Texas Instruments

2020 Retiree Health Benefits Summary Plan Description

With updates as of June 2020
(indicated by dark blue text)

Original version: October 2019

Update to the
2020 Summary Plan Description
2020 Summary of Material Modifications

Texas Instruments Incorporated (TI) is required to notify participants of important changes to the TI Welfare Benefits Plan and/or the TI Retiree Health Benefit Plan (collectively the "Plan"). This notification, called a Summary of Material Modifications (SMM), reflects the provisions that are effective March 1, 2020. And, it is intended to update the Plan's 2020 Summary Plan Description (SPD), and is incorporated as such. The complete 2020 SPD can be found under the Health & Insurance Reference Library on the Fidelity NetBenefits® website at netbenefits.com/ti.

Due to the impact of COVID-19, the U.S. Departments of Labor and Treasury (together, the "***Departments***") recently issued a notice (the "***Notice***") requiring that all group health plans, disability and other types of employee welfare benefit plans subject to ERISA disregard the period from March 1, 2020 until 60 calendar days after the announced end of the COVID-19 National Emergency or such other date as announced by the Departments in a future notice (the "***Outbreak Period***") for certain key employee benefit plan deadlines. The Notice effectively suspends the following deadlines under the Plan during the Outbreak Period, and these deadlines do not start to run again until after the Outbreak Period is over:

- The 30-calendar-day period (or 60-calendar-day period, if applicable) to request HIPAA special enrollment (for medical coverage only) as a result of:
  - Loss of eligibility for group health coverage or individual health insurance coverage
  - Acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption
  - Loss of Medicaid/CHIP eligibility
  - Becoming eligible for a state premium assistance subsidy under Medicaid/CHIP
- The 60-calendar-day election period for COBRA continuation coverage
- The 45-calendar-day deadline for making an initial COBRA premium payment and the 30-calendar-day grace period for making subsequent COBRA premium payments
- The 60-calendar-day deadline to notify the Plan of a COBRA qualifying event such as divorce/legal separation or a dependent child losing eligibility under the plan or a disability determination

- The date by which you may file a benefit claim under the Plan's claims procedures
- The date by which you may file an appeal of an adverse benefit determination under the Plan's appeals procedures
- The four-month deadline by which you may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination
- The deadline by which you may provide information to perfect a request for external review upon a finding that the request was not complete

You can find additional details regarding these extensions at:

dol.gov/newsroom/releases/ebsa/ebsa20200428

For specifics regarding these changes and how they may impact you, or if you would like a printed copy of the SPD, please contact the TI Benefits Center at Fidelity through TI HR Connect at (888) 660-1411, option 1. 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.

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IMPORTANT CONTACT INFORMATION

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	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
• Delta Dental Basic/Dental Plus	Dental benefits and claim status	888-660-1411 deltadentalins.com/TI
• TI Benefits Center at Fidelity	Billings and coverage status	888-660-1411 netbenefits.com/ti
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* – 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 NUMBER/ WEB ADDRESS:
Kaiser HMO	(Northern California)	800-278-3296 kp.org

Dental Health Maintenance Organization	PHONE NUMBER/ WEB ADDRESS:
Aetna DMO	800-772-1416 aetna.com

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, 2020. Extended Health Benefits 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) who are under age 65.

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 documents, the plan documents will govern. Plan documents include any documents describing the self-insured benefits as well as any insurance policy or contract detailing the 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. 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 the TI Benefits Center at Fidelity through TI HR Connect 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 secondary 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. When you or your dependent, are Medicare eligible, your benefits will be paid as if you have Medicare Parts A and B for your primary coverage.

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/domestic partner 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. In addition, if your surviving domestic partner enters a subsequent committed relationship with a domestic partner or a marriage, your surviving domestic partner's coverage WILL END and the surviving domestic partner WILL NOT be eligible to continue coverage under COBRA.
You become divorced while enrolled in TI group retiree medical or dental coverage.	Contact the 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.

EVENT	ACTION REQUIRED	REMINDERS
You move.	Contact the 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. In such cases, you must contact the 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 invoice or automatic bank withdrawal.	Contact the TI Benefits Center at Fidelity through TI HR Connect.	The TI Benefits Center at Fidelity sends out all TI group retiree medical and dental coverage invoices and provides automatic bank withdrawals.

ELIGIBILITY

When you terminate employment from TI, you may be eligible for TI Extended Health Benefits or Via Benefits.

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, 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. For more information on Via Benefits, see section beginning on page 114.

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 insurance 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 114.

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 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 financial 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 the 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 and such disability lends them incapable of self-support, 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. To continue coverage, you must contact the TI Benefits Center at Fidelity prior to the dependent child's 26th birthday, to notify them of the dependent child's disabled status otherwise eligibility will be forfeited.

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 129.

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 114.

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 114.

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 116 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 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), as well as the right to delegate these duties to a Claims Administrator. 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 an agent of TI or the Claims Administrator change the terms of the benefit plan. If you are in doubt about benefit provisions, contact the designated Claims Administrator.

