2010 Health and Insurance Benefits Guide

With updates as of Jan. 15, 2010
(see Addendum on page 165)

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Health and Insurance Benefits Guide
Table of Contents

Important Phone Numbers

TI HR Connect - One number to access benefit providers • Blue Cross Blue Shield (BCBS) PPO • Employee Assistance Program (EAP) (Magellan Health) • MetLife Dental Basic / Dental Plus • Pharmacy Network (CVS Caremark) (BCBS PPO participants) • Spending Accounts • TI Benefits Center	**888-660-1411**
• EyeMed Eye-Care Discount Program	866-723-0391
• International SOS — worldwide health assistance (collect calls are accepted) for TravelWell program	215-244-1149
• Life Insurance (MetLife)	800-638-6420
• Nutrition Network (BCBS PPO participants)	800-888-9560
• TravelWell	972-917-3516
• VSP® (formerly known as Vision Service Plan)	800-877-7195
• Zurich American (BTA and AD&D)	800-347-9115 x1022

Health Maintenance Organizations (HMOs)

HMO	(Area Served)	Main Number
• CIGNA HMO	(Arizona)	800-244-6224
• CIGNA HMO Houston/Austin	(Houston/Austin)	800-244-6224
• CIGNA HMO	(North Carolina)	800-244-6224
• CIGNA HMO Dallas/North Texas	(North Texas)	800-244-6224
• HMO Blue New England*	(CT, MA, NH, RI)	800-832-3871
• HMO Illinois**	(Illinois)	800-892-2803
• Kaiser HMO	(Northern and Southern California)	800-464-4000
• Optimum Choice (MAMSI) HMO***	(DC, DE, MD, VA, WV)	800-815-8958
• PacifiCare HMO***	(California)	800-624-8822

* Offered by Blue Cross Blue Shield of Massachusetts

** Offered by Blue Cross Blue Shield of Illinois

*** PacifiCare is a UnitedHealthcare Company

Dental Health Maintenance Organization

• Aetna DMO	800-772-1416

Introduction

This guide is the Summary Plan Description of Texas Instruments Incorporated's (TI's) health and welfare benefit plans and programs. Some of the plans and programs described in this guide are governed by the Employee Retirement Income Security Act of 1974 (ERISA).

The summary description is written in plain language to help you understand how the plans and programs work. If there is a conflict between the information in this guide and the plan documents and/or contracts, the plan documents and/or contracts will govern. The benefits described herein are only available to eligible employees of TI and its designated subsidiaries.

Your eligibility for and participation in these plans and programs is not a contract of employment.

Eligibility

Except if otherwise noted in the summary description of a plan or program, you are eligible to participate in TI's health and welfare benefits plans and programs if you are a full-time TIer or part-time TIer on an alternative work schedule (minimum 20-hours-a-week schedule). You are not eligible for coverage if:

- You (regardless of how you are characterized for wage withholding purposes or any other purpose by the Internal Revenue Service (IRS), or any other agency, court, authority, individual or entity) are an employee who is classified by TI, acting in its sole absolute discretion, as a TIer on an alternative work schedule for less than 20 hours a week
- You are an employee who is a leased employee as defined by federal tax law
- You (regardless of how you are characterized for wage withholding purposes or any other purpose by the IRS, or any other agency, court, authority, individual or entity) are classified by TI, acting in its sole and absolute discretion, as a co-op program employee
- Your compensation is reported to the IRS on a form other than a Form W-2, regardless of whether you are treated as an employee for federal income tax purposes
- You have agreed in writing that you are not an employee or are not otherwise eligible to participate

Eligible Dependents - for medical, dental, vision, accidental death and dismemberment (AD&D) and life insurance benefits

All eligible dependents must provide a 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 dependents/domestic partners qualify as such under TI's health and welfare benefit plans and programs. The Plan Administrator reserves the right to determine the documentation that is necessary to provide eligibility.

