Texas Instruments

2019 Retiree Health Benefits Summary Plan Description

Issued: September 2018

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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 at Fidelity**	**888-660-1411**
• Blue Cross Blue Shield (BCBS) HDHP and PPO A & B	Medical benefits and claim status	888-660-1411 bcbstx.com
• BCBS HDHP and PPO Pharmacy Network Administrator (CVS Caremark)	Pharmacy benefits and claim status	888-660-1411 caremark.com
• MetLife Dental Basic/Dental Plus	Dental benefits and claim status	888-660-1411 metlife.com/dental
• TI Benefits Center at Fidelity	Billings and coverage status	888-660-1411 netbenefits.com/ti
Dental Health Maintenance Organization		
Aetna DMO	Dental benefits and claim status	800-772-1416 aetna.com
Medicare	Medicare benefits and claim status	800-633-4227 medicare.gov
Social Security	Social Security benefits	800-772-1213 socialsecurity.gov
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 kp.org

INTRODUCTION

This is the Summary Plan Description (SPD) for Texas Instruments Incorporated's (TI's) Extended Health Benefits, offered through the TI Retiree Health Benefit Plan (the "Plan"), as of January 1, 2019. 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 SPD is written in plain language to help you understand how the Plan works. If there is a conflict between the information in this SPD and the plan document, the plan document will govern. The plan document is the Plan for self-insured benefits and the plan document is the insurance policy or contract for fully-insured benefits.

The SPD 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 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 at Fidelity 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 at Fidelity 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 at Fidelity 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, or a regional HMO (if available in your area). In such cases, you must contact TI Benefits Center at Fidelity 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 at Fidelity through TI HR Connect.	TI Benefits Center at Fidelity sends out all TI group retiree medical and dental coverage bills.

ELIGIBILITY

TI Extended Health Benefits under the TI Retiree Health Benefit Plan provides access to TI group retiree medical (includes prescription drug) 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. Via Benefits also offers access to vision coverage. When you terminate employment from TI, you may be eligible for TI Extended Health Benefits or Via Benefits. For more information on Via Benefits, see section beginning on page 115.

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 at Fidelity through TI HR Connect.

IMPORTANT NOTES:

- **For those under age 65**:
    - **When TI coverage ends:** Your active TI coverage ends on your termination date.
    - **Requirements for TI Extended Health Benefits coverage:** If you meet the above requirements, you must enroll in TI Extended Health Benefits coverage within 30 calendar days of the date you terminate employment or forego eligibility in the future.
- **For those ages 65 or over, or eligible for split-family coverage:**
    - **When TI coverage ends:** Your active TI coverage ends the last calendar day of the month, following the month of your termination. Here, active coverage continues for a longer period to try and prevent a gap in your coverage while you follow the process required to enroll in Medicare benefits and purchase an individual policy through Via Benefits. The cost of such continued active coverage is paid by TI.
    - **Requirements for Retiree Reimbursement Account (RRA) contributions:** If you are eligible and wish to receive the annual RRA contribution from TI, you must enroll in an individual medical and/or prescription drug insurance policy through Via Benefits within a 60-calendar-day window.

        If you are working for TI when you retire at age 65 or older, the 60-calendar-day window starts on the first calendar day of the month following the month in which you terminate employment.

        If you are enrolled in TI Extended Health Benefits when you reach age 65, the 60-calendar-day window starts on the first calendar day of the month in which you turn age 65 unless your birthday is on the first calendar day of the month in which case the 60-calendar-day window starts on the first calendar day of the prior month. For example, if your 65th birthday is on August 8th, your eligibility starts on August 1st. And, if your 65th birthday is on August 1st, your eligibility starts on July 1st.

For more information on Via Benefits, see section beginning on page 115.

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 at Fidelity.

Other Important Information

Eligibility and plan rules for TI Extended Health Benefits coverage 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 coverage offered through the TI Retiree Health Benefit Plan. TI Extended Health Benefits 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 coverage 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 at Fidelity 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 at Fidelity 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 at Fidelity. 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 at Fidelity 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 130.

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 115.

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, they are eligible to purchase an individual medical, prescription drug or dental insurance policy through Via Benefits, as long as they continue to be eligible for dependent coverage.

For more information on Via Benefits, see section beginning on page 115.

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 117 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 at Fidelity
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 at Fidelity
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 all New York Stock Exchange holidays except Good Friday) 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 and sole and complete discretion to interpret the Plan and its benefit options (excepting fully-insured benefits), including the plan document and/or contracts, as well as the right to delegate these duties. Such discretionary interpretations of the Plan (including any policies or procedures under which it is operated) will be final and binding.

In no event may any representations by a TI employee or third party administrator 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, 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 38 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 40 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 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 document.

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. See page 42 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-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 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 at Fidelity 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 38 for medical and page 76 for prescription drugs.

If you want to drop coverage, you must contact TI Benefits Center at Fidelity 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.

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 at Fidelity 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 at Fidelity. 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 at Fidelity.