MEDICAL — Blue Cross Blue Shield High Deductible Health Plan and PPO, and Regional HMO for Participants under age 65

ERISA PLAN, offered through the TI Retiree Health Benefit Plan

A Quick Look

Pre-Medicare and Medicare-Eligible Blue Cross Blue Shield (BCBS) Preferred Provider Organization (PPO)

- Services for COVID-19 testing (performed according to CDC criteria as determined by your health care provider) and treatment are covered at 100% (no copay, coinsurance, or deductible applies). *Please remember that services by non-network providers are covered at 100% of the Allowable Amount*.
- For services by a network provider: the individual medical deductible is $400 per calendar year and the family medical deductible is $800 per calendar year. For services by a non-network provider: the individual medical deductible is $400 per calendar year and the family medical deductible is $800 per calendar year. The TI group retiree PPO option medical benefits are aligned with the TI group active PPO option, except for the lifetime maximums (see page 46 for 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

- Services for COVID-19 testing (performed according to CDC criteria as determined by your health care provider) and treatment are covered at 100% (no copay, coinsurance, or deductible applies). *Please remember that services by non-network providers are covered at 100% of the Allowable Amount*.
- For services by a network provider: the individual medical deductible is $1,500 per calendar year and the family deductible is $3,000. For services by a non-network provider: the individual medical deductible is $1,500 per calendar year and the family deductible is $3,000. The TI group retiree HDHP option medical benefits are aligned with the TI group active HDHP option, except for the lifetime maximums (see page 46 for 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 HMO

- Services for COVID-19 testing are covered at 100% (no copay or coinsurance applies). Services for COVID-19 treatment are covered in accordance with the terms of the regional HMO.
- Key features of the regional HMO (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 regional HMO can be found in the Important Contact Information chart, at the beginning of this document.

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 PPO 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 option at the level of coverage (for example, you + family) you had the previous calendar year. The design is shown in detail on page 42 for medical and page 74 for prescription drugs.

If you want to drop coverage, you must contact the 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 into TI or acquired by TI 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 into TI or acquired by TI 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 into TI or acquired by TI 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 to the TI Benefits Center at Fidelity 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 PPO

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 42-43 in the chart “Deductibles, Copays and Coinsurances in the BCBS PPO” and on pages 44-45 in the chart “Deductibles, Copays and Coinsurances in the BCBS HDHP”.

	HDHP	PPO
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	PPO
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 care/pharmacy deductible	No deductible
Pharmacy expenses applied to out-of-pocket maximum	Applied to combined medical/behavioral health care/pharmacy out-of-pocket maximum	Separate out-of-pocket maximums for medical/behavioral health care 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 PPO. 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. Expenses covered as part of a "clinical trial" are not required to meet the above standards for medically necessary.

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

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

- Eligible medical/behavioral health care practitioners:
  - Covered services must be provided by a legally qualified medical/behavioral health care practitioner. Such practitioner must be licensed in the state in which they are practicing and practicing within the scope of their license (not a resident physician or intern).
  - Examples of legally qualified medical practitioners 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.).
  - Examples of legally qualified behavioral health care practitioners include M.D., Ph.D. psychologist, licensed professional counselor, licensed marriage and family therapist, ABA therapist and masters of social work.
- Eligible hospitals include the following institutions when they are rendering covered services:
  - an institution which is primarily engaged in providing, for compensation and on an inpatient basis, surgical and medical care,

diagnosis, and treatment 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 offer 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 facilities. 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.

Preauthorization Requirements

Preauthorization establishes in advance the medical necessity of certain care and services. Preauthorization does not guarantee payment of benefits. Coverage is always subject to other requirements, such as limitations, exclusions and eligibility at the time care and services are provided.

The BCBS HDHP and PPO options require advance approval (preauthorization) for inpatient care, outpatient care, behavioral health care, advanced imaging and other services. In addition, inpatient care also requires preauthorization when your care involves (i) an extended stay beyond the approved days, (ii) transfer to another hospital/facility or (iii) transfer to or from a specialty unit within the hospital/facility.

When you use a network provider, they will preauthorize your care and services as required. The network provider will be held financially responsible for reduced or denied claims that were incurred without preauthorization.

When you use a non-network provider, you or your provider must obtain preauthorization of your care and services as required. You will be held financially responsible for reduced or denied claims that were incurred without preauthorization.

Inpatient maternity admissions – You or your provider will not be required to obtain preauthorization for a hospitalization of up to 48 hours following a vaginal delivery and up to 96 hours following a Cesarean-section delivery. If you require a longer stay, you or your provider must seek an extension for the additional days by obtaining preauthorization.

Inpatient admissions – In the case of an elective admission, the call for preauthorization should be made at least two business days in advance. In the case of an emergency, the call for preauthorization should be made at least two business days after admission, or as soon thereafter as reasonably possible.

The numbers to call for preauthorization are listed on your BCBS ID card. If you have any questions about preauthorization (including which care and services require preauthorization), you may contact a BCBS representative at 866-866-2300.

Preauthorization is not required when BCBS is not the primary plan. For more information, see the Coordination of Benefits section beginning on page 68.

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 150% of the Medicare rate in a geographic area (1.5 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 $1,350 (150% 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 $1,350, 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.

Allowable Amount for Out-of-Network HDHP and PPO Emergency Services

For out-of-network emergency services received under the BCBS HDHP or PPO option, the Allowable Amount shall be equal to the greatest of the following three possible amounts (not to exceed billed charges):

- the median amount negotiated with in-network providers for emergency care services furnished;
- the amount for the emergency care service calculated using the same method the plan generally uses to determine payments for out-of-network provider services but substituting the in-network cost-sharing provisions for the out-of-network cost sharing provisions; or
- the amount that would be paid under Medicare for the emergency care service.

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 92.

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

Retirees share in the cost of coverage through the deductibles, copays and coinsurances, as shown in the chart below. The deductible, copay and 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]	$400 individual $800 family	$400 individual $800 family
Annual Deductible — Pharmacy	No deductible	
Annual Hospital Copay	$0	$300
Benefit	**Coinsurance Paid by Participant**	
Doctor [2]	10%	50%
MDLIVE Virtual Visit	10%	Not covered
Professional Services [7]	10%	50%
Hospitals/Facilities (inpatient & outpatient) [5]	20%	50%
Nutrition Network	10%	Not covered
Behavioral Health Care (doctor)	10% [4]	50% [3,4]
Behavioral Health Care (facility/outpatient) [5]	20% [4]	50% [3,4]
Behavioral Health Care (hospital/inpatient) [5]	20% [4]	50% [3,4]
Annual Out-of-Pocket Maximum for Medical/Behavioral Health Care [1]	$3,000 individual $6,000 family	$6,000 individual $12,000 family
Annual Out-of-Pocket Maximum for Pharmacy [6]	$4,000 individual $8,000 family	$4,000 individual $8,000 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. Preauthorization may be required, see page 37 for more information.

[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, ABA therapist or masters of social work.

[5] Hospitals/Facilities include, but are not limited to, emergency rooms, skilled nursing facilities and hospice facilities. Preauthorization may be required, see page 37 for more information.

[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. Preauthorization may be required, see page 37 for more information.

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

Retirees share in the cost of coverage through the deductibles, copays and coinsurances, as shown in the chart below. The deductible, copay and 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]	$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%	Not covered
Professional Services [3]	10%	50%
Hospitals/Facilities [4] (inpatient & outpatient)	20%	50%
Nutrition Network	10%	Not covered
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. Preauthorization may be required, see page 37 for more information.

[3] Professional services include(s), but are not limited to, surgeons, radiologists, anesthesiologists, physical therapists and home health care providers. Preauthorization may be required, see page 37 for more information.

[4] Hospitals/Facilities include, but are not limited to, emergency rooms, skilled nursing facilities and hospice facilities. Preauthorization may be required, see page 37 for more information.

[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, ABA 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.

Lifetime Dollar Limits

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

Benefit	HDHP and PPO 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., infertility benefits).

Adult and Baby/Child 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, as well as that of their covered dependents. Targeted preventive care services help detect risks and health problems early when they are easiest to treat. Periodic preventive health office visits and recommended screening tests and immunizations are covered at 100%. Preventive health care includes evidence-based services rated A or B in the current recommendations of the U.S. Preventive Services Task Force (uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/) and routine immunizations that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (cdc.gov/vaccines/schedules/easy-to-read/index.html). (See the websites for additional details.)

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. 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.

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.

Women's Health Preventive Services

The BCBS HDHP and PPO options provide coverage of FDA-approved contraceptive methods including, but not limited to, barrier methods, hormonal methods, and implanted devices. Contraceptive methods that are generally available over-the-counter are covered if the method is both FDA-approved and prescribed for a woman by her health care provider. Contraception for men is not covered. 100% of the total cost of a generic contraceptive prescription drug is covered without cost-sharing. If, however, a generic version is not available, or would not be as medically appropriate for the patient as a prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient), then coverage is provided without cost-sharing, subject to reasonable medical management. (See sections on BCBS Prescription Drug Benefits – HDHP and PPO for additional information on pharmacy coinsurance rates.)

Services, as prescribed by a health care provider, related to patient education and counseling, follow-up and management of side effects of FDA-approved contraceptive methods, counseling for continued adherence, and device removal are covered. These services are covered without cost-sharing, subject to reasonable medical management.

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.

Inpatient Maternity Admissions

For mothers and their new babies, the BCBS HDHP and PPO 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. Emergency care received outside of the network will be reimbursed at the Allowable Amount for in-network as required under Section 2719A(b) of the Public Health Service Act and the regulations and guidance issued thereunder. 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. (See earlier section on Allowable Amount for Out-of-Network HDHP and PPO Emergency Services for additional information on the eligible expenses of out-of-network providers in an emergency situation.)

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**
Coinsurance for doctor services is 10% and for hospital care is 20% of covered expenses, after the medical deductible (up to plan limits). Preauthorization may be required, see page 37 for more information.	Select your own behavioral health care provider — licensed M.D., Ph.D. psychologist, licensed professional counselor, licensed marriage and family therapist, ABA 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).

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

Services are not covered under the BCBS HDHP and PPO 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.

The BCBS HDHP and PPO options provide for mental health parity in accordance with the law. As a result, on a classification by classification basis, financial requirements and restrictions applied to medical and surgical benefits are not more favorable than those applied to behavioral health care benefits (including co-pays, deductibles, out-of-pocket maximums and limitations applied to treatments).

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 PPO

Other covered expenses under the BCBS HDHP and PPO 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
- Tubal ligation covered at 100%, deductible does not apply
- 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 unless they are part of a clinical trial (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.
- 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
- Medically necessary transsexual surgery (gender reassignment surgery)

- 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.

- Applied behavior analysis prescribed for treatment of autism spectrum disorder. Preauthorization required, see page 37 for more information. Applied behavior 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

Allergy Testing and Treatment

Benefits coverage for allergy testing and treatment:

- Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Bariatric Surgery

Bariatric surgery coverage will only be available for those who meet the following criteria:

- Diagnosis of morbid obesity, defined as a:
  - Body mass index (BMI) equal to or greater than 40kg/meter; or
  - BMI equal to or greater than 35kg/meters with at least one (1) of the following clinically significant obesity-related diseases or complications that are not controlled by best practice medical management:

        - Hypertension,
        - Dyslipidemia,
        - Diabetes mellitus,
        - Coronary heart disease,
        - Sleep apnea, or
        - Osteoarthritis

- Documentation the patient has satisfied the following requirements:
    - Growth is completed (generally by age 18)
    - Patient has completed evaluation by a licensed professional counselor, psychologist or psychiatrist within the 12 months preceding the request for surgery

- Documentation from the surgeon attesting that the patient has been educated in and understands the post-operative regimen, which should include ALL of the following components:
    - Nutrition program, which may include a very low calorie diet or a recognized commercial diet-based weight loss program;
    - Behavior modification or behavioral health care interventions;
    - Counseling and instruction on exercise and increased physical activity; and
    - Ongoing support for lifestyle changes to make and maintain appropriate choices that will reduce health risk factors and improve overall health

- Surgery must be received at a Blue Distinction Center for Bariatric Surgery. Blue Distinction Centers for Bariatric Surgery can be found on bcbstx.com – go to Find a Doctor and select provider type = Blue Distinction Bariatric Centers.

Benefits coverage for bariatric surgery (services provided at a Blue Distinction Center for Bariatric Surgery):

- Network coinsurance is 20%, after the deductible is met
- **Non-network benefits are not available**

Patients who reside more than 75 miles from a Blue Distinction Center for Bariatric Surgery may be eligible for bariatric surgery coverage at facilities other than a Blue Distinction Center. Contact BCBS to determine whether you reside in a Blue Distinction Center for Bariatric Surgery geographic area.

Benefits coverage for bariatric surgery for patients who reside more than 75 miles from a Blue Distinction Center for Bariatric Surgery:

- Network coinsurance is 20%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Lap band adjustments (if needed) are covered in an office setting if the patient's surgery was at a Blue Distinction Center for Bariatric Surgery or if the initial lap band was placed prior to 2020.

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 coverage for chiropractic services:

- Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met
- Maximum benefit is 35 visits per person per calendar year (combined network and non-network)

Durable Medical Equipment

If you require durable medical equipment, the following benefits coverage applies:

- 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.

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.

The following benefits coverage applies:

- Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met
- Maximum hearing aid benefit per person is 1 set of hearing aids every 3 years

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.

Benefits coverage for Home Health Care:

- Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Preauthorization required, see page 37 for more information.

To receive network benefits coverage, 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

Home Health Care covered services 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

Care must require skilled nursing interventions.

Home Health Care services not covered include:

- 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

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 coverage for Hospice Care:

- Network coinsurance is 20%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Preauthorization required, see page 37 for more information.

Hospice Care covered services include:

- Room and board and other necessary services and supplies furnished to an individual while full-time inpatient
- Part-time or intermittent outpatient nursing care by an RN, APN or LVN

Hospice Care services not covered include:

- 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

Infertility

Medical benefits coverage for infertility:

- Network coinsurance for doctor and professional services is 10%, after the deductible is met
- Network coinsurance for hospitals/facilities is 20%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

- Lifetime maximum is $25,000 for medical benefits (combined network and non-network)

Pharmacy benefits coverage for infertility:

- See page 72 for the HDHP prescription drug benefits
- See page 74 for the PPO prescription drug benefits
- Lifetime maximum is $10,000 for pharmacy benefits (combined network and non-network)

Infertility covered services include:

- Artificial insemination (AI) or intrauterine insemination (IUI)
- Reproductive procedures, which include:
    - in vitro fertilization (IVF)
    - uterine embryo lavage
    - gamete intrafallopian tube transfer (GIFT)
    - intracytoplasmic injection (for male factor infertility)
    - low tubal ovum transfer
    - embryo transfer (ET) or blastocyst transfer
    - zygote intrafallopian tube transfer (ZIFT)
- Charges for fertility and/or infertility medications

Services/expenses not covered under infertility include:

- Assisted hatching, co-culture of embryos,
- Cryopreservation of ovarian tissue or oocytes
- Cryopreservation of testicular tissue of prepubertal boys as a method of preserving fertility
- Intracytoplasmic sperm injections (ICSI) in the absence of male factor infertility
- Tests of sperm DNA integrity, including but not limited to, sperm chromatin assays and sperm DNA fragmentation assays
- Reversal of voluntary sterilization
- Expenses for medical services or supplies rendered to a surrogate for purposes of child birth
- Expenses associated with cryopreservation and storage of sperm, eggs and embryos
- Expenses associated with the procurement of sperm, or harvesting of eggs and embryos from a donor
- Living and/or travel expenses
- Immunotherapy

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 PPO, 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.

Benefits coverage for Medical Nutrition Therapy:

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

For you or your covered dependents 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 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.

Outpatient Physical Therapy Benefits

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

- Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Skilled Nursing Facility

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

- Network coinsurance is 20%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

	HDHP	PPO
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)

Preauthorization required, see page 37 for more information. 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. Preauthorization may be required, see page 37 for more 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.

Benefits coverage for human organ or tissue transplants:

	HDHP and PPO	
	Network	**Non-Network**
Doctor [1]	10%, after the deductible is met	50%, after the deductible is met
Professional Services [2]	10%, after the deductible is met	50%, after the deductible is met
Hospitals/Facilities [3] **(inpatient & outpatient)**	20%, after the deductible is met	50%, after the deductible is met

[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. Preauthorization may be required, see page 37 for more information.

[2] Professional services include(s), but are not limited to, surgeons, radiologists, anesthesiologists, physical therapists and home health care providers. Preauthorization may be required, see page 37 for more information.

[3] Hospitals/Facilities include, but are not limited to, emergency rooms, skilled nursing facilities and hospice facilities. Preauthorization may be required, see page 37 for more information.

Treatment for Loss or Impairment of Speech

Speech therapy services are eligible for benefits 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 coverage for outpatient treatment for loss or impairment of speech:

- Network coinsurance is 10%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

MDLIVE Virtual Visit

Benefits coverage 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 or via the MDLIVE app on your smart phone. 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.

Right to Rescind Coverage – BCBS HDHP and PPO

The plan may rescind your coverage retroactively only in the event you, or someone claiming benefits on behalf of you or your dependents, makes an intentional material misrepresentation as to a fact under the plan with regard to eligibility, obtaining coverage or any matter related to the plan or benefits under the plan or any such individual commits fraud on the plan. In the event the Plan Administrator determines that you or your dependent's coverage should be rescinded, the Plan Administrator shall provide you notice of the date such rescission shall be effective. You may submit an appeal of such decision to the Plan. Additionally, the plan will cancel coverage retroactive to your last paid through date if you fail to pay your premiums on a timely basis.

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 under the HDHP or PPO options, except that certain clinical trial coverage is available under the HDHP or PPO options (see the section titled "Clinical Trials" on page 79). Experimental or investigational treatment includes procedures, treatments, care, services and supplies which do not represent a commonly accepted form of treatment; are not generally accepted by the medical community in the United States as effective, appropriate and essential for the treatment of a diagnosed condition; or are not proven effective in the treatment of an illness. 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 and Baby/Child Preventive Health Care section 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
- 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
- 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

- Foot orthotics are not covered, unless medically necessary and prescribed by a physician, chiropractor and/or other qualified provider. Orthotic devices used for sports-related activities; and/or are upgraded splints (e.g., decorative items, or functionality or features beyond what is required for management of the patient's current medical condition) are not considered medically necessary.
- 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 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.

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 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 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 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 PPO 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 PPO 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 allowed 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 chiropractic visits, skilled nursing facility days, etc.) will only be reduced if BCBS makes a payment on the claim.

If You Have Other Private Medical Insurance

The BCBS HDHP or PPO 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 PPO 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 terminate on the earliest of the following dates:

- 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 terminate on the earliest of the following dates 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
- Date of 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 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. If your surviving domestic partner enters a subsequent committed relationship with a domestic partner or a marriage, your surviving domestic partner's coverage WILL END and the surviving domestic partner 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.

Routine 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
Prescription Contraceptives for Women	Total drug cost covered, you pay $0 – applies to generic drugs and brand-name drugs (when no generic available), for women only		
Annual pharmacy deductible	No separate pharmacy deductible; pharmacy claims are applied to the BCBS HDHP medical deductible		

HDHP			
Type	**In-Network Coinsurance/ Maximum**	**Out-of-Network Coinsurance**	**Mail-Order Program* Coinsurance/ Maximum**
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 77. 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
Prescription Contraceptives for Women	Total drug cost covered, you pay $0 – applies to generic drugs and brand-name drugs (when no generic available), for women only		
Annual pharmacy deductible	No deductible		

PPO		
	In-Network	**Out-of-Network**
Annual pharmacy out-of-pocket maximum***	$4,000 individual $8,000 family	$4,000 individual $8,000 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 annual pharmacy out-of-pocket maximum.

**** For more information, see the Specialty Medications section on page 77. 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.

The CVS Caremark specialty step therapy program uses evidence-based protocols that may require the use of a preferred drug(s) before a non-preferred specialty drug is covered. A clinical exception process is available for individuals who require access to a non-preferred medication due to medical necessity.

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.

Clinical Trials

In accordance with the requirements of health care reform, the plan covers routine patient care costs related to clinical trials where the participant is eligible to participate in an approved clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition (disease or condition where the likelihood of death is probable unless the course is interrupted).

Routine patient care costs generally include items and services that typically would be covered under the plan for an individual not enrolled in a clinical trial, such as radiological services, laboratory services, intravenous therapy, anesthesia services, hospital services, physician services, office visits, room and board and medical supplies.

The plan may require the covered individual to participate in the trial through an in-network provider if a network provider is a participant in the clinical trial and the provider accepts the individual as a participant in the trial. A qualified individual may participate in an approved clinical trial conducted outside the state in which they reside (such individual should contact their Claims Administrator).

The plan will not discriminate against the individual on the basis of the individual's participation in a clinical trial. BCBS determines coverage for clinical trials, 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.

If You are Entitled to Medicare (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 first 30 months after you become eligible to enroll in Medicare.

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 or a rescission of 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 PPO	
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 PPO	
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 calendar 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 calendar day after the receipt of all information, followed up in writing within three 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 calendar 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 option, 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 PPO	
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 calendar 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 calendar 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 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 ORGANIZATION (HMO) for Participants under age 65

Some retirees can choose a regional Health Maintenance Organization (HMO) as an alternative to the BCBS HDHP or PPO. This section offers an overview of the services that HMOs generally provide. Details about the regional 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.

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 dependent (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:

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 the TI Benefits Center at Fidelity through TI HR Connect 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 dependent 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 dependent 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 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.

When you, or your dependent, 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 — Delta 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

Delta Dental Insurance Company (Delta Dental)

Retirees may choose from two Delta Dental PPO plan 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 – only covered under Dental Plus

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 Delta 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 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.

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 had no coverage the previous calendar year, you will be assigned no coverage for the new calendar year.

If your dental plan is no longer available for the new calendar year and you do not make an election, you will automatically be enrolled in Delta Dental Basic at the level of coverage (for example, you + family) you had the previous calendar year.

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.

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 to the TI Benefits Center at Fidelity 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 (Delta 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 a TI 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 (only covered under Dental Plus)**
Periodic oral exams Cleanings Preventive x-rays	Fillings, Routine extractions, Non-surgical periodontal services	Crowns, Dentures, Oral surgery, Root canals, Surgical periodontics, Implants, Non-Surgical TMJ	Braces Other services to straighten teeth

Network Providers You can choose any dentist to obtain dental services. Visit a dentist in the PPO network to maximize your savings. These dentists have agreed to reduced fees, and you won’t get charged more than your expected

share of the bill. If you cannot find a PPO dentist, Delta Dental Premier dentists offer the next best opportunity to save. Unlike non-Delta Dental dentists, they have agreed to set fees, and you won't get charged more than your expected share of the bill. By having network prices, you and TI pay less for dental care. There is not a penalty if you do not use a Delta Dental network dentist, but reasonable and customary reimbursement limits apply. 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 Delta Dental Basic and Dental Plus

Retirees share in the cost of coverage through the deductible and coinsurances, as shown in the chart below. 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	30%	10%
- Routine extractions	30%	10%
- Non-surgical periodontal services	30%	10%
Major services	**Dental Basic**	**Dental Plus**
- Crowns	60%	40%
- Dentures	60%	40%
- Endodontics (root canal therapy)	60%	40%
- Oral surgery	60%	40%
- Surgical Periodontics	60%	40%
- Implants (requires review by dental consultant)	60%	40%

Orthodontia services	Dental Basic	Dental Plus
- Orthodontia services (adult and children)	Not covered	50%

* Annual deductible applies to Basic and Major services only, not preventive and diagnostic or orthodontia services. 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*	N/A	$1,500
TMJ lifetime maximum*	$750	$750

* 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 follows: if less than $500, Delta Dental will pay in one lump sum at date of banding. If greater than $500, Delta Dental will pay 50% at date of banding and 50% 12 months later pending eligibility. The payment(s) is subject to the applicable coinsurance level and lifetime maximum amount, shown in the charts above.

Orthodontia and TMJ Lifetime Maximums: If you were enrolled in Dental Basic or Dental Plus through MetLife, you and/or your covered dependents current accrual for the orthodontia and TMJ lifetime maximums will carry forward to Delta Dental. Note - Orthodontia is only covered under Dental Plus.

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 asking them to submit a pretreatment estimate to Delta Dental 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
- Enhanced coverage for pregnant women includes an additional exam, cleaning or periodontal procedure as needed, once pregnancy is confirmed
- 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 up to age 19
- Topical application of fluoride – for children up to age 19; limited to two per calendar year
- Sealants – for children up to age 19, 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 6 consecutive months
- Denture adjustments – covered if more than six months after installation
- Temporomandibular joint dysfunction (TMJ) – maximum lifetime 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 seven years ago
- Replacement of an existing crown/inlay/onlay that was installed less than seven 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 up to age 19

- 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 Delta Dental.

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, Delta Dental may determine that a more cost-effective treatment is available that is adequate and meets generally accepted standards of dental care. If so, Delta Dental 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 Delta Dental website at deltadentalins.com/TI) 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 Delta Dental for review.
Delta Dental	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 Delta Dental.

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 Delta Dental **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.

Administrative Claim Procedures

How to File a Claim (Dental Basic and Dental Plus)

Delta Dental claim forms can be found on the Fidelity NetBenefits® website at netbenefits.com/ti. You can also obtain a claim form by contacting Delta Dental through TI HR Connect at 888-660-1411 or you can go to the deltadentalins.com/TI 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:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

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 Delta Dental, the Claims Administrator, at the time and in the manner prescribed by the Claims Administrator.

If Delta Dental determines that you are not entitled to receive all or part of the benefits you claim in a post-service claim (other than a claim involving concurrent care), a notice will be provided within a reasonable period of time, but no later than 30 calendar days from receipt. This notice (in writing by mail, or hand delivery, or through e-mail) will describe (i) Delta Dental’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, Delta Dental may not be able to make a determination within 30 calendar days after receiving your claim. In such situations, Delta Dental may extend the 30-calendar-day period for up to an additional 15 calendar days. Delta Dental will provide 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 notice will describe the information needed and give you up to 45 calendar days 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 before the end

of the period of time or number of treatments constitutes an adverse benefit determination. Delta Dental 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.

Delta 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 Delta Dental. Your written request for an appeal must be received by Delta Dental within 180 calendar days of the date you received your denial notice. Your request for an appeal should be mailed to:

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits, without regard to whether such information was submitted and considered in the initial determination of your claim. You will receive written acknowledgment within 5 days upon receipt of your appeal. 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.

Delta Dental will conduct a full and fair review and may ask for more documents during this review, if needed. Delta Dental's review will (i) take into account the information submitted (comments, documents, records or other information), regardless of whether such information was submitted or considered initially, (ii) not afford deference to the initial adverse determination, and (iii) be conducted by someone who is neither the individual who made the initial determination nor a 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 is experimental or not medically necessary or appropriate), Delta Dental will consult with a dentist with the appropriate training and experience. When requested by you, Delta Dental will provide you with the name of the dentist whose advice was sought in connection with your appeal.

If, after reviewing your appeal and any further information that you have submitted, Delta Dental denies your claim, either in whole or in part, a notice will

be provided (in writing by mail, or hand delivery, or through e-mail) within 30 calendar days from receipt of your request for a review.

If, after reviewing your appeal and any further information that you have submitted, Delta Dental denies your appeal, either in whole or in part, you must appeal Delta Dental's denial by requesting a second-level review of your claim. Your written request for a second-level appeal must be received by Delta Dental within 90 calendar days of the date you received your denial notice. The remainder of your second-level appeal will be handled as discussed above. Your request for a second-level appeal should be mailed to:

Delta Dental Insurance Company
Second-Level Appeals
P.O. Box 1809
Alpharetta, GA 30023-1809

If, after reviewing your appeal and any further information that you have submitted, Delta Dental denies your second-level appeal, either in whole or in part, a notice will be provided (in writing by mail, or hand delivery, or through e-mail) within 30 calendar days from receipt of your second-level appeal.

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.

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 notice will include an explanation of the scientific or clinical judgment for the determination (or the availability of such an explanation).

This second-level 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 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 Delta 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 Delta 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 allowed 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, Delta Dental annual and maximum benefit amounts will be reduced, whether or not Delta Dental pays toward the claim.

If You Have Other Private Dental Insurance

Delta 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, Delta 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 terminate on the earliest of the following dates:

- 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 terminate on the earliest of the following dates 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
- Date of 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 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. If your surviving domestic partner enters a subsequent committed relationship with a domestic partner or a marriage, your surviving domestic partner's coverage WILL END and the surviving domestic partner 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 you terminate your TI group retiree dental coverage, dental coverage ends. However, Delta Dental will pay for covered services incurred while you were eligible if the procedures were completed within 30 calendar days of the date your coverage ended. A dental service is incurred:

- for an appliance (or change to an appliance), provided the final impression was made before coverage ended;
- for a crown, bridge or cast restoration, provided it was fully prepared before coverage ended;
- for root canal therapy, at the time the pulp chamber is opened, provided it was fully prepared before coverage ended; or
- for all other dental services, provided the services and supplies were fully prepared before 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. 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 insurance 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 20.

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 14 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 initial eligibility, 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 without authorization as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illnesses.

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

COBRA Continuation Coverage

This notice has important information about your right to continuation health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which provides for a temporary extension of health coverage under the TI Retiree Health Benefit Plan ("the Plan"). **This notice explains when COBRA continuation coverage may become available to eligible members of your family, and what they need to do to obtain it.** TI, in accordance with COBRA allows "qualified beneficiaries" to elect to continue TI group retiree medical and/or dental benefits beyond the date coverage is otherwise scheduled to end because of the occurrence of certain events known as "qualifying events." See the section below entitled "Qualifying Events – When COBRA continuation coverage is available" for a description of the qualifying events. Your spouse or domestic partner, and your dependent children (or children of your domestic partner) could become qualified beneficiaries if coverage is lost because of a qualifying event.

This notice also contains information about their rights to obtain other health coverage alternatives that may be available to them through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, they may qualify for lower costs on their monthly premiums and lower out-of-pocket costs. Additionally they may qualify for a 30 calendar day special enrollment period for another group health plan for which they are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees. If a qualified beneficiary loses coverage under the Plan, they should contact the Health Insurance Marketplace available in their state regarding when they must notify the Health Insurance Marketplace about qualifying events so they do not miss any deadlines for such notices to be eligible to elect coverage on the Health Insurance Marketplace.

Qualified beneficiaries may elect to continue one or more of TI group retiree medical and/or dental benefits in any combination. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage during the 60-calendar-day period following a qualifying event. A COBRA enrollment notice will

be provided to qualified beneficiaries explaining when and how they can elect COBRA coverage. Additionally, they should contact the Health Insurance Marketplace in their state to determine when they may enroll in the health insurance coverage offered through the Marketplace because its election period may be different than the COBRA continuation coverage election period.

Qualified beneficiaries electing to receive COBRA benefits have all the rights of retirees and dependent(s) 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.

Qualifying Events – When COBRA continuation coverage is available

A retiree is not a qualified beneficiary because they were previously offered COBRA coverage at the time of retirement.

If you are the spouse or domestic partner of a covered retiree, you will become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

- Death of the covered retiree;
- The covered retiree becomes entitled to Medicare benefits (under Part A, Part B, or both);
- Divorce or legal separation from the covered retiree; or
- The end of your domestic partnership with the covered retiree.

The qualifying events for dependent children are the same as above for the spouse/domestic partner with one addition:

- Loss of dependent child status under the Plan rules

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 retiree covered under the Plan, the retiree will become a qualified beneficiary. The retiree's spouse, surviving spouse, and dependent children will also become qualified beneficiaries 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 (such as 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 the Plan. You must also provide updated contact information for the spouse or dependent.

Electing COBRA Coverage

Once the TI Benefits Center at Fidelity has been notified of the occurrence of a qualifying event, the qualified beneficiaries will be provided with instructions on how to elect COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered retirees may elect COBRA continuation coverage on behalf of their spouses or domestic partners or dependent children, and parents may elect COBRA continuation coverage on behalf of their children. Your spouse may also elect COBRA continuation coverage on behalf of themself and their dependent children. They must elect COBRA continuation coverage within the 60-calendar-day period as specified in the enrollment notice. If they initially decline COBRA continuation coverage within the specified 60-calendar-day period, they may still elect COBRA

continuation coverage provided such election is made within the specified 60-calendar-day period. However, in no event can they elect COBRA continuation coverage after the specified 60-calendar-day period.

In considering whether to elect COBRA continuation coverage, qualified beneficiaries should take into account that they have special enrollment rights under U.S. federal laws. Qualified beneficiaries have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 calendar days after their group health coverage under the Plan ends because of a qualifying event. They will also have the same special enrollment right at the end of continuation coverage if they get continuation coverage for the maximum time available to them.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for 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. Additionally, in the Marketplace, they could be eligible for a tax credit that lowers your monthly premiums right away, and they can see what their premium, deductibles, and out-of-pocket costs will be estimated to be by the Marketplace before they make a decision to enroll. Qualified beneficiaries can learn more about many of these options at www.healthcare.gov.

Maximum Period of COBRA Coverage

Upon the occurrence of a qualifying event, COBRA coverage will be available to qualified beneficiaries until the earliest of:

- 36 months from the date COBRA benefits began;
- The date the qualified beneficiary fails to pay the required monthly premium when due or following the end of any applicable grace period;
- The date of cancellation of the Plan if the Plan is canceled for all retirees; or
- The date (after they elect COBRA continuation coverage) that they become covered under another group health plan or entitled to Medicare (for additional information, see the Important Note in Premiums section).

Medicare Coverage at Age 65

When your spouse reach age 65, their TI COBRA benefits become secondary to those benefits they receive – or are eligible to receive – from Medicare. They are responsible for any Medicare premium charges for themself and their 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 they receive full medical coverage protection, they should check with their Social Security office at least three months before they reach age 65.

Even if they do not enroll in Medicare Part B, the 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 retirees;
- The premium for COBRA continuation coverage is not paid in a timely manner;
- The qualified beneficiary becomes covered (after electing COBRA continuation coverage) under another group health plan;
- The qualified beneficiary 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); or
- The qualified beneficiary notifies the TI Benefits Center at Fidelity that they wish to cancel continuation coverage.

Qualified beneficiaries must notify the Plan Administrator within 30-calendar-days of their loss of coverage in order to prevent being charged a monthly premium after loss of eligibility. They may not receive a refund for any premium paid for coverage after they lose eligibility if they fail to notify the Plan Administrator within this 30-calendar-day period.

COBRA Premiums

A qualified beneficiary does not have to show they are insurable in order to choose COBRA continuation coverage. But a qualified beneficiary must have been actually covered under the TI group retiree medical and/or dental benefits offered under the Plan on the calendar day before the qualifying event occurs in order to qualify for COBRA coverage.

A qualified beneficiary will have to pay all of the applicable COBRA premiums, which generally equals 102% of the Plan costs for a 12-month period. 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 Plan increase.

Qualified beneficiaries must make their first premium payment for COBRA continuation coverage no later than 45 calendar days after the date of their election.

After they make their first payment for COBRA continuation coverage, they will be required to make monthly 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 a qualified beneficiary becomes covered under another group health plan. They must notify the Plan Administrator within 30-calendar-days of their loss of coverage in order to prevent being charged a monthly premium after loss of eligibility. They may not receive a refund for any premium paid for coverage after they lose eligibility if you fail to notify the Plan Administrator within this 30-calendar-day period.

If Qualified Beneficiaries Have Questions

Questions concerning the Plan or their COBRA continuation coverage rights should be addressed to the contact or contacts identified below in the ‘Plan Contact Information’ section. For more information about their rights under Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 their area or visit www.dol.gov/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

Qualified beneficiaries should notify the TI Benefits Center at Fidelity of any address changes.

Plan Contact Information

Qualified beneficiaries may obtain additional information about their rights and responsibilities under the 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. The 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 Delta Dental.

Delta Dental Insurance Company
P.O. Box 1809
Alpharetta, GA 30023-1809

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.

3.TF-H-441C.102