Your eligible dependents include:

- Your legal spouse (only a spouse who qualifies as a spouse under the Federal Defense of Marriage Act will be considered a spouse)
- Your biological children, legally adopted children or children for whom adoption papers were filed
- Stepchildren who live with you and are supported by you
- A child for whom you are legal guardian or managing conservator
- A foster child, placed in your care by a court, who is no longer eligible for state-provided medical coverage

- A child covered under a Qualified Medical Child Support Order (QMCSO)
- Same-gender domestic partner and dependents
- Your grandchild who lives with you and is claimed by you as a dependent on IRS tax filings

Children

Children must meet all of the following conditions:

- Unmarried
- Not work on a regular full-time basis

For most plan locations, coverage ends on your child's 19th birthday unless your child meets the following additional conditions. To be covered beyond age 18, your child must be:

- A full-time student (at an accredited college or university or at a vocational, technical or other recognized post secondary education institution) younger than 25
- Dependent upon you for more than 50 percent of his or her support

If your child meets both of these additional conditions, you must contact the TI Benefits Center before your child's 19th birthday to continue coverage. You are also required on an annual basis to certify (through the TI Benefits Center or the Fidelity NetBenefits® Web site) that your child continues to meet these requirements. Coverage will end when the child fails to meet all of the conditions or on his or her 25th birthday, if earlier. To determine the guidelines for dependents in your location, contact the TI Benefits Center.

Dependent Child Enrolled in HMO

In some locations, if you chose an HMO and you are a resident of that state and covered under an HMO policy issued in the respective state, you may be entitled to continue your child's coverage as described below:

- Texas: If you have an unmarried, dependent child, coverage is available to your unmarried, dependent child up to age 25 regardless of their student status. This exception does not apply to the BCBS PPO or to any HMO issued outside of Texas.
- Massachusetts: You may cover your unmarried, dependent child up to age 25 or for up to two years past your child's loss of dependent status. This exception does not apply to the BCBS PPO or to any HMO issued outside of Massachusetts.

Other state dependent coverage mandates only apply to HMOs issued in that state. If your coverage is issued in one state and you reside in another, you are subject to any mandates that apply to the state where your coverage is issued. Refer to any HMO coverage you are considering for details on dependents covered under that HMO.

For federal income tax purposes, individuals covered as a dependent under these state mandates may not be treated as dependents eligible for pre-tax treatment. Such different tax treatment may result in the benefits for dependents covered under the extended HMO definition being taxed to you and subject to additional withholding.

Medically Necessary Leave of Absence from School

If you have a child who is a dependent student who takes a medically necessary leave of absence from school, your child may continue coverage for up to 12 months, or, if earlier, until such coverage would

otherwise terminate under the terms of the health insurance coverage. You must provide TI with a doctor's certificate of the need for such leave to qualify for the continuation of coverage. A "medically necessary leave of absence" is a leave of absence from a post secondary educational institution or any change in enrollment at such institution that commences while your child is suffering from a serious illness or injury, is medically necessary and causes your child to lose dependent status for purposes of health insurance coverage.

If Your Dependent Child is Disabled

Dependent children 19 years of age or older who are physically or mentally disabled may continue to be covered after the child otherwise ceases to meet the definition of an eligible dependent child, provided they were covered as dependents on the day before their 19th birthday (or such later date as is applicable for *covered* full-time students under the age of 25) and if the disability occurred before the time that their status as a dependent child would otherwise end. Coverage is subject to approval. Contact the TI Benefits Center to find out how to apply for coverage.

Two TIers Who are Married

If you are married to another TIer, only one TIer may enroll the eligible dependents. TIers can't be covered both as an employee and as a dependent.