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 38-39 and 42-43 in the chart “Deductibles, Copays and Coinsurances in the BCBS PPOs” and on pages 40-41 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
- 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.

Illness means any kind of bodily or mental disorder. An illness includes diseases, pregnancy, and injuries that a person sustains in an accident.

What Physicians and Hospitals are Covered under the BCBS HDHP and PPO Options

- Eligible physicians:
    - For medical this means a legally qualified practitioner and includes the following when they are rendering covered services, are licensed in the state in which they are practicing and are practicing within the scope of their license (not a resident physician or intern); eligible physicians include Medical Doctor (M.D.), Osteopath (D.O.), Podiatrist (D.P.M.), Chiropractor (D.C.), Dentist (D.D.S. or D.M.D.), Optometrist (O.D.), Ophthalmologist (M.D. or D.O) and Certified Nurse-Midwife (C.N.M.).
    - For behavioral health care this is a licensed M.D., Ph.D. psychologist, licensed professional counselor, licensed marriage and family therapist, ABA therapist and masters of social work.
- Eligible hospitals includes the following institutions when they are rendering covered services:
    - an institution which is primarily engaged in providing, for compensation and on an inpatient basis, for the surgical and medical care, diagnosis, and treatment of persons through medical, diagnostic, and major surgical facilities. These facilities must be

provided on the institution's premises, under the supervision of a staff of physicians, and with 24-hours-a-day registered graduate (R.N.) nursing services. The institution must be operated consistently with all laws;

- an institution which is accredited as a hospital by The Joint Commission; or
- any institution that the Plan Administrator so designates in their sole discretion.

Inpatient hospital facilities include but are not limited to hospitals, skilled nursing facilities and hospice. The term hospital shall not include any institution (or any part of an institution) which is used (other than incidentally) as a convalescent facility, nursing home, rest home, or a facility for the aged.

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 they participate in the Claims Administrator's *ParPlan* - a simple direct−payment arrangement. If the physician or other licensed medical professional participates in the *ParPlan,* they agree 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 at Fidelity. 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 93.

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

Retirees share the cost of coverage through deductibles, copays and coinsurances; 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%
MDLIVE Virtual Visit	10%	N/A
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] This includes e-visits, virtual visits and telemedicine visits. 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 coinsurances; 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%
MDLIVE Virtual Visit	10%	N/A
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] This includes e-visits, virtual visits and telemedicine visits. 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 coinsurances; 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%
MDLIVE Virtual Visit	10%	N/A
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] This includes e-visits, virtual visits and telemedicine visits. 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.

Lifetime dollar limits may apply to certain covered services (e.g., hospice care).

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

Screening Tests (continued)	Ages Covered	Recommended Frequency	Gender	
			M	F
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 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

Pregnancy Screenings (continued)		Recommended Frequency	Gender	
			M	F
Urine Culture		12 to 16 weeks gestation or at the 1st prenatal visit, if later		X
Anemia screening for iron deficiency		During pregnancy		X
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)	50 and older	One series	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.

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.

- Developmental delay therapies related to a medical condition, including, but not limited to:
  - Psychosocial speech delay
  - Behavioral problems
  - Attention disorders
  - Conceptual handicap
  - Reduced cognitive function
- 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 their 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
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)

MDLIVE Virtual Visit

Benefits for MDLIVE virtual visit:

- Network coinsurance is 10%, after the deductible is met
- Benefits outside the network are not covered

When to use MDLIVE virtual visit:

Non-emergency medical conditions, such as:

- Allergies
- Cold and flu
- Earache
- Fever
- Headache
- Insect bites
- Nausea
- Pinkeye
- Sore throat

Pediatric care for **non-emergency** medical conditions, such as:

- Cold and flu
- Earache
- Nausea

There are several ways to access the MDLIVE virtual visit services.

- You can call MDLIVE at 888-680-8646; customer service is available 7 days per week, 24 hours per day. You will speak with a care coordinator to confirm MDLIVE virtual visit services are appropriate and be directed to a list of eligible doctors to select from, then you can automatically connect with an available doctor or schedule a future appointment.
- You can also visit MDLIVE's website at MDLIVE.com/BCBSTX. You can receive system assistance to confirm virtual visit services are appropriate and you can view a list of eligible doctors using specialty, language,

gender or next available doctor criteria, then you can automatically connect with an available doctor via online portal or schedule a future appointment.

Telephone and video availability varies by state.

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, which includes procedures, treatments, care, services and supplies that 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. BCBS determines experimental and investigational treatment, according to its medical policies and procedures on such matters. For a copy of such policies and procedures, please refer to bcbstx.com/important-info/policies.
- 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
    - 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 medical coverage, contact BCBS. If you have any questions about prescription drug coverage, contact CVS Caremark.

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 submitted according to administrative claim procedures and 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.

Administrative Claim Procedures

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 their 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 at Fidelity 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. Certain immunizations are covered, check the caremark.com website for coverage or contact CVS Caremark through TI HR Connect at 888-660-1411.

Pre-Medicare BCBS Prescription Drug Benefits – HDHP

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

HDHP			
Type	**In-Network Coinsurance/ Maximum**	**Out-of-Network Coinsurance**	**Mail-Order Program* Coinsurance/ Maximum**
Generic Drugs	20% / $25 (whichever is less) 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% / $75 (whichever is less) of the total drug cost, for up to a 90-calendar-day supply
Preferred Brand-name Drugs**	30% / $75 (whichever is less) 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	30% / $225 (whichever is less) of the total drug cost, for up to a 90-calendar-day supply
Non-preferred Brand-name Drugs**	50% / $100 (whichever is less) 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	50% / $300 (whichever is less) 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 79. For Specialty Medications, only the amounts actually paid by the participant will apply to the annual medical deductible and the annual medical out-of-pocket maximum.

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	20% 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
Preferred Brand-name Drugs**	30% 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	30% of the total drug cost, for up to a 90-calendar-day supply
Non-preferred Brand-name Drugs**	50% 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	50% 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 annual pharmacy out-of-pocket maximum — you must still pay the difference, even if your annual pharmacy 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 PPO annual pharmacy out-of-pocket maximum.

**** For more information, see the Specialty Medications section on page 79. For Specialty Medications, only the amounts actually paid by the participant will apply to the annual pharmacy out-of-pocket maximum.

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 (including all components of the compound) 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) for Participants under age 65

The following plan provisions apply uniformly to BCBS (including CVS Caremark), 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	
For Medical Complaints:	**For 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

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. 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	
For Medical Claims:	**For 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

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.*

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	
For Medical Claims:	**For 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

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.

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. 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, or a regional HMO except during annual enrollment, or when you move away from the geographic area served by the regional HMO.

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 at Fidelity. 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 at Fidelity 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.

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 do decide to join a Medicare drug plan and drop your current TI coverage, be aware that you and your dependents will not be able to get this coverage back.

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 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 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…

Call the TI Benefits Center at Fidelity toll-free through TI HR Connect at 888-660-1411, option 1, to speak with a representative. Representatives are available from 8:30 a.m. to 8:30 p.m. U.S. Eastern time Monday through Friday, excluding all New York Stock Exchange holidays except Good Friday. **Note:** You'll get this notice 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

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 at Fidelity 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 at Fidelity 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 at Fidelity. 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 at Fidelity 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.

Deductible and Coinsurances in MetLife Dental Basic and Dental Plus

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

Your Cost	Dental Basic	Dental Plus
Annual deductible*	$50	$50
Benefits	**Coinsurance Paid by Participant****	
Preventive care	**Dental Basic**	**Dental Plus**
- Oral exam, preventive x-rays, cleanings	0%	0%

Basic services	Dental Basic	Dental Plus
- 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. 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 dental expenses after you meet your deductible (unless otherwise noted).

Annual and Lifetime Maximums

	Dental Basic	Dental Plus
Annual maximum*	$1,000	$2,000
Orthodontic lifetime maximum*	$1,000	$1,500

* This is the maximum amount the plan will pay. You must pay for any expenses, after the plan pays up to the maximum amount.

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 submitted according to administrative claim procedures and 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.

Administrative Claim Procedures

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 at Fidelity 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.

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 at Fidelity. 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 document 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 of first becoming eligible to purchase an individual policy through Via Benefits, 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. Disclosures for purposes of payment must meet the minimally necessary standard.

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. Disclosures for purposes of health care operations must meet the minimally necessary standard. 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; (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.

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 their 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 them, 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 their termination of employment may be provided with a second opportunity to elect COBRA continuation coverage, provided that they notify the TI Benefits Center at Fidelity, 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 at Fidelity within 60 calendar days after the qualifying event occurs. You must provide this notice by calling the TI Benefits Center at Fidelity 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 at Fidelity 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 at Fidelity 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 at Fidelity within 60 calendar days after the qualifying event occurs. Failure to notify the TI Benefits Center at Fidelity 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 at Fidelity through TI HR Connect at 888-660-1411, or by mail to:

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

The TI Benefits Center at Fidelity must also be notified of any change in address.

How is COBRA continuation coverage provided?

Once the TI Benefits Center at Fidelity 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 at Fidelity 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 at Fidelity. 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 they are no longer disabled; or
- The retired employee, spouse/domestic partner or dependent(s) notifies the TI Benefits Center at Fidelity 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 at Fidelity Informed of Address Changes

To protect your family's rights, you should let the TI Benefits Center at Fidelity 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 at Fidelity.

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 at Fidelity through TI HR Connect at 888-660-1411. When calling the TI Benefits Center at Fidelity please be prepared to provide your Social Security number and Fidelity password. TI Benefits Center at Fidelity representatives are available between

8:30 a.m. and 8:30 p.m., Eastern time, Monday through Friday (excluding all New York Stock Exchange holidays except Good Friday). 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

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.