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

(1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
(2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
(3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
(4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
(5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

Claim Determination Period

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

Reasonable Cash Value

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

Order of Benefit Determination Rules

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

(1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;

(2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;

(3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:

(a) first, if a court decree states that one parent is responsible for the child's health care expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;

(b) then, the Plan of the parent with custody of the child;

(c) then, the Plan of the spouse of the parent with custody of the child;

(d) then, the Plan of the parent not having custody of the child, and

(e) finally, the Plan of the spouse of the parent not having custody of the child.

(4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(5) The Plan that covers you under a right of continuation which is provided by U.S. federal or state laws shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.

(6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended except for anyone who is Disabled or diagnosed with End Stage Renal Disease for 30 months or less, in which case this Plan will be the Primary Plan. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

Effect on the Benefits of This Plan

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Copay Plan option would have paid if it had been the Primary Plan, and the benefit payments that this Copay Plan option had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Thus, the benefit reserve results from benefit savings determined from the Copay Plan's original liability minus the Copay Plan's actual payment after coordinating benefits. Cigna will use this benefit reserve to pay any Allowable Expense (e.g., your future covered out-of-pocket expenses) not otherwise paid during the Claim Determination Period.

As each claim is submitted, Cigna will determine the following:

(1) Cigna's obligation to provide services and supplies under this Copay plan option;

(2) whether a benefit reserve has been recorded for you; and

(3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, Cigna will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

Recovery of Excess Benefits

If Cigna pays charges for benefits that should have been paid by the Primary Plan, or if Cigna pays charges in excess of those for which the Plan is obligated

to provide under the Policy, Cigna will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

Cigna will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, health care plan or other organization. If the Plan requests, you must execute and deliver such instruments and documents as the Plan determines are necessary to secure the right of recovery.

Right to Receive and Release Information

Cigna, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 calendar days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

Expenses For Which A Third Party May Be Responsible

The Copay Plan option does not cover:

(1) Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
(2) Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

Subrogation/Right of Reimbursement

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claims administrator, another party may be responsible or for which the Participant may receive payment as described above:

1. Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have an equitable lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan, subject to reduction for the Plan's pro rata share of legal expenses the TI Retiree or other covered person incurred to obtain such recovery. Such lien shall have first priority over such proceeds. Any proceeds received by a Participant from such third party shall be held by the Participant in a segregated account in a constructive trust for the benefit of the TI Retiree Health Benefit Plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.
2. Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise, subject to reduction for the Plan's pro rata share of legal expenses the TI Retiree or other covered person incurred to obtain such recovery. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

Lien of the Plan

By accepting benefits under the Plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan less any reduction for the Plan's pro rata share of legal expenses incurred in obtaining the recovery as described above against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan less any reduction for the Plan's

pro rata share of legal expenses incurred in obtaining the recovery as described above.

Additional Terms

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the Plan. The Plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the Plan.
- The Plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Common Fund Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder, specifically; no court costs, attorneys' fees or other representatives' fees may be deducted from the Plan's recovery except as described above in the Subrogation/Right of Reimbursement section without the prior express written consent of the Plan. Such right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".
- The Plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise and shall only be subject to reduction as described above.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law

would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

Payment of Benefits

To Whom Payable

All Medical Benefits are payable to you. However, at the option of Cigna, all or any part of them may be paid directly to the person or institution on whose charge the claim is based.

Medical Benefits are not assignable unless agreed to by Cigna. Cigna may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of Cigna, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, Cigna may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, Cigna may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release Cigna from all liability to the extent of any payment made.

Time of Payment

Benefits will be paid by Cigna when it receives due proof of loss.

Recovery of Overpayment

When an overpayment has been made by Cigna, Cigna will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

Calculation of Covered Expenses

Cigna, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

Termination of Coverage

Your TI group retiree medical coverage will end the earlier of the following:

- When you reach age 65, your medical coverage ends effective the last calendar day of the month prior to your eligibility for Medicare
- For those under age 65, who are eligible for Medicare due to disability - when you reach age 65, your medical coverage ends effective the last calendar day of the month prior to your 65th birthday
- Date you die
- Date the plan is discontinued or amended to eliminate TI group retiree medical coverage under TI Extended Health Benefits
- Retroactive to the last calendar day of the last month for which payment was received, if you fail to submit monthly payments within 30 calendar days of the due date. See important note in Cost – Who Pays section.

It is your responsibility to inform the TI Benefits Center that a dependent's coverage should end. Your dependent coverage will end the earlier of the following in most cases:

- Date a dependent becomes covered as a TIer
- Date the dependent does not meet the definition of an eligible dependent
- Date of their death
- Date your retiree coverage ends for reasons other than death
- Date dependent coverage is no longer offered under the plan
- Last date for which payment was made for dependent coverage
- Expiration of the period to which a Qualified Medical Child Support Order or a National Medical Support Notice applies

Death

If you die while an employee of TI and you were eligible for TI Extended Health Benefits under the TI Retiree Health Benefit Plan or were eligible for Via Benefits (formerly OneExchange) at the time of your death (service and age must satisfy

the eligibility rules for TI Extended Health Benefits or Via Benefits), coverage for your eligible dependents may be elected under TI Extended Health Benefits or Via Benefits, as long as they continue to be eligible for dependent coverage. If your surviving spouse remarries, your surviving spouse's coverage WILL END and the surviving spouse WILL NOT be eligible to continue coverage under COBRA.

Coverage for TI Extended Health Benefits or Via Benefits must be elected within 30 calendar days of your death, by at least one survivor. If your survivors do not enroll in dental coverage through TI Extended Health Benefits within 30 calendar days of your death, they will only be eligible to enroll for dental coverage in the event of an appropriate qualified status change or during annual enrollment as long as they are enrolled in medical coverage through TI Extended Health Benefits. If none of your survivors enroll in medical coverage through TI Extended Health Benefits, or if they all opt out at a later date, none of the survivors will be eligible to enroll for medical or dental coverage through TI Extended Health Benefits in the future.

U.S. Federal Requirements

The following pages explain your rights and responsibilities under U.S. federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks

You may access a list of Providers who participate in the network by visiting cigna.com; mycigna.com or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with Cigna HealthCare.

Coverage for Maternity Hospital Stay

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a U.S. federal law known as the "Newborns' and Mothers' Health Protection Act": restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in

consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

Women's Health and Cancer Rights Act (WHCRA)

Do you know that your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

Group Plan Coverage Instead of Medicaid

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by U.S. federal laws.

Claim Determination Procedures Under ERISA for Claims for Benefits under the Plan

The following is designed to comply with internal claims and appeals procedures for benefits and new external review procedures resulting from health care reform. These procedures are described as currently understood, and may be subject to modification upon additional guidance from the government.

Procedures Regarding Medical Necessity Determinations

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan. Medical Necessity determinations are made on either a pre-service, concurrent, or post-service basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "pre-service medical necessity determination." The Plan describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical

Necessity determinations according to the procedures described below, in the Plan, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Plan, in your provider's network participation documents, and in the determination notices.

Pre-service Medical Necessity Determinations

When you or your representative request a required Medical Necessity determination prior to care, Cigna will notify you or your representative of the determination within 15 calendar days after receiving the request. However, if more time is needed due to matters beyond Cigna's control, Cigna will notify you or your representative within 15 calendar days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 calendar days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 calendar days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, Cigna will make the pre-service determination on an expedited basis. Cigna's Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. Cigna will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, Cigna will notify you or your representative within 24 hours after receiving the request to specify what information is needed. You or your representative must provide the specified information to Cigna within 48 hours after receiving the notice. Cigna will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 calendar days by written or electronic notification.

If you or your representative fails to follow Cigna's procedures for requesting a required pre-service medical necessity determination, Cigna will notify you or your representative of the failure and describe the proper procedures for filing within 5 calendar days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

Concurrent Medical Necessity Determinations

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, Cigna will notify you or your representative of the determination within 24 hours after receiving the request.

Post-service Medical Necessity Determinations

When you or your representative requests a Medical Necessity determination after services have been rendered, Cigna will notify you or your representative of the determination within 30 calendar days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control Cigna will notify you or your representative within 30 calendar days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 calendar days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to Cigna within 45 calendar days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

Post-service Claim Determinations

When you or your representative requests payment for services which have been rendered, Cigna will notify you of the claim payment determination within 30 calendar days after receiving the request. However, if more time is needed to make a determination due to matters beyond Cigna's control, Cigna will notify you or your representative within 30 calendar days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 calendar days after receipt of the request. If more time is

needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 calendar days after receiving the notice. The determination period will be suspended on the date Cigna sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

Notice of Adverse Determination

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding your claim, and an explanation of the scientific or clinical judgment for a determination that is based on a Medical Necessity, experimental treatment or other similar exclusion or limit; (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim and (7) the information necessary to identify the claim, including the date of service, health care provider, claim amount and a statement that upon request, the diagnosis code and its meaning and the treatment code and its corresponding meaning will be provided, and a description of the Plan’s standard used in denying the claim and a description of available internal appeals and external appeal procedures, including information regarding how to initiate an appeal, and contact information for the office of health insurance consumer assistance or the ombudsman.

Discretionary Authority

The Plan Administrator delegates to Cigna the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to Cigna the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

Plan Modification, Amendment and Termination

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan together with termination of the insurance policy(s) which funds the Plan benefits will have no adverse effect on any benefits to be paid under the policy(s) or Plan for any covered medical expenses incurred prior to the date that policy(s) or Plan terminates. Likewise, any extension of benefits under the policy(s) or Plan due to you or your Dependent's total disability which began prior to and has continued beyond the date the policy(s) or Plan terminates will not be affected by the Plan termination. Rights to purchase limited amounts of life and medical insurance to replace part of the benefits lost because the policy(s) terminated may arise under the terms of the policy(s) or Plan. A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan will end on the earliest of the following dates:

- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) or Plan terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this Plan. No extension of benefits or rights will be available solely because the Plan terminates.

Definitions

Bed and Board

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

Charges

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with Cigna for a different amount.

Chiropractic Care

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

Custodial Services

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

Emergency Medical Condition

Emergency medical condition means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Services

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which

could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency. Emergency services shall with respect to an emergency condition include medical screening examinations that are within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate emergency medical conditions, and such further medical examinations and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required to stabilize the patient in compliance with 42 USC 1395dd.

Employer

The term Employer means Texas Instruments Incorporated, the plan sponsor self-insuring the benefits described in this booklet, on whose behalf Cigna is providing claim administration services.

Expense Incurred

An expense is incurred when the service or the supply for which it is incurred is provided.

Free-Standing Surgical Facility

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;

- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

Hospice Care Program

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;
- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

Hospice Care Services

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

Hospice Facility

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by Cigna; and
- fulfills any licensing requirements of the state or locality in which it operates.

Hospital

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or

- an institution which: (a) specializes in treatment of Mental Health and Substance Use Disorders or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

Hospital Confinement or Confined in a Hospital

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Use Disorders Services in a Mental Health or Substance Use Disorders Residential Treatment Center.

Injury

The term Injury means an accidental bodily injury.

Maintenance Treatment

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

Maximum Reimbursable Charge

The Maximum Reimbursable Charge applies to medical services received out-of-network which are covered at the in-network benefit level due to authorization or receipt of emergency care. The Maximum Reimbursable Charge is the charge for a covered service after the application of a discount, if available, under Cigna's cost containment program. If a discount is unavailable, the Maximum Reimbursable Charge for physician/professional services is 80% of the charges made by providers of such services in the geographic area where the services are received as compiled in a database selected by Cigna. Facility services are covered at billed charges.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by Cigna. Additional information about how Cigna determines the Maximum Reimbursable Charge is available upon request.

Medicaid

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

Medically Necessary/Medical Necessity

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

Medicare

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

Necessary Services and Supplies

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

Nurse

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

Other Health Care Facility

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

Other Health Professional

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

Participating Pharmacy

The term Participating Pharmacy means a retail pharmacy with which Cigna Health and Life Insurance Company has contracted to provide prescription services to insureds; or a designated mail-order pharmacy with which Cigna has contracted to provide mail-order prescription services to insureds.

Participating Provider

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with Cigna to provide covered services with regard to a particular plan under which the participant is covered.

Patient Protection and Affordable Care Act of 2010 (PPACA)

Patient Protection and Affordable Care Act of 2010 means the Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152.)

Pharmacy

The term Pharmacy means a retail pharmacy, or a mail-order pharmacy.

Pharmacy & Therapeutics (P & T) Committee

A committee of Cigna Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

Physician

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

Prescription Drug

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under U.S. federal or state laws, be dispensed only pursuant to a Prescription Order.

Prescription Drug List

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

Prescription Order

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

Preventive Treatment

The term Preventive Treatment means treatment rendered to prevent disease or its recurrence.

Primary Care Physician

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

Psychologist

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

Related Supplies

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

Review Organization

The term Review Organization refers to an affiliate of Cigna or another entity to which Cigna has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance use disorder professionals, and other trained staff members who perform utilization review services.

Sickness – For Medical Insurance

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

Skilled Nursing Facility

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

Stabilize

Stabilize means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

Terminal Illness

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

Urgent Care

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by Cigna, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

MEDICAL - REGIONAL HEALTH MAINTENANCE ORGANIZATIONS (HMOs) for Participants under age 65

Some retirees can choose a regional Health Maintenance Organization (HMO) as an alternative to the BCBS HDHP or PPOs or the Cigna Copay Plan. Because TI offers different HMOs to retirees across the U.S., this section offers an overview of the services that HMOs generally provide. Details about each HMO can be obtained on the Fidelity NetBenefits® website at netbenefits.com/ti or directly from the HMO. Before choosing a TI group retiree medical option, you should carefully weigh the benefits under the health care options available to you, the accessibility of that care and the cost.

An HMO is an organization that provides comprehensive hospital and medical care, with no claim forms, to its members who generally live within its geographic service area. Instead of paying for health care services by reimbursing for charges, an HMO either provides the care itself or makes arrangements with specific physicians, hospitals and other medical providers for the delivery of health care services. You typically pay a copay for services.

If you enroll in an HMO, you must agree to receive all health care from the medical professionals and hospitals associated with the HMO, except for emergency treatment when you are not in the HMO's service area.

The HMOs vary on “guesting” privilege coverage (i.e., coverage for dependent children who attend school in a different location, or a 'snowbird' who has a different residence during the winter). Specific HMO access information can be found on the Fidelity NetBenefits® website at netbenefits.com/ti. You can also call the HMO directly to find out what benefits, if any, are available.

The HMO will provide you with information about its benefits, services, and claim procedures. Review the information from the HMO regarding limitations on claim filing and complaints or grievances.

Enrolling in an HMO may not be advisable if:

- You and your family already have a relationship with a personal physician who is not affiliated with the HMO in your service area
- HMO services are not located within easy access of your home
- Your eligible dependents do not live in the HMO service area

You cannot change your enrollment from a BCBS HDHP or PPO, the Cigna Copay Plan, or a regional HMO except during annual enrollment, or when

you move away from the geographic area served by the regional HMO or the area served by the Cigna Copay Plan.

Newborn or Adopted Children

To add coverage for a newborn or adopted child, coverage must be elected within 60 calendar days from the date of birth, date of adoption or date adoption papers were filed. You must enroll your child on the Fidelity NetBenefits® website at netbenefits.com/ti or contact the TI Benefits Center. The next opportunity to add coverage, absent a change in coverage consistent with a qualified status change, will be during annual enrollment. Changes made during annual enrollment are effective on the first calendar day of the calendar year following annual enrollment.

NOTE: All claims are administered by the HMO Claims Administrator. TI has not reserved the right to interpret the terms of the plan or insurance policy with respect to fully-insured benefits. All benefits are provided solely through the insurance policy issued by the Claims Administrator. No benefits other than the benefits available under the insurance policy are available. No benefits are provided by TI outside of the insurance policy.

Continuation of Benefits (COBRA)

For information on continuation of benefits (COBRA), see the COBRA section.

Overview of Medicare

Medicare is a U.S. federal medical coverage program that helps Americans age 65 or older, and some disabled people younger than 65, to pay for health care. You must maintain a permanent U.S. address to be eligible for Medicare. Medicare has different types of benefits.

- Hospital coverage (Part A) helps pay for inpatient care and for certain follow-up care after you leave the hospital. This coverage is generally automatic when you attain age 65 if you met the working requirements.
- Medical coverage (Part B) helps pay for physicians' fees, outpatient services and many other medical items and services not covered under hospital coverage. You must elect and pay for this coverage.
- Medicare Advantage Plans (like HMOs and PPOs) are sometimes referred to as Medicare Part C. They provide all of your Part A and Part B, and often Part D coverage. These plans often have networks, which means you may have to see certain doctors and go to certain hospitals in the plan's network to get care. You must elect and pay for this coverage.
- Prescription drug coverage (Part D) may be added to your Part A and/or Part B coverage. You must elect and pay for this coverage.

Generally, everyone age 65 or older (and some disabled people younger than 65) is eligible for Medicare Part A (generally automatic coverage) and Part B (elected enrollment). To enroll and ensure that you receive full medical coverage protection, check with your Social Security office at least three months before you or your covered spouse reaches age 65. As a disabled retiree or covered spouse (with coverage under a TI group retiree medical option), eligible for Medicare, be sure to enroll in Medicare Parts A and B.

Automatic enrollment for Medicare (Part A) may not be available to people who are age 65 and have not worked long enough to be eligible for Social Security retirement benefits on their own work record. They may however be eligible under their spouses' work record, provided their spouse is at least age 62 and eligible for Social Security benefits.

If you or your spouse (or domestic partner) applies for or is receiving Social Security retirement benefits, you will be enrolled automatically for Medicare hospital coverage (Part A). At the same time, you are eligible for Medicare medical coverage (Part B). You must elect and pay the required monthly premium (or have it deducted from your Social Security check) for such coverage.

If you don't enroll in Medicare Parts A and B within a timely manner, you may have to pay a higher Medicare monthly premium (a penalty). Visit medicare.gov for more information.

For those under age 65 who are eligible for Medicare due to disability:

Once you or your spouse (or domestic partner) have enrolled in Medicare Parts A and B and have received your Medicare card, contact Fidelity and if covered through the BCBS PPO, you will need to call and tell them that you want to verify that they have your, or your dependent's, Medicare information in their system. At that time, they will ask you for your, or your dependent's, Medicare number (which Medicare calls the Medicare Claim Number) located on your, or your dependent's, Medicare card. They will also ask for the Medicare effective date.

Once you or your spouse (or domestic partner) have enrolled in Medicare, all your TI group retiree medical claims must be filed with Medicare first. No claim under the BCBS PPO will be accepted until your Medicare claim has been processed.

If you or your spouse (or domestic partner) does not enroll in Medicare Part B the BCBS PPO will continue to pay secondary and BCBS will estimate the portion that would have been paid by Medicare. If you or your spouse (or domestic partner) previously declined enrollment in Medicare Part B you should consider enrolling in Medicare Part B immediately to minimize Medicare's late enrollment penalty.

When you, or your spouse (or domestic partner), are Medicare eligible, your benefits will be paid as if you have Medicare Parts A and B for your primary coverage.

Creditable Prescription Drug Coverage Notice[1]

The following pages provide a sample of the Creditable Prescription Drug Coverage Notice. You should have received a copy of this notice. If you didn't receive a copy of this notice, you can contact the TI Benefits Center through TI HR Connect at 888-660-1411, and select option 1 to speak to a representative to request a notice.

[1] Applies only to those under age 65 who are eligible for Medicare due to disability.

Important Notice from Texas Instruments Incorporated
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Texas Instruments Incorporated (TI) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **TI has determined that the prescription drug coverage offered by the TI Retiree Health Benefit Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current TI coverage will not be affected. Medicare will remain primary and TI will pay secondary.

TI has determined that your prescription drug coverage with TI is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage, including the following plans:

- BCBS Medicare-eligible PPO

If you decide to join a Medicare prescription drug plan, your TI Retiree Health Benefit Plan (TI plan) coverage will not change. Detailed below is more information about what happens to your coverage if you join a Medicare prescription drug plan.

If you elect to join a Medicare prescription drug plan and also have coverage under the TI plan, Medicare will pay your claims first. The TI plan may (or may not) pay any amount that remains unpaid after Medicare has paid.

Your current coverage under the TI plan pays for other health expenses in addition to prescription drug coverage. If you join a Medicare prescription drug plan, you and your eligible dependents will still be eligible to be enrolled in the TI plan.

Since you now have prescription drug coverage that, on average, is as good as Medicare coverage, you can choose to join a Medicare prescription drug plan later. You will not have to pay the higher premium (described below) as long as you do not go 63 calendar days or longer without prescription drug coverage that is as good as Medicare.

If you do decide to join a Medicare drug plan and drop your current TI coverage, be aware that you and your eligible dependents WILL NOT be able to get TI coverage back at any time.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with TI and don’t join a Medicare drug plan within 63 continuous calendar days after your

current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous calendar days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Please call the TI Benefits Center toll-free through TI HR Connect at 888-660-1411, option 1, Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 a.m. and 8:30 p.m. U.S. Eastern time to speak with a representative. **Note:** You'll get this each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through TI changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "*Medicare & You"* handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "*Medicare & You"* handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

DENTAL — MetLife Dental (Basic and Plus) and Aetna Dental Health Maintenance Organization (DHMO) for Participants under age 65

ERISA PLAN, offered through the TI Retiree Health Benefit Plan

A Quick Look

MetLife Dental

Retirees may choose from two MetLife Dental options with different costs and coverage:

- Dental Basic
- Dental Plus

The major coverage difference between these options is the coinsurance amounts paid for services. Types of services covered:

- Preventive and diagnostic — Periodic oral exams, cleanings and preventive x-rays
- Basic Services – Fillings, routine extractions and non-surgical periodontal services
- Major Services — Crowns, dentures, root canals, surgical periodontics, implants and other oral surgery
- Orthodontics — Braces and other services to straighten teeth

DHMO

Key features of the Aetna DHMO (if available in your area) can be viewed on the Fidelity NetBenefits® website at netbenefits.com/ti.

Enrollment and Maintaining Your Coverage

If you are eligible for TI Extended Health Benefits, you and your eligible dependents can obtain TI group retiree dental coverage through the MetLife Dental (Basic or Plus) or the TI-sponsored Aetna DHMO (if available in your area) on the first calendar day following your termination of employment. To cover yourself and your eligible dependents, you must make an election on the Fidelity NetBenefits® website at netbenefits.com/ti or contact the TI Benefits Center through TI HR Connect within 30 calendar days of your termination of employment date. Eligible dependents must be enrolled for the same TI group retiree dental coverage that the TI Retiree is enrolled in — family members cannot have TI group retiree dental coverage under different options.

To have TI group retiree dental coverage offered through the TI Retiree Health Benefit Plan, you must elect TI Extended Health Benefits within 30 calendar days from the date you terminate employment or forego eligibility in the future. You may not opt in and out of TI Extended Health Benefits; once you elect it, you must continue paying costs without lapse in order to maintain coverage. If you don't enroll in TI group retiree dental coverage through TI Extended Health Benefits within 30 calendar days from the date you terminated employment, you'll be eligible to enroll for TI group retiree dental coverage later (during annual enrollment or in the event of an appropriate qualified status change) as long as you're enrolled in TI group retiree medical coverage through TI Extended Health Benefits.

If you elect coverage, you may also enroll your eligible dependents, unless they are eligible for coverage under another health plan. In this case, you may not cover your dependents under this plan. If a dependent loses eligibility for coverage at a later date, it will be considered a qualified status change, and you may enroll the dependent at that time, as long as you remain enrolled in TI Extended Health Benefits. You may also add an eligible dependent during any annual enrollment period.

When You Can Change to a Different Coverage

You may change from Dental Basic / Dental Plus to a DHMO (or vice versa) only during annual enrollment or when you move away from the geographic area served by the DHMO.

When You Can Make Changes

During the annual enrollment period or within 30 or 60 calendar days depending on the type of qualified status change, you may make changes in TI group retiree dental coverage. Please see the Eligibility section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement.

Effective Date of Coverage

Retiree

Coverage for you, provided you enroll within the first 30 calendar days of your termination of employment, takes effect retroactive to your termination of employment date.

Dependents

Coverage for your dependent(s), provided you enroll them within the first 30 calendar days of your termination of employment, takes effect retroactive to your termination of employment date.

If adding coverage subject to an appropriate qualified status change, provided you enroll your eligible dependent within 30 or 60 calendar days depending on the type of qualified status change, coverage takes effect retroactive to the date of the qualified status change. Please see the Eligibility section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement. The next opportunity to add coverage, absent a change in coverage consistent with a qualified status change, will be during annual enrollment. Changes made during annual enrollment are effective on the first calendar day of the calendar year following annual enrollment.

If terminating coverage due to an appropriate qualified status change, coverage is terminated retroactive to the date of the qualified status change, provided you notify the TI Benefits Center within 30 or 60 calendar days depending on the type of qualified status change. Please see the Eligibility section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement.

Newborn or Adopted Children

To add coverage for a newborn or adopted child, coverage must be elected within 60 calendar days from the date of birth, date of adoption or date adoption papers were filed. You must enroll your child on the Fidelity NetBenefits® website at netbenefits.com/ti or contact the TI Benefits Center. The next opportunity to add coverage, absent a change in coverage consistent with a qualified status change, will be during annual enrollment. Changes made during annual enrollment are effective on the first calendar day of the calendar year following annual enrollment.

Cost — Who Pays

You must pay the entire cost of TI group retiree dental coverage for both yourself and any dependents you cover. TI Benefits Center will bill you directly for the cost of the TI group retiree dental option in which you are enrolled.

For the above to apply, you must be eligible for and elect TI Extended Health Benefits, as discussed in the Enrollment and Maintaining Your Coverage section above.

IMPORTANT NOTE*:* If you fail to submit monthly payments within 30 calendar days of the due date, your coverage will end retroactive to the last calendar day of the last month for which payment was received.
If your coverage is dropped because of non-payment, you WILL NOT BE ELIGIBLE to re-enroll in a TI health option at any time.

Your Benefits (MetLife Dental Basic and Dental Plus)

Pre-Existing Condition Limitations

The initial installation of any prosthesis including a denture, bridge or implant to replace one or more natural teeth lost before coverage began under the Dental Plan or as a replacement for congenitally missing natural teeth are not covered under the Dental Plan.

What is Covered

This chart provides an overview of the types of services covered.

Preventive and Diagnostic	Basic Services	Major Services	Orthodontics
Periodic oral exams Cleanings Preventive x-rays	Fillings, Routine extractions, Non-surgical periodontal services	Crowns, Dentures, Oral surgery, Root canals, Surgical periodontics, Implants	Braces Other services to straighten teeth

Network Providers You can choose any dentist to obtain dental services. There is not a penalty if you do not use a MetLife network dentist, but reasonable and customary reimbursement limits apply. Dentists in the MetLife network must negotiate their rates, resulting in lower fees. By having network prices, you and TI pay less for dental care. Reasonable and customary reimbursement limits do not apply if you use network providers.

The listing of network dentists can be found on the Fidelity NetBenefits® website at netbenefits.com/ti. You can search for a provider based on defined criteria or by the provider name.

How the Plan Pays

The following chart shows the amount paid by the participant.

Benefit Limits	Dental Basic	Dental Plus
Annual deductible*	$50	$50
Annual maximum**	$1,000	$2,000
Orthodontic lifetime maximum**	$1,000	$1,500
Benefits for:		
Preventive care		
- Oral exam, preventive x-rays, cleanings	0%	0%
Basic services		
- Fillings	50%	20%
- Routine extractions	50%	20%
- Non-surgical periodontal services	50%	20%
Major services	**Dental Basic**	**Dental Plus**
- Crowns	50%	40%
- Dentures	50%	40%
- Endodontics (root canal therapy)	50%	40%
- Oral surgery	50%	40%
- Surgical Periodontics	50%	40%
- Implants (requires review by dental consultant)	50%	40%
Orthodontia services (adult and children)	50%	50%

* Annual deductible applies to Basic and Major services only, not preventive and diagnostic

** This is the maximum amount the plan will pay

Benefits for orthodontia treatment (for you or your covered dependents), are paid as a one-time lump sum benefit, once treatment begins. The lump sum payment is subject to the applicable coinsurance level and lifetime maximum amount, shown in the chart above.

Orthodontia Lifetime Maximum: If you are enrolled in Dental Basic when orthodontia treatment begins, the $1,000 lifetime maximum is the maximum reimbursement amount that you and/or your covered dependents are entitled to. If you move to Dental Plus after being enrolled in Dental Basic and you and/or your covered dependents are receiving orthodontia treatment, you and/or your covered dependents are NOT entitled to the additional orthodontia lifetime maximum benefits.

Reasonable and Customary Charges (applies to non-network providers only)

A reasonable and customary charge is the usual cost for comparable treatment in a local geographic area. Reasonable and customary limits will apply to all non-network dental services.

How Reasonable and Customary is Determined
The reasonable and customary reimbursement level is set at the 90th percentile of charges in a geographic area. For example, this means that if 90 out of 100 charges in this area are lower than or equal to $900 for a procedure, $900 would be the most that would be reimbursed for that procedure. You would be responsible for charges over $900, in addition to your deductible and coinsurance.

It's not always possible to plan dental expenses, but you can estimate expenses by calling your doctor's office and MetLife before receiving dental care.

Limitations and Exclusions (Dental Basic/Dental Plus)

The following are limitations:

- Preventive/diagnostic exams – two per calendar year
- Cleanings – two per calendar year
- Periodontal cleanings – combined limit of four per calendar year, including two routine cleanings
- Periodontal scaling and root planing – once per quadrant in 24 consecutive months
- Periodontal surgery – once per quadrant in 36 consecutive months
- Bitewing x-rays one (1) set per calendar year for adults
- Bitewing x-rays two (2) sets per calendar year for children through age 18 (second set must be 6 months after first set)
- Topical application of fluoride – for children through age 17; limited to two per calendar year
- Sealants – for children through age 13, applies only to permanent premolars/molars, replacement limit of once every 60 consecutive months

- Complete intraoral x-ray series (including bitewings) OR panoramic film (without bitewings) – once during a period of 60 consecutive months
- Denture relining – covered if more than six months after installation; one per denture during any period of 36 consecutive months
- Denture adjustments – covered if more than six months after installation
- Temporomandibular joint dysfunction (TMJ) – maximum benefit per person is $750. Surgical expenses associated with TMJ are not paid under the TI group retiree dental plan; however, they may be covered under your TI group retiree medical plan.

The following are exclusions:

- Treatment or service not performed by a licensed dentist, licensed physician or licensed dental hygienist acting under the direction of a licensed dentist
- Treatment or service performed primarily for cosmetic purposes, including facings and personalization of teeth
- Procedures, services or supplies that are not necessary or do not meet accepted standards of dental practice, including charges for experimental or investigational procedures
    - Experimental or investigational treatment includes procedures, treatments, care, services and supplies which do not represent a commonly accepted form of treatment; are not generally accepted by the dental community in the United States as effective, appropriate and essential for the treatment of a diagnosed condition; or are not proven effective in the treatment of an illness
- Covered procedures that are performed more frequently than the plan allows
- Replacing a lost or stolen prosthetic device
- Any duplicate prosthetic device or any other duplicate appliance
- A permanent prosthetic device received more than 12 months after receipt of the temporary device
- Oral hygiene, dietary instructions or plaque control program
- Expenses that would not have been charged if the TI group retiree dental plan did not exist, or expenses that you are not required to pay
- Treatment or service covered under Workers' Compensation or a similar program
- Replacement of an existing denture or fixed bridgework that was installed less than five years ago
- Replacement of an existing crown/inlay/onlay that was installed less than five years ago

- Dental expenses that are covered under a TI group retiree medical benefit option under the TI Retiree Health Benefit Plan
- The initial installation of any prosthesis including a denture, bridge or implant to replace one or more natural teeth lost before coverage began under a TI group retiree dental plan or as a replacement for congenitally missing natural teeth
- Services or supplies received by a covered person before the TI group retiree dental plan benefits start for that person
- Replacement of a lost, missing or stolen crown, bridge or denture
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the TI group retiree dental plan benefits for the covered person are in effect
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride for children through age 17
- Periodontal splinting
- Temporary or provisional restorations
- Temporary or provisional appliances
- Services or supplies furnished by a family member
- Accidents to sound, natural teeth (may be covered under medical)

The Plan may impose further limitations and exclusions on certain procedures according to accepted standards of dental practice. *These additional limitations and exclusions may not be included in the list*. If you have any questions about coverage, contact MetLife.

Alternate Benefits (Dental Basic/Dental Plus)

Sometimes there are several ways to treat a particular dental problem. During the dental necessity review of the submitted documentation, MetLife may determine that a more cost-effective treatment is available that is adequate and meets generally accepted standards of dental care. If so, MetLife will provide benefits based upon that alternate treatment. You and your dentist may choose the more costly treatment, but you will be responsible for the difference in charges. This applies even if you don't get a pretreatment estimate (see below for more information on a pretreatment estimate). It is recommended that a pretreatment estimate of benefits is obtained for all services in excess of $300 so that you are aware of what the TI group retiree dental plan will pay for eligible services.

Pretreatment Estimate (Dental Basic/Dental Plus)

When You Should Ask for an Estimate

If you think your bill will exceed $300, or if you are not sure it is a covered expense (for example, bleaching after an accident), obtaining a pretreatment estimate helps avoid any unpleasant surprises by letting you know ahead of time:

- The cost of the dental service you are considering
- The amount the plan will cover (coordination of benefits and benefit maximums are not considered in this estimate)
- The estimated amount of out-of-pocket expenses you will have to pay
- Whether a professional result can be achieved by another form of treatment. In this case, you have the chance to discuss your options with the dentist before you have the work done.

Most dentists are familiar with this procedure. Here is how it works:

You	1. Fill out the standard dental claim form (available from the Fidelity NetBenefits® website at netbenefits.com/ti or the MetLife website at metlife.com/dental) and take it to your dentist.
Your Dentist	2. Fills in the description of the proposed treatment and its cost. (Be sure the dentist does not sign the section that certifies that the treatment has been completed.)
	3. Submits the form to MetLife for review.
MetLife	4. Reviews the proposed treatment and costs. 5. Tells you and your dentist approximately how much the plan will cover.

Once you have the dental work done, your dentist must fill in the date of service, sign the form and submit it to MetLife.

As the TI group retiree dental plan does not require precertification, seeking and obtaining a pretreatment estimate will not be treated as a claim for benefits. As a result, the claims procedures set forth below under “If a Claim is Denied” are not applicable. Only when you submit a post-service claim with a denial of benefits, either in whole or in part, will it result in the application of the claims procedures.

Claiming Dental Benefits

When You Must File Your Claims

All dental expense claims must be postmarked to MetLife **no later than June 30** following the end of the calendar year in which the expenses were incurred; claims submitted after this deadline will be denied as untimely. It is your responsibility to ensure that your claims are filed before the June 30 deadline.

How to File a Claim (Dental Basic and Dental Plus)

MetLife claim forms can be found on the Fidelity NetBenefits® website at netbenefits.com/ti. You can also obtain a claim form by contacting MetLife through TI HR Connect at 888-660-1411 or you can go to the metlife.com/dental website. Fill in the patient information section on the claim form. Be sure to include your Social Security number and sign the form. Your dentist should complete the dentist's section of the form or provide an itemized bill for you to submit.

Claims should be sent to:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282

Any additional itemized bills must include the retiree's Social Security number, name of patient, and service provided.

Claim Denial and Appeal Information

If a Claim is Denied

A claim for TI group retiree dental benefits under the plan must be submitted to MetLife, the Claims Administrator, at the time and in the manner prescribed by the Claims Administrator.

If your claim for dental benefits involves urgent care, MetLife will notify you as soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the urgent care claim. If MetLife requires additional information in order to render a decision, MetLife will notify you of the specific information necessary to complete the urgent care claim within 24 hours of receipt of the urgent care claim. You have 48 hours to provide more information. MetLife must render a decision on the urgent care claim that required additional information no later than the earlier of 48 hours after receipt of the initial urgent

care claim or by the end of the time period MetLife gave you to provide the additional information.

If MetLife determines that you are not entitled to receive all or part of the benefits you claim in a post-service claim for benefits (other than a claim involving concurrent care), a notice will be provided to you within a reasonable period of time, but no later than 30 calendar days from the business day your claim was received by MetLife. This notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will describe (i) the Claims Administrator's determination, (ii) the basis for the determination (along with appropriate references to pertinent plan provisions on which the denial is based), (iii) the procedure you must follow to obtain a review of the determination, including a description of the appeals procedure, and (iv) your right to bring a cause of action for benefits under section 502(a) of ERISA. This notice will also explain, if appropriate, how you may properly complete your claim and why the submission of additional information may be necessary.

In certain instances, MetLife may not be able to make a determination within 30 calendar days from the business day your claim for benefits was received. In such situations, MetLife, in its sole and absolute discretion, may extend the 30-calendar-day period for up to 15 calendar days, as long as MetLife determines that the extension is necessary due to matters beyond the control of the TI Retiree Health Benefit Plan or the Claims Administrator and provides you with a written notice within the initial 30-calendar-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected. If the reason for the delay is due to your failure to provide information necessary to decide your claim, the above-mentioned notice will describe the information needed and afford you up to 45 calendar days from the calendar day you receive the notice to provide the required information.

If your claim for dental benefits involves an ongoing course of treatment to be provided over a period of time or number of treatments (also known as concurrent care), any reduction or termination of such dental care (other than by a plan amendment or termination) before the end of the period of time or number of treatments constitutes an adverse benefit determination. MetLife will notify you of any such reduction or termination in time to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

If you request an extension of the course of treatment beyond the period of time or number of treatments, your claims will be decided as soon as possible, taking into account the medical exigencies. MetLife will notify you of the outcome of your claim (whether adverse or not) within 24 hours after the receipt of your claim by the Plan (provided you made the claim at least 24 hours prior to the expiration of the prescribed period of time or number of treatments).

MetLife Dental Basic and Dental Plus Plan Claim Appeals

If your claim for benefits is denied, either in whole or in part, you must appeal the denial by requesting a review of your claim by MetLife. Your written request for an appeal must be received by MetLife within 180 calendar days of the date you received your notice that MetLife denied your claim. Your request for an appeal should be mailed to:

MetLife
P.O. Box 14589
Lexington, KY 40512

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits. You may also request reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You will not be charged for this information. MetLife's review will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in the initial determination of your claim. You will also be provided a review that does not afford deference to the initial adverse determination to be conducted by someone who is neither the individual who made the initial determination nor the subordinate of such individual.

If your appeal involves a determination based in whole or part on a dental judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), MetLife will consult with a dental health care professional with the appropriate training and experience in the field of medicine at issue in your appeal. The dental health care professional consulted will be an individual who is neither an individual who was consulted in connection with the initial determination that is the subject of the appeal nor the subordinate of any such individual. When requested by you, MetLife will provide you with the name of any dental or vocational experts whose advice was sought in connection with your appeal.

If, after reviewing your appeal and any further information that you have submitted, MetLife denies your claim, either in whole or in part, a notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 30 calendar days from the business day your request for a review was received by MetLife.

If, after reviewing your appeal and any further information that you have submitted, MetLife denies your appeal, either in whole or in part, you must appeal MetLife's denial by requesting a review of your claim by the Plan Administrator. Your written request for an appeal must be received by the Plan Administrator within 90 calendar days of the date you received your notice that MetLife denied your claim. The remainder of your second-level appeal will be handled as discussed above. Your request for a second-level appeal should be mailed to:

Texas Instruments
Plan Administrator
ATTN: Formal Appeals
P. O. Box 650311, MS 3905
Dallas, TX 75265

If, after reviewing your appeal and any further information that you have submitted, the Plan Administrator denies your second-level appeal, either in whole or in part, a notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 30 calendar days from the business day your request for a review was received by the Plan Administrator.

This notice will describe: (i) the specific reason or reasons for the decision, including any adverse determinations, (ii) references to the specific plan provisions on which the decision was based, (iii) your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (iv) your right to bring a cause of action for benefits under section 502(a) of ERISA. If you do not agree with any of the Claims or Plan Administrators' decisions you must exhaust all levels of appeals provided by the Plan before you can proceed to court.

Your notice will also describe, if applicable, any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or the availability of such internal rule, guideline, protocol or other similar criterion free of charge upon request). Also, if your appeal involved a question of medical necessity or the experimental nature of a treatment, or a similar exclusion or limit, the explanation of the scientific or clinical judgment for the determination (or the availability of such an explanation) will be provided to you.

The Plan Administrator's decision shall be the final determination of the claim. If it is not furnished within the appropriate period described above, the claim should be considered denied on review.

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under

Section 502(a) of ERISA if you file such complaint in a federal court within the earlier of three (3) years from the date on which the claim was incurred (for example, when the service was provided), or within one (1) year of the date such claim was denied in the final level of the appeal process outlined above.

Any claim or complaint filed in court after the expiration of the deadline above shall be barred and subject to dismissal for failing to file on a timely basis.

Coordination of Benefits

If You Have Other Dental Insurance

If you have coverage under another group dental plan, your coverage under MetLife Dental will be coordinated. This means that one of your plans is considered primary and the other secondary. The primary plan pays your expenses first.

Benefits are coordinated for participants in MetLife Dental using a method referred to as Maintenance of Benefits. Under this method, when the TI dental plan is secondary, the plan will pay the difference between what it would have paid as the primary plan and the amount paid by the other group dental plan. The TI plan will use the lowest eligible amount of the primary or secondary plan due to the provider in this calculation. **If the primary plan pays the same or more than TI's plan, the TI plan WILL NOT pay on the claim – the TI plan will only pay if its benefits are higher than the primary plan.**

For all retirees, each time a secondary claim is submitted, MetLife Dental annual and maximum benefit amounts will be reduced, whether or not MetLife Dental pays toward the claim.

If You Have Other Private Dental Insurance

MetLife Dental will not coordinate with other private dental insurance policies such as those available through individual insurance purchased on your own. If you carry insurance, other than another group plan, MetLife Dental will ignore the private policy.

Birthday Rule

When dependents are covered by two group plans which have the birthday rule, the plan of the parent whose birthday occurs first in the year is primary. When one plan does not have the birthday rule, the father's plan is primary.

Termination of Coverage

Your TI group retiree dental coverage will end the earlier of the following:

- When you reach age 65, your dental coverage ends effective the last calendar day of the month prior to your eligibility for Medicare
- For those under age 65, who are eligible for Medicare due to disability - when you reach age 65, your dental coverage ends effective the last calendar day of the month prior to your 65th birthday
- Date you die
- The date the plan is discontinued or amended to eliminate TI group retiree dental coverage under TI Extended Health Benefits
- Retroactive to the last calendar day of the last month for which payment was received, if you fail to submit monthly payments within 30 calendar days of the due date. See important note in the Cost – Who Pays section.

It is your responsibility to inform the TI Benefits Center that a dependent's coverage should end. Your dependent coverage will end the earlier of the following in most cases:

- Date a dependent becomes covered as a TIer
- Date the dependent does not meet the definition of an eligible dependent
- Date of their death
- Date your retiree coverage ends for reasons other than death
- Date dependent coverage is no longer offered under the plan
- Last date for which payment was made for dependent coverage
- Expiration of the period to which a Qualified Medical Child Support Order or a National Medical Support Notice applies

Death

If you die while an employee of TI and you were eligible for TI Extended Health Benefits under the TI Retiree Health Benefit Plan or were eligible for Via Benefits (formerly OneExchange) at the time of your death (service and age must satisfy the eligibility rules for TI Extended Health Benefits or Via Benefits), coverage for your eligible dependents may be elected under TI Extended Health Benefits or Via Benefits, as long as they continue to be eligible for dependent coverage. If your surviving spouse remarries, your surviving spouse's coverage WILL END and the surviving spouse WILL NOT be eligible to continue coverage under COBRA.

Coverage for TI Extended Health Benefits or Via Benefits must be elected within 30 calendar days of your death, by at least one survivor. If your survivors do not enroll in dental coverage through TI Extended Health Benefits within 30 calendar days of your death, they will only be eligible to enroll for dental coverage in the event of an appropriate qualified status change or during annual enrollment as long as they are enrolled in medical coverage through TI Extended Health Benefits. If none of your survivors enroll in medical coverage through TI Extended Health Benefits, or if they all opt out at a later date, none of the survivors will be eligible to enroll for medical or dental coverage through TI Extended Health Benefits in the future.

When Benefits Change

If TI group retiree dental coverage ends, expenses incurred for dentures, fixed bridgework and crowns will be covered if all of the following conditions are met:

- Final impressions were taken before coverage ended
- Teeth had been fully prepared to receive the item before coverage ended
- The item is delivered or installed no more than 30 calendar days after your coverage ends

Dental Health Maintenance Organization (DHMO)

Most retirees can choose a Dental Health Maintenance Organization (DHMO) as an alternative to Dental Basic / Dental Plus. This section offers an overview of the services that DHMOs generally provide. Details about the DHMO can be obtained on the Fidelity NetBenefits® website at netbenefits.com/ti or directly from the DHMO.

A DHMO is an organization that provides benefits for most dental care needs, with no claim forms, to its members who generally live within its geographic service area. You need to choose a dentist from a list of providers in the service area when you enroll. You typically pay a copay for services.

You must receive care from your selected dentist, or be referred by your dentist to another in-network provider, to receive benefits from a DHMO. If you receive care from a dentist not approved by the DHMO, you won't receive benefit coverage.

The DHMO will provide you with information about its benefits, services, and claim procedures. Review the information from the DHMO regarding limitations on claim filing and complaints or grievances.

Enrolling in a DHMO may not be advisable if:

- You and your family already have a relationship with a personal dentist who is not affiliated with the DHMO in your service area
- DHMO services are not located within easy access of your home
- Your eligible dependents do not live in the DHMO service area

You'll be able to compare the available options, including their costs and benefits, when you enroll or when you're eligible to make mid-year changes to your coverage (appropriate qualified status change).

You cannot change DHMO coverage or enroll in Dental Basic / Dental Plus except during annual enrollment, or when you move away from the geographic area served by the DHMO.

Newborn or Adopted Children

To add coverage for a newborn or adopted child, coverage must be elected within 60 calendar days from the date of birth, date of adoption or date adoption papers were filed. You must enroll your child on the Fidelity NetBenefits® website at netbenefits.com/ti or contact the TI Benefits Center. The next opportunity to

add coverage, absent a change in coverage consistent with a qualified status change, will be during annual enrollment. Changes made during annual enrollment are effective on the first calendar day of the calendar year following annual enrollment.

NOTE: All claims are administered by the DHMO Claims Administrator. TI has not reserved the right to interpret the terms of the plan or insurance policy with respect to fully-insured benefits. All benefits are provided solely through the insurance policy issued by the Claims Administrator. No benefits other than the benefits available under the insurance policy are available. No benefits are provided by TI outside of the insurance policy.

Continuation of Benefits (COBRA)

For information on continuation of benefits (COBRA), see the COBRA section.

Medical, Prescription Drug and Other Coverage for Participants age 65 or over

Individual Insurance Policies, not an ERISA PLAN

Once you or your eligible spouse (or domestic partner) reaches age 65 your, or your spouse's (or domestic partner's), coverage will no longer be provided directly through TI's group retiree coverage. Instead, you or your eligible spouse (or domestic partner) will have the opportunity to purchase an individual medical and/or prescription drug insurance policy through Via Benefits (formerly OneExchange). This approach offers you the opportunity to choose the coverage that best meets your needs from a variety of individual Medicare supplement, Medicare Advantage and Medicare prescription drug insurance policies.

Via Benefits also offers access to dental and vision coverage.

To be eligible you must meet one of the following conditions:

- For anyone who turns age 65, who is enrolled in pre-65 medical and/or dental coverage through TI Extended Health Benefits immediately prior to first becoming eligible to purchase an individual policy through Via Benefits, or
- For those ages 65 or over, who are currently eligible for enrollment in TI Extended Health Benefits at the time of termination of TI employment.

And you meet all of the following conditions:

- Enrolled in Medicare Part A and Part B, and
- Maintain a permanent U.S. address, which cannot be in Puerto Rico, Guam or U.S. Virgin Islands.

If you've met the above conditions, your eligible spouse (or domestic partner) must meet the following conditions to be eligible for coverage:

- Enrolled in Medicare Part A and Part B, and
- Maintain a permanent U.S. address, which cannot be in Puerto Rico, Guam or U.S. Virgin Islands.

Split-family coverage

A “split-family” occurs when one family member is age 65 or over and the other is under age 65. For more information, see the Eligibility section on page 17.

Approaching age 65

Prior to your 65th birthday, Via Benefits will send you – or your spouse (or domestic partner) – information about enrolling in individual insurance policies that are available to those who are age 65 or over. The information contains instructions for purchasing the individual medical and/or prescription drug insurance policy of your choice through Via Benefits.

Your TI group retiree medical and dental coverage will end regardless of whether you purchase one or more policies through Via Benefits. You must be enrolled in Medicare Parts A and B (for purchasing an individual medical or prescription drug insurance policy) and maintain a permanent U.S. address, which cannot be in Puerto Rico, Guam or U.S. Virgin Islands.

You or your eligible spouse (or domestic partner) may purchase individual insurance policies through Via Benefits on the first calendar day of the month of their 65th birthday. *For example, if your birthday is on June 13, you are eligible to purchase individual insurance policies as of June 1.* However, if your 65th birthday falls on the first calendar day of the month, you will be eligible one month earlier. *For example, if your birthday is on June 1, you are eligible to purchase individual insurance policies as of May 1.*

To avoid a gap in coverage as you transition benefits, you must purchase an individual medical, prescription drug and/or dental insurance policy through Via Benefits no later than the date you are first eligible to participate.

If you are currently enrolled in TI group retiree medical coverage, such coverage will end when you turn age 65. You must join a Medicare drug plan within 63 continuous calendar days following the termination of your existing TI coverage in order to avoid paying a higher premium (a penalty) to join a Medicare drug plan at a later date. Visit medicare.gov for more information.

If Coverage is Dropped

If you want to drop coverage, you must contact Via Benefits.

IMPORTANT NOTE: If your individual medical and prescription drug insurance policy at Via Benefits is dropped for any reason (e.g., you decide to not pay the premium or you purchase a medical and/or prescription drug policy outside of Via Benefits), your eligible dependents under the age of 65 will permanently lose their TI group retiree medical and dental coverage and they WILL NOT be eligible to enroll again at any time in the future.

If you or your eligible spouse (or domestic partner) are age 65 or over you may still purchase one or more individual insurance policies on your own through Via Benefits, but eligibility for the Retiree Reimbursement Account will be permanently lost.

Retiree Reimbursement Account (RRA) Contributions

If you terminated employment on or before January 4, 1993 with five or more years of service and met TI Extended Health Benefits eligibility requirements* – TI will contribute annually to an RRA on your behalf as well as that of your covered spouse (or domestic partner). If you have less than five years of service, you and any covered spouse (or domestic partner) will receive no RRA contribution.

If you terminated employment after January 4, 1993, were hired before January 1, 2001, have 15 or more years of service upon termination of employment and met TI Extended Health Benefits eligibility requirements* – TI will contribute annually to an RRA on your behalf. This TI contribution increases with each year of service up to 30 years of service. TIers who terminated employment with 30 years of service or more will receive the largest RRA contribution. Your covered spouse (or domestic partner) will receive no RRA contribution.

If you were hired on or after January 1, 2001 and met TI Extended Health Benefits eligibility requirements* – You and any covered spouse (or domestic partner) will receive no RRA contribution.

If you were employed by NSC on September 23, 2011 and met TI Extended Health Benefits eligibility requirements* – You and any covered spouse (or domestic partner) will receive no RRA contribution.

See page 11 of this Guide for TI Extended Health Benefits eligibility

IMPORTANT NOTES:

- If you and your eligible spouse (or domestic partner) do not purchase an individual medical and/or prescription drug insurance policy through Via Benefits within 60 calendar days after the loss of current TI group medical coverage, you and your eligible spouse (or domestic partner) WILL NEVER be eligible to participate in the RRA. However, you and your eligible spouse (or domestic partner) may still purchase one or more individual insurance policies on your own through Via Benefits.
- If you purchase a medical or prescription drug plan outside of Via Benefits, your medical or prescription plan through Via Benefits will automatically cancel and will result in losing eligibility for RRA.
- If you previously had TI group retiree dental coverage **only** you are not eligible for an RRA contribution.

The RRA contribution amount may change at any time. TI reserves the right to amend, modify or terminate the RRA and the TI Retiree Health Benefit Plan at any time.

If you have any questions, you can contact Via Benefits at 844-638-4642. Via Benefits customer service representatives are available Monday through Friday, from 8:00 a.m. to 9:00 p.m. Eastern time. The website for Via Benefits is My.ViaBenefits.com/TI.

THIS FORM WAS PREPARED FOR COMPLIANCE WITH U.S. FEDERAL HIPAA PRIVACY. YOU SHOULD CONSULT THE APPLICABLE STATE LAWS FOR STATE DIFFERENCES

NOTICE OF PRIVACY RIGHTS – HEALTH CARE RECORDS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 23, 2013, and applies to health information received about you by the Texas Instruments Incorporated Retiree Health Benefit Plan (the "Plan"). You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). The Privacy Regulations were most recently amended effective January 17, 2013. Additionally, the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA") both amended the privacy requirements under the Privacy Regulations. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan, including genetic information (your "Protected Health Information" or "PHI"). This notice is intended to inform you about how the Plan will use or disclose your Protected Health Information, your privacy rights with respect to the Protected Health Information, the Plan's duties with respect to your Protected Health Information, your right to file a complaint with the Plan or with the U.S. Department of Health and Human Services and the office to contact for further information about the Plan's privacy practices. The following uses and disclosures of your Protected Health Information may be made by the Plan:

For Payment. Your Protected Health Information may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, and disclosures to obtain reimbursement under insurance, reinsurance or stop loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your Protected Health

Information may be disclosed to other health plans maintained by Texas Instruments Incorporated for any of the purposes described above. ARRA requires disclosures for purposes of payment to meet its minimally necessary standard effective on and after February 17, 2010.

For Treatment. Your Protected Health Information may be used or disclosed by the Plan for purposes of treating you. For example, if your doctor requests information on what other drugs you are currently receiving.

For the Plan's Operations. Your Protected Health Information may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances; however, your genetic information, if any, contained in your PHI will not be disclosed for underwriting, premium rating, renewal of coverage, or for securing or placing a contract for reinsurance of risk. ARRA requires disclosures for purposes of health care operations to meet its minimally necessary standard effective on and after February 17, 2010. The Plan may disclose your Protected Health Information for purposes of referring you to case management or a pharmacy benefit manager.

When Required by Law. The Plan may also be required to disclose or use your Protected Health Information for certain other purposes when the Plan is required by law to disclose or use your Protected Health Information. For example, if certain types of wounds occur that require reporting, or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena.

For Workers' Compensation. The Plan may disclose your Protected Health Information as authorized by you or your representative and to the extent necessary to comply with laws relating to workers' compensation and similar programs providing benefits for work-related injuries or illnesses if either (1) the health care provider provides health care to the individual at the request of the employer to determine if the individual has a work-related illness or injury or to provide medical surveillance of the workplace and the health care provider is employed by the employer; or (2) if the employer is a health care provider and the health care provider is a member of the employer's work force; or (3) you authorize the disclosure. You must authorize the disclosure in writing and you will receive a copy of any authorization you sign.

Pursuant to Your Authorization. Any other use or disclosure of your Protected Health Information will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to

the extent the Plan has taken any action relying on your authorization for disclosure. The revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.

For Appointment Reminders and Health Plan Operations. Your Protected Health Information may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. Information may be provided to the sponsor of the Plan provided that the sponsor has certified that this information will not be used for any other benefits, employee benefit plans or employment related activities.

Other Uses or Disclosures of Protected Health Information

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release:

Disclosure of your Protected Health Information to family members, other relatives and your close personal friends involved in your health care or the payment for your health care is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care;
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected;
- the information is needed for notification purposes; or
- if you are deceased, your Protected Health Information is relevant to such person’s involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

Uses and disclosures for which authorization or opportunity to object is not required:

Use and disclosure of your Protected Health Information is allowed without your authorization or any opportunity to agree or object under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when

necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Protected Health Information may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.

- When authorized or required 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. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.
- When the disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under U.S. federal or state laws when the parents or other representatives may not be given access to a minor's Protected Health Information.
- When the Protected Health Information is immunization records for a student or prospective student that is disclosed to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.
- The Plan may disclose your Protected Health Information to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your Protected Health Information when required for judicial or administrative proceedings. For example, your Protected Health Information may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the

Plan is unable to obtain the individual's agreement because of emergency circumstances.

- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose Protected Health Information for research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- The Plan may disclose your Protected Health Information to your employer, provided certain requirements are met, and provided that the Protected Health Information is not used for any other employment decision and it is not further disclosed or used; however, no genetic information may be used in underwriting or obtaining bids for coverage.
- The Plan may use your Protected Health Information (excluding any genetic information) for underwriting purposes. The Plan is prohibited from using or disclosing Protected Health Information that is genetic information of an individual for such purposes.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization. State laws may provide you with additional rights or protections.

Uses and Disclosures Requiring an Authorization

The Plan may only use your Protected Health Information if you provide your written authorization to so use your Protected Health Information for the following uses or disclosures:

- Any access to psychotherapy notes from your treatment or counseling sessions (whether individual or group);
- If the Plan wants to use your Protected Health Information for marketing purposes, for example using your phone number to contact you to try to sell you a product unrelated to your health care; or
- If the Plan wants to sell your Protected Health Information. (This notice regarding the selling of your Protected Health Information is required to

comply with the Privacy Regulations. The Plan has no intention to sell your Protected Health Information.)

You may revoke any authorization that you have previously provided to the Plan. You should contact the Plan in writing to revoke any prior written authorization.

The Plan's Obligations

The Plan is required by law to maintain the privacy of the Protected Health Information it creates or receives, to provide individuals with notice of its legal duties and privacy practices with respect to Protected Health Information, and to notify affected individuals following a breach of unsecured Protected Health Information. The Plan is required to abide by the terms of the Plan's current privacy notice.

Rights You May Exercise

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your protected health information in writing. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to any restriction you may request.

In certain circumstances, the Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243.

To Access. You have the right to request access to your Protected Health Information and to inspect and copy your Protected Health Information in the designated record set under the policies and procedures established by the Plan. The designated record set is the series of codes that make up each electronic claim. This does not include psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or Protected Health Information that is maintained by a covered entity that is a clinical laboratory. The requested information will be provided within 30 calendar days if the information is maintained on site or within 60 calendar days if the information is maintained offsite. A single 30-calendar-day extension is allowed if the Plan is unable to comply with the deadline. To the extent that the Plan uses or maintains an electronic health record you have a right to obtain a copy of your PHI from the Plan in an electronic format. In

addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person designated by the individual.

You or your personal representative will be required to complete a form to request access to the Protected Health Information in your designated record set. Requests for access to Protected Health Information should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the U.S. Department of Health and Human Services.

To Amend. You have the right to request an amendment to your Protected Health Information in writing under the policies established by the Plan. The Plan has 60 calendar days after the request is made to act on the request. A single 30-calendar-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your Protected Health Information. Requests for amendment of Protected Health Information in a designated record set should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243. You or your personal representative will be required to complete a written form to request amendment of the Protected Health Information in your designated record set.

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your Protected Health Information, other than those for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your Protected Health Information during the six years prior to the date of your request. However, such accounting need not include Protected Health Information disclosures made: (1) to carry out treatment, payment or health care operations, except that such disclosures from a plan using electronic health records occurring after January 1, 2014 will be required to be included in the accounting for three years; (2) to individuals about their own Protected Health Information; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on January 1, 2011.

If the accounting cannot be provided within 60 calendar days, an additional 30 calendar days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To Request a Paper Copy of this Notice. An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, contact the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243.

To Request Confidential Communication. You have the right to request to receive confidential communications of your Protected Health Information. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate certain reasonable requests to receive communications of PHI by alternative means or at alternative locations. Such requests should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243.

A Note About Personal Representatives

You may exercise your rights through a personal representative (e.g., having your spouse or domestic partner call for you). Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your Protected Health Information or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a signed authorization completed by you;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your Protected Health Information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all Protected Health Information the Plan maintains. Any Protected Health Information that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all Protected Health Information it receives or maintains.

Any revised version of this notice will be distributed within 60 calendar days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing Protected Health Information or when requesting Protected Health Information from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of Protected Health Information necessary to accomplish the intended purpose of the use, disclosure or request.

However, the minimum necessary standard will not apply in the following situations: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual; (3) disclosures made to the U.S. Department of Health and Human Services; (4) uses or disclosures made pursuant to an authorization you signed; (5) uses or disclosures in the designated record set; (6) uses or disclosures that are required by law; (7) uses or disclosures that are required for the Plan's compliance with legal regulations; and (8) uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan may use or disclose a “Limited Data Set” which may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set. Disclosures of a Limited Data Set need not be included in any accounting of disclosures by the

Plan. Effective for uses or disclosures on and after February 17, 2010, the minimally necessary shall be defined as the Limited Data Set, or the minimal amount necessary as determined by the recipient, until such time as regulations defining what constitutes the minimally necessary are promulgated and effective.

You have the right to file a complaint with the Plan or the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. You will not be retaliated against for filing a complaint, but such complaint must be filed within 180 calendar days of any alleged violation.

You may file a complaint with the Plan by sending a letter describing when you believe the violation occurred and what you believe the violation was to Texas Instruments Incorporated, Attention: Privacy Complaint Official, 13570 N. Central Expressway, MS 3999, Dallas, Texas 75243, calling 214-479-1242, or sending an email to privacy_complaint_official@list.ti.com.

You may also file a complaint by sending a letter to the U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington, DC 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

If you would like to receive further information, you should contact the Privacy Official or the Privacy Complaint Official for the Plan. This notice will remain in effect until you are notified of any changes, modifications or amendments.

CONTINUATION OF TI GROUP RETIREE MEDICAL AND/OR DENTAL BENEFITS (COBRA Benefits) for Participants under age 65 — Does Not Apply to Individual Insurance Policies a Retiree or Dependent Purchases through Via Benefits (formerly OneExchange)

COBRA Continuation Coverage

TI, in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, allows you, your spouse or domestic partner and your eligible dependent children (or children of your domestic partner) to elect to continue TI group retiree medical and/or dental benefits offered under the TI Retiree Health Benefit Plan beyond the date coverage is otherwise scheduled to end because of the occurrence of certain events known as “qualifying events.” **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. This notice also contains information about your right to obtain other health coverage alternatives that may be available to you through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally you may qualify for a 30 calendar day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan), even if that plan generally doesn’t accept late enrollees. Specific qualifying events are described later in this notice. You should contact the Health Insurance Marketplace available in your state regarding when you must notify the Health Insurance Marketplace about your qualifying events so you do not miss any deadlines for such notices to be eligible to elect coverage on the Health Insurance Marketplace. When a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified individual." You, your spouse or domestic partner, and your dependent children could become qualified individuals if coverage under one of the plans described above is lost because of the qualifying event. Covered retirees may elect COBRA continuation coverage on behalf of their spouses or domestic partners or dependent children. Your spouse may also elect COBRA continuation coverage on behalf of herself/himself, you and your dependent children. Qualified individuals who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualified individuals may elect to continue one or more of TI group retiree medical and/or dental benefits in any combination. Each qualified individual will have an independent right to elect COBRA continuation coverage during the 60-calendar-day period as specified in the enrollment notice. You should contact the Health Insurance Marketplace in your state to determine when you may enroll in the health insurance coverage offered there because its election period is distinct from the COBRA continuation coverage election period.

Qualified individuals electing to receive COBRA benefits have all the rights of employees and dependent(s) (or of retirees and dependent(s) if a retiree elects under the TI Retiree Health Benefit Plan) covered under the TI group retiree medical and/or dental benefits, including the right to add newborn children, children placed for adoption, and other dependent(s) within 60 calendar days following an appropriate qualified status change, or within 60 calendar days if the qualified status change is gaining eligibility or losing eligibility for CHIP or Medicaid coverage. Dependent(s) not covered when COBRA benefits began may also be added during annual enrollment.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-calendar-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Qualifying Events – When COBRA continuation coverage is available

If you are a retiree, you will not become a qualified individual.

If you are the spouse or domestic partner of a retiree, you will become a qualified individual if you lose your coverage under the TI Retiree Health Benefit Plan because any of the following qualifying events happens:

- Your spouse/domestic partner dies;
- Your spouse/domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both);
- You become divorced or legally separated from your spouse; or
- Your domestic partnership ends.

Your dependent children will become qualified individuals if they lose coverage

under the plan because any of the following qualifying events happens:

- The parent-retired employee dies;
- The parent-retired employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Finally, an individual who receives a certification indicating that they qualify for benefits under the Trade Adjustment Act ("TAA") within six months of his/her termination of employment may be provided with a second opportunity to elect COBRA continuation coverage, provided that they notify the TI Benefits Center, at the address specified below, of their TAA certification within the same six-month period. A copy of the TAA certification is required for enrollment.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Texas Instruments Incorporated, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified individual. The retired employee's spouse, surviving spouse, and dependent children will also become qualified individuals if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- Death of the retiree;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The retiree's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the retiree and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the TI Benefits Center within 60 calendar days after the qualifying event occurs. You must provide this notice by calling the TI Benefits Center through TI HR Connect at 888-660-1411 or by logging onto the Fidelity NetBenefits® website at netbenefits.com/ti. You must provide the date of your

divorce or legal separation or the date your dependent stopped being eligible to be covered under this Plan. You must also provide updated contact information for the spouse or dependent.

Notice Requirements for COBRA Continuation Coverage

COBRA continuation coverage will be available to qualified individuals only after the TI Benefits Center has been notified that a qualifying event has occurred. When you become entitled to Medicare benefits (under Part A, Part B, or both) or following your death, you or your dependent should notify the TI Benefits Center of this qualifying event.

You Must Give Notice of Some Qualifying Events

For a qualifying event occurring due to the divorce or legal separation of you and your spouse, the date your domestic partner ceases to qualify as your domestic partner or your child losing eligibility for coverage as a dependent, you must notify the TI Benefits Center within 60 calendar days after the qualifying event occurs. Failure to notify the TI Benefits Center within this 60-calendar-day period will result in the loss of any right to COBRA continuation coverage. Notice can be provided by logging onto the Fidelity NetBenefits® website at netbenefits.com/ti or by calling the TI Benefits Center through TI HR Connect at 888-660-1411, or by mail to:

TI Benefits Center
P.O. Box 770003
Cincinnati, OH 45277-1060

The TI Benefits Center must also be notified of any change in address.

How is COBRA continuation coverage provided?

Once the TI Benefits Center receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered retired employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

Electing COBRA Coverage

Once the TI Benefits Center has been notified of the occurrence of a qualifying

event, you will be provided with instructions on how to elect COBRA continuation coverage. You must elect COBRA continuation coverage within the 60-calendar-day period as specified in the enrollment notice. If you initially decline COBRA continuation coverage within the specified 60-calendar-day period, you may still elect COBRA continuation coverage provided such election is made within the specified 60-calendar-day period. However, in no event can you elect COBRA continuation coverage after the specified 60-calendar-day period.

In considering whether to elect COBRA continuation coverage, you should take into account that you have special enrollment rights under U.S. federal laws. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 calendar days after your group health coverage ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

There may be other coverage options for you and your family. You may be able to buy coverage through the Health Insurance Marketplace if you choose such coverage promptly after you lose coverage. You should contact www.healthcare.gov to learn about any time limits on your electing coverage in the Marketplace. In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be estimated to be by the Marketplace before you make a decision to enroll. You should contact the Marketplace for your state to determine if you have a special enrollment right with the Health Insurance Marketplace and when such special enrollment right ends. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 calendar days of the date your coverage under this plan terminated. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

Maximum Periods of Coverage

The maximum length of COBRA continuation coverage available for loss of TI group retiree medical and/or dental benefits will vary depending on your situation. COBRA continuation coverage for loss of TI group retiree medical and/or dental benefits is available for up to 36 months as outlined below.

Qualifying Event Extension

If your family experiences a qualifying event, your spouse and dependent children can get up to a maximum of 36 months of COBRA continuation coverage, if notice of the qualifying event is properly given to the TI Benefits Center. This extension may be available to your spouse and any dependent children receiving COBRA continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or get divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

If you receive an extension for your COBRA continuation coverage because of the occurrence of a second qualifying event, COBRA continuation coverage for TI group retiree medical and/or dental benefits will continue until the earliest of:

- 36 months from the date your COBRA benefits began;
- The last calendar day for which you have paid the required premium;
- The date of cancellation of the plan if the plan is canceled for all employees or retirees; or
- The date after you elect COBRA continuation coverage on which you or your covered dependent(s) first become covered under another group health plan that does not include any limitation or exclusion on a pre-existing condition that applies to you or your covered dependent(s), or you or your covered dependent(s) become entitled to Medicare.

36-Month COBRA Continuation Coverage Period

Upon the occurrence of one of the following qualifying events, COBRA continuation coverage for TI group retiree medical and/or dental benefits will be available to your spouse, your domestic partner and your eligible children (or children of your domestic partner):

- Loss of coverage for your eligible dependent(s) under the TI group retiree medical and/or dental options because of your death, or your divorce or legal separation from your lawful spouse/domestic partner;
- A dependent child ceasing to be a dependent child under the terms of the plan; and
- Loss of coverage under the plan because of your entitlement to Medicare.

In these circumstances, your eligible dependent(s) may elect to continue coverage until the earliest of:

- 36 months from the date COBRA benefits began;
- The last calendar day for which the required premium was paid;
- The date of cancellation of the plan if the plan is canceled for all employees or retirees; or
- The date after you elect COBRA continuation coverage on which your covered dependent(s) first become covered under another group health plan that does not include any limitation or exclusion on a pre-existing condition that applies to your covered dependent(s), or you or your dependent(s) become entitled to Medicare (for additional information, see the Important Note in Premiums section).

Medicare Coverage at Age 65

When you or your spouse reach age 65, your TI COBRA benefits become secondary to those benefits you receive – or are eligible to receive – from Medicare. You are responsible for any Medicare premium charges for yourself and your dependents.

Generally, everyone age 65 or older is eligible for Medicare Part A (generally automatic coverage) and Part B (elected enrollment). To enroll and ensure that you receive full medical coverage protection, check with your Social Security office at least three months before you or your covered spouse reaches age 65.

Even if you do not enroll in Medicare Part B, the TI plan will continue to pay secondary and will estimate the portion that would have been paid by Medicare.

Early Termination of COBRA Continuation Coverage

COBRA continuation coverage may be terminated before the maximum period described above for any of the following reasons:

- Texas Instruments no longer provides group health coverage to any of its employees or retirees;
- The premium for continuation coverage is not paid in a timely manner;
- The retired employee, spouse/domestic partner or dependent(s) first becomes covered after electing COBRA continuation coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition;
- The retired employee or spouse/domestic partner first becomes entitled to Medicare (Note: COBRA continuation coverage will be offered for the maximum period to an individual who is eligible for Medicare before experiencing a COBRA qualifying event);
- The retired employee, spouse/domestic partner or dependent(s) received extended continuation coverage up to 29 months due to a Social Security disability and a final determination has been made that he or she is no longer disabled; or
- The retired employee, spouse/domestic partner or dependent(s) notifies the TI Benefits Center that they wish to cancel continuation coverage.

You must notify the Plan Administrator within 30-calendar-days of your loss of coverage in order to prevent being charged a monthly premium after loss of eligibility. You may not receive a refund for any premium paid for coverage after you lose eligibility if you fail to notify the Plan Administrator within this 30-calendar-day period.

Premiums

A retired employee, spouse, domestic partner or dependent(s) does not have to show they are insurable in order to choose continuation coverage. But a retired employee, spouse, domestic partner or dependent(s) must have been actually covered under the TI group retiree medical and/or dental benefits offered under the TI Retiree Health Benefit Plan the calendar day before the qualifying event in order to qualify for COBRA coverage.

A retired employee, spouse, domestic partner or dependent(s) may have to pay all of the applicable premiums, which generally cannot exceed 102% of the plan costs for a 12-month period. An exception exists for coverage of employees with disabilities during the extension from the 19th month to the 29th month. During that time, 150% of the plan costs may be charged. Because the cost of COBRA continuation coverage is based on the amount of the applicable premium, the cost for COBRA continuation coverage will increase if the cost of premiums for TI group retiree medical and/or dental benefits offered under the TI Retiree Health Benefit Plan increase.

You must make your first premium payment for COBRA continuation coverage not later than 45 calendar days after the date of your election.

After you make your first payment for COBRA continuation coverage, you will be required to make periodic premium payments. There is a 30-calendar-day grace period following the date regularly scheduled monthly premiums are due.

IMPORTANT NOTE: Coverage can be terminated before the 36-month period if you or your eligible dependent(s) are covered under another group health plan with no pre-existing condition limitation that applies to you or your eligible dependents. You must notify the Plan Administrator within 30-calendar-days of your loss of coverage in order to prevent being charged a monthly premium after loss of eligibility. You may not receive a refund for any premium paid for coverage after you lose eligibility if you fail to notify the Plan Administrator within this 30-calendar-day period.

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below in the 'Plan Contact Information' section. For more information about your rights under Employee Retirement Income Security Act (ERISA), including COBRA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep the TI Benefits Center Informed of Address Changes

To protect your family's rights, you should let the TI Benefits Center know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the TI Benefits Center.

Plan Contact Information

You may obtain additional information about your rights and responsibilities under the TI Retiree Health Benefit Plan by accessing the Fidelity NetBenefits® website at netbenefits.com/ti or by contacting the TI Benefits Center through TI HR Connect at 888-660-1411. When calling the TI Benefits Center please be prepared to provide your Social Security number and Fidelity password. TI Benefits Center representatives are available between 8:30 a.m. and 8:30 p.m., Eastern time, Monday through Friday (excluding New York Stock Exchange

holidays). The website is available virtually 7 days per week, 24 hours per day, except for scheduled maintenance windows.

ERISA — Does Not Apply to Individual Insurance Policies a Retiree or Dependent Purchases through Via Benefits

ERISA Guidelines

The Employee Retirement Income Security Act of 1974 (ERISA) protects your rights under your benefit plans and ensures you receive appropriate information.

- TI Retiree Health Benefit Plan (includes TI group retiree medical and dental)

Texas Instruments Retiree Benefit Plans Under ERISA

TI Retiree Health Benefit Plan

Type of Plan
Hospitalization and Medical-Care Benefit
Dental Benefit

Employer Identification Number: 75-0289970

Plan Number: 502

Plan Trustee
The Northern Trust Company
Corporate Financial Services
50 South LaSalle Street
Chicago, Illinois 60603

Plan Year
January 1 through December 31

Sponsoring Employer
Texas Instruments Incorporated
12500 TI Boulevard
Dallas, Texas 75243

Agent for Service of Legal Process
Cynthia Trochu, Secretary
Texas Instruments Incorporated
12500 TI Boulevard
Dallas, Texas 75243

Plan Administrator:

TI Retiree Health Benefit Plan
Attn: Plan Administrator
P.O. Box 650311, MS 3905
Dallas, Texas 75265

Claims Administrators/Insurance Companies:

The Administration Committee is the appointed Plan Administrator for purposes of claim appeals related TI group retiree medical benefits under the TI Retiree Health Benefit Plan.

PPO: Blue Cross Blue Shield PPO benefits are administered by Blue Cross and Blue Shield of Texas. This option is self-insured by TI, and TI is responsible for payment of such claims.

Blue Cross Blue Shield PPO
Blue Cross Blue Shield
P.O. Box 655488
Dallas, TX 75265-5488

HDHP: Blue Cross Blue Shield HDHP benefits are administered by Blue Cross and Blue Shield of Texas. This option is self-insured by TI, and TI is responsible for payment of such claims.

Blue Cross Blue Shield HDHP
Blue Cross Blue Shield
P.O. Box 655488
Dallas, TX 75265-5488

Cigna: Cigna Copay Plan (Open Access Plus In Network) benefits are administered by Cigna. This option is self-insured by TI, and TI is responsible for payment of such claims.

Cigna
900 Cottage Grove Road
Hartford, CT 06152

HMO: HMO benefits are fully-insured and claims are administered by the HMO.

Kaiser Northern California
1950 Franklin Street
Oakland, CA 94612

Dental: The Dental benefit is self-insured and claims are administered by MetLife Dental.

MetLife Dental
P.O. Box 14093
Lexington, KY 40512

DHMO: The DHMO benefit is fully-insured and claims are administered by Aetna.

Aetna
2777 Stemmons Freeway, #300
Dallas, TX 75207

Your Rights Under ERISA

As a participant in any or all of the plans described in this Summary Plan Description, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office or at other specified locations, all documents governing the Plan, including insurance contracts, and a copy of the latest summary annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Administrator(s), copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest summary annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people that are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Enforce Your Rights

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time frames.

Additional Rights Under ERISA

Under ERISA, there are steps you can take to enforce the above listed rights. For instance, if you request a copy of Plan documents or the latest summary annual report from the Plan and do not receive them within 30 calendar days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a calendar day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or part and you have exhausted your administrative appeals, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order and you have exhausted your administrative appeals, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or you are discriminated against for asserting your rights and you have exhausted your appeals, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have

sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the appropriate Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.