Same-Gender Domestic Partner

Active TI employees can enroll their eligible same-gender domestic partners in medical, dental, vision, accidental death and dismemberment (AD&D) and life insurance benefits. The employee, however, must be enrolled in the medical, dental, vision, AD&D and/or life insurance plan for the same-gender domestic partner coverage to be effective. Same-gender domestic partners and their dependent(s) are not eligible to receive COBRA continuation coverage.

To be eligible for same-gender domestic partner benefits, the following criteria must be met:

- Same gender
- At least 18 years or older
- Unmarried and otherwise legally able to marry
- Not be related by blood
- Financially interdependent
- Share a common residence and intend to do so indefinitely
- Affirm you are in a committed relationship and intend to remain so

Children of the same-gender domestic partner are eligible if they are all of the following:

- Unmarried
- 18 years or younger (unless the child qualifies as a dependent to be covered beyond age 18 - See Children section above for details)
- Not employed full-time
- Dependent upon you for more than 50 percent of his or her support

Election Change Events

Except if otherwise noted in the summary description of a plan or program, you can only make appropriate changes in your coverage, or add or drop dependents, as follows:

- Within 30 days of your first day as a TI employee
- Within 30 days of a qualified status change, which includes:
    - Changes in legal marital status (judgment, decree or order resulting from a divorce, legal separation or annulment)
    - Changes in number of dependents
    - Changes in employment status (yours or spouse's or same-gender 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 or spouse's or same-gender domestic partner's, or dependents)
    - Changes in residence of the employee, spouse or same-gender domestic partner, or dependent (move out of an HMO's coverage area)
    - Changes in FMLA leave status
    - Significant changes in cost of dependent care
    - Entitlement to Medicare or Medicaid by the employee, spouse or same-gender domestic partner, or dependent
    - Significant curtailment of health coverage or loss of health coverage
    - Loss of coverage under a governmental plan or educational institution plan, excluding the state CHIP program 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 same-gender domestic partner/dependent
    - Spouse or same-gender domestic partner, or dependent goes on or returns from a strike or lockout
    - Expiration of COBRA coverage for a spouse or same-gender domestic partner/dependent
    - Change made by spouse or same-gender domestic partner/dependent during annual enrollment for plan of the spouse or same-gender domestic partner/dependent
    - Loss of coverage or become eligible to participate in a premium assistance program under Medicaid or a State child health insurance program (in which case you have 60 days instead of 30 days to make any changes)

    Note: Changes in coverage must be consistent with the change in status.
- Each year during annual enrollment

Within 30 days of a qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance program), you may make appropriate changes to coverage by processing the Life Event change on the Fidelity NetBenefits® Web site (click on the "What To Do When Life Events…" link on the "Health & Insurance" tab) or by contacting the TI Benefits Center. After you have made the appropriate changes, you should print your "Confirmation of Benefit Election" page for your records, as this will serve as your confirmation.

If you move, you will need to update your home address with TI. To update your home address go to my.ti.com (select My Tools, then under Update My Data, select Home Address). If you are covered by an HMO and move out of that HMO's service area, you may enroll in the Blue Cross Blue Shield PPO. In such cases, you must process your request on the Fidelity NetBenefits® Web site or contact the TI Benefits Center within 30 days of your move.

Other Important Information

ERISA Information

In addition to your rights and obligations under these plans and programs, 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

These plans and programs have 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 any of the plans, any programs or provisions without notice. Also, as the federal government changes tax regulations from time to time, it may be necessary to review and change provisions of these plans and programs. This right can be exercised at any time.

Plan Interpretation

TI has reserved the right to interpret some of the applicable ERISA-governed plans and programs, including the plan documents and/or contracts. In some of the plans and programs, the right to interpret the terms of a plan will be exercised by an entity other than TI. Nevertheless, such discretionary interpretations of a plan will be final and binding.

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

Before-Tax Pay Plan

(Note: This plan does not apply to COBRA participants)
ERISA PLAN

A Quick Look

TI offers employees the opportunity to pay some of their insurance costs on a before-tax basis. This benefit is offered pursuant to the Internal Revenue Code Section 125.

There is no need to enroll for the Before-Tax Pay Plan; if you are eligible for the benefit, you are automatically enrolled.

Prices you pay for the following plans will be paid on a before-tax basis:

- TI Employees Health Benefit Plan:
  - Blue Cross Blue Shield PPO or Health Maintenance Organizations (HMOs)
  - MetLife Dental (Basic or Plus) or Dental Health Maintenance Organizations (DHMOs)
- Texas Instruments Incorporated Welfare Benefits Plan:
  - VSP®
- Disability Pay Continuance benefits through the Disability Benefit Plan of Texas Instruments Incorporated (Disability Benefit Plan)
- Accidental Death and Dismemberment Insurance
- Group Life Insurance (except child life which is on a after-tax basis)

Your Benefits

Your share of costs for medical, dental, vision, disability pay continuance, life (except child life) and accidental death and dismemberment will be deducted from your pay on a before-tax basis. This means you reduce your taxes because the amount that is deducted is not subject to federal income or Social Security (FICA) taxes.

Any benefit you receive from the Disability Benefit Plan is taxable.

Costs for coverage of a same-gender domestic partner and/or their dependents will be taxable to you on a before-tax basis in the form of imputed income. The imputed income will be added to your paycheck in the Taxable Benefits section.

Limitations

Life Insurance Coverage

If your total group life insurance coverage is greater than $50,000, you may be subject to additional income tax.

Taxable Benefits

The Internal Revenue Service (IRS) sets the value of group term life insurance amounts that are more than $50,000. If the actual cost you pay is less than the value set by the IRS, the difference is taxable to you in the form of imputed income. You will not actually receive this amount but you must include it as income for tax purposes. This amount is based on your age, the amount of coverage elected in excess of $50,000 and your cost. The taxable amount is shown on your paycheck in the Taxable Benefits section.

Impact on Social Security Benefits

If you make less than the Social Security taxable wage base, paying less in Social Security (FICA) taxes now may result in a reduction in your Social Security benefits when you retire.

Effect of a Leave of Absence

While on an unpaid leave of absence (LOA), payment of plan prices on a before-tax basis stops, and you will be billed for the plan prices on an after-tax basis. When you return to work, payment on a before-tax basis will automatically begin through TI payroll deductions.

Flexible Benefits Plan

(Note: Only the Health Care Spending Account applies to COBRA participants)
ERISA PLAN, offered through the Texas Instruments Incorporated Flexible Benefits Plan

A Quick Look

TI offers two separate Spending Accounts to eligible employees through the Flexible Benefits Plan:

- Health Care Spending Account: An account for out-of-pocket health care expenses for you and your eligible family members.
- Dependent Daycare Spending Account: An account for dependent daycare expenses to be used if you and your spouse are both employed.

The following are highlights of the Spending Accounts. A more detailed description of each of the Spending Accounts follows these highlights.

- You have the opportunity to save taxes by paying for health care and dependent daycare expenses with money deducted from your pay before taxes are withheld.
- **You must enroll each year.** Your enrollment does not carry over to the next plan year. The plan year is from January 1 – December 31.
- Your participation is voluntary. You may contribute separately to both accounts, one account or neither account.
- There is no interest paid to you and no administrative fees (except if you are on COBRA for the health care spending account) are charged to you.
- Your contributions are made through payroll deductions.
- Expenses must be submitted for reimbursement. Only eligible expenses are reimbursable (See section on Filing Claims for information on automatic submission of health care claims).
- The money in your Spending Account(s) cannot be transferred between the two Spending Accounts.
- Any money left in your Spending Account(s) which is not used by the end of the plan year and not reimbursed by March 31 of the following plan year will be forfeited. No refunds or carryovers are allowed.
- IRS regulations prohibit reimbursement from Spending Accounts for expenses of same-gender domestic partners and/or their dependents, except for those who meet the applicable tax law definition of "dependent."

Impact on Social Security Benefits

Under current law, no FICA tax withholding is required on spending account contributions, so your Social Security benefits may be slightly less when you retire. This will depend on the length of time you participate in the program and whether or not your taxable income exceeds the Social Security wage base.

Possible required modifications for Highly Compensated Employees

If it is determined, before or during any plan year, that the plan may fail to satisfy for such plan year any nondiscrimination requirements imposed by the Internal Revenue Code, then TI shall take such action as deemed appropriate to assure compliance. Such action may include, without limitation, a modification of

elections by Highly Compensated Employees or Key Employees (as determined by the IRS) with or without the consent of such employees.

Health Care Spending Account

How the Health Care Spending Account Works

During the plan year, you can contribute up to $5,000, in whole dollar amounts, to the Health Care Spending Account. If you choose to participate, the minimum annual contribution is $100.

Contributions to your account are deducted from your pay before federal income taxes and Social Security (FICA) taxes. In some cases, state income taxes are withheld.

Your contributions are held for you in a special account. When you incur an eligible expense for health care, you must pay the bill. Depending on the medical and dental plan in which you enroll, you may need to submit a receipt for the paid expense to the Health Care Spending Account Claims Administrator. You will be reimbursed in full from your account for all eligible expenses submitted by the required deadline up to the amount for which you enrolled. This is true even if your current deduction balance does not cover the cost of claims submitted. Any reimbursement for eligible expenses is not taxable.

TIers must stay enrolled for the full plan year, unless you have an appropriate qualified status change as described in the Introduction section. If you have an appropriate qualified status change, you cannot reduce your Health Care Spending Account election to an amount less than the contributions you have already made. However, if the change in coverage is consistent with the qualified status change, you may choose to increase your Health Care Spending Account election amount. Due to IRS regulations, the increased amount will be effective on the day following the qualified status change.

How to Put Money in the Health Care Spending Account — Enrollment

You will make contributions to your account over the course of the plan year through payroll deductions. **According to IRS regulations, any contributions placed in the Health Care Spending Account that are not used by the end of the plan year will be forfeited. No refunds or carryovers are allowed.** This means that you should put aside money only for expenses that you are confident you will incur during the plan year.

If you go on a paid leave of absence, your contributions for the Health Care Spending Account will continue to be deducted from your pay. While on an unpaid leave of absence, you will receive a bill for your Health Care Spending Account coverage.

Contribution amounts must be set at the beginning of the plan year or at your date of hire or within 30 days following an appropriate qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance program). You cannot stop, reduce or increase your contributions during the plan year unless an appropriate qualified status change occurs. **The IRS does not make an exception to this rule even if you make a mistake**. If you have an appropriate qualified status change, you cannot reduce your Health Care Spending Account election to an amount less than the contributions you have already made. However, if the change in coverage is consistent with a qualified status change, you may choose to increase your Health Care Spending Account election amount. Due to IRS regulations, the increased amount will be effective on the day following the qualified status change.

It is important to consider the amount of money you elect to contribute to your Health Care Spending Account carefully. Money cannot be transferred between the Health Care Spending Account and Dependent Daycare Spending Account.

Filing Claims

If you are enrolled in any of the following health plans: Blue Cross Blue Shield PPO (for both medical expenses and CVS Caremark prescription drug expenses), or MetLife Dental (Basic or Plus), your claims will be automatically submitted for reimbursement to Ceridian. If you don't want to have these claims automatically sent to Ceridian, you can change the election at any time by contacting the TI Benefits Center. When it is important that you receive reimbursement promptly, you may choose to submit the claim manually. Please understand that auto-claim submissions are only received by Ceridian after the claim has been submitted by your provider and processed by any of the automatic submission eligible health plans. As you may be aware, some providers may delay submitting claims for 30 days or more.

If you are enrolled in the Blue Cross Blue Shield PPO, you choose to file claims manually, and you have several pharmacy claims to submit, an alternative to submitting individual receipts for each prescription is to print and submit your history information from the www.caremark.com® Web site. A Ceridian claim form must accompany the CVS Caremark history information.

You can obtain a claim form on the Fidelity NetBenefits® Web site. From the "Home Page" tab, select the "Health & Insurance" tab. You can click on the "Forms" link in the View column or select "All Health & Insurance Forms" at the bottom of the benefit summary. You can also obtain a claim form online at benefits.ti.com (click Health Benefits Web Site > Forms) or by contacting the Ceridian Service Center directly at 877-799-8820 or through their Web site www.ceridian-benefits.com. Claims should be sent to:

Ceridian FSA Services
P.O. Box 534134
St. Petersburg, FL 33747

or faxed to:
866-717-3820

Please do not use a fax cover sheet when submitting claims by fax, as this can cause delays.

You'll need to include itemized receipts or other supporting documentation, such as an Explanation of Benefits (EOB). Please refer to the Ceridian claim form for information regarding the details required on receipts and other forms of supporting documentation that may be required. If you've lost your receipt, contact the provider to request a copy, or call your health plan or visit their Web site to request an EOB.

Once your claim has been processed, you'll receive notification from Ceridian regarding the status of your claim. If your claim is approved for reimbursement, you'll receive either a check or an electronic funds transfer to your designated bank account. If you've already established direct deposit of your payroll check through TI, your spending account reimbursement will be deposited automatically to the same bank account that you have established for your net pay for TI payroll.

Deadline for Submitting Claims

All claims must be mailed and postmarked or faxed to Ceridian **no later than three months after the end of the plan year (March 31)** in which the expenses were incurred; claims submitted after this deadline will be denied as untimely.

Receiving Reimbursement

Expenses incurred prior to enrollment in the plan are not eligible for reimbursement. Expenses will be reimbursed for the calendar year the participant receives the health care, not in the calendar year when the participant is billed, charged for or pays for the health care expense.

Health Care Spending Account claims will be reimbursed as received up to the amount of your total annual contribution.

Health Care Spending Account Claim Denial and Appeal Information

If a Claim is Denied

A Health Care Spending Account claim for benefits under the Flexible Benefits Plan must be submitted to Ceridian, the Claims Administrator, at the time and in the manner prescribed by the Claims Administrator.

If Ceridian determines that you are not entitled to receive all or part of the benefits you claim in a post-service claim for benefits (other than a claim involving concurrent care), a notice will be provided to you within a reasonable period of time, but no later than 30 days from the day your claim was received by Ceridian. This notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will describe (i) the Claims Administrator's determination, (ii) the basis for the determination (along with appropriate references to pertinent Flexible Benefits Plan provisions on which the denial is based), and (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, Ceridian may not be able to make a determination within 30 days from the day your claim for benefits was submitted. In such situations, Ceridian, in its sole and absolute discretion, may extend the 30-day period for up to 15 days, as long as the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Flexible Benefits Plan or the Claims Administrator and provides you with a written notice within the initial 30-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected. If the reason for the delay is due to your failure to provide information necessary to decide your claim, the above-mentioned notice will describe the information needed and afford you 45 days from the day you receive the notice to provide the required information. However, a delay brought about by your failure to provide information necessary to decide your claim may result in a delay of the determination by Ceridian.

Health Care Spending Account Claim Appeals

If your claim for Health Care Spending Account benefits according to the terms of the Flexible Benefits Plan is denied, you may appeal Ceridian’s denial by requesting a review of your claim by the Plan Administrator. Your written request for an appeal must be received by the Plan Administrator within 180 days of the date you received your notification of Ceridian’s denial. Your request for an appeal should be mailed to:

TI Flexible Benefits Plan
Plan Administrator
ATTN: Formal Appeals
P.O. Box 650311, MS 3905
Dallas, TX 75265

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim. 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. The review will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in Ceridian’s initial determination of your claim. The Plan Administrator's review will not afford any deference to the initial determination and, to the

extent that the determination of whether your claim is eligible for reimbursement involves medical judgment, the Plan Administrator will consult with a health care professional (one who was not involved in the initial determination or the subordinate of a medical professional involved in the initial determination) with the appropriate training and experience.

If, after reviewing your appeal, the Plan Administrator denies your claim, a notice will be provided to you within a reasonable period of time, but not later than 60 days from the day your request for a review was received by the Plan Administrator.

This notice will describe: (i) the specific reason or reasons for the decision, including any adverse determinations, (ii) references to the specific plan provisions on which the decision was based, (iii) your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (iv) your right to bring a cause of action for benefits under section 502(a) of ERISA.

The Plan Administrator's decision shall be the final determination of the claim. If it is not furnished within the appropriate period described above, the claim should be considered denied on review.

If You Terminate Employment with TI

Only the expenses you incurred while working as a TIer are eligible for reimbursement, unless COBRA is elected following termination.

If your employment with TI terminates while you are participating in the Health Care Spending Account, you may continue to claim reimbursement for eligible expenses incurred after your termination date if you contribute to the Health Care Spending Account with after-tax dollars by electing COBRA coverage (See COBRA section) for the remainder of the plan year. If you do not elect COBRA coverage, you may only claim reimbursement for eligible expenses incurred prior to your termination date.

Eligible Expenses

Generally, the Internal Revenue Service (IRS) rules allow reimbursement for any health care expense that would be considered deductible if you were to itemize your medical and dental deductions on Schedule A, Form 1040, of your federal income tax return. Some eligible itemized expenses under the IRS code may not be eligible for reimbursement.

This eligible expense list is subject to change at any time based on IRS rulings. If you have questions about whether an expense is covered, verify the reimbursement eligibility with the Ceridian Service Center by calling 877-799-8820.

Following are some examples of expenses recognized as reimbursable from your Health Care Spending Account.

Examples of Eligible Expenses

- Acupuncture
- Ambulance services
- Amounts that exceed reasonable and customary charges that are not covered by the health plans
- Artificial insemination and in vitro fertilization
- Chemical dependency
- Coinsurance and copay amounts you owe that are not covered by the health plans
- Contact lenses

- Deductibles under the health care plans
- Dental/orthodontic fees beyond what is covered by your family's coverage plan
- Eyeglasses, including exam fee beyond what is covered by your family's coverage plan
- Hearing aids
- Medical care provided in a nursing or retirement home
- Nicotine patches (physician's prescription required)
- Over-the-counter drugs used for the treatment of an illness or disease (such as antacids, allergy medicines, pain relievers, and cold medicines)
- Payments to a special school for a child with a severe learning disability caused by a mental or physical impairment if the main reason for using the school is its resources for relieving the disability (requires a physician's statement)
- Psychiatric care
- Refractive eye surgery
- Sterilization
- Stop-smoking programs
- Wheelchairs

Maternity Benefits

Benefits can only be claimed for the year that the services were received. Maternity expenses are considered received when the baby is born. Money paid to the providers before the birth is not reimbursable under either the medical plan or the spending account until the time of delivery. The only exception is the initial prenatal visit. If your delivery will not be payable under a global maternity benefit, this charge is separate from the charges for the delivery. It is, therefore, payable when services are rendered. Please plan your reimbursement deposits to coincide with the year of expected delivery.

Examples of Ineligible Expenses

You cannot be reimbursed for eligible expenses under the program if you have deducted or will deduct the same expense on your federal income tax form. Some expenses are not eligible for reimbursement. They include:

- Any costs for insurance coverage
- Bleaching, bonding, or whitening of teeth
- Cosmetic surgery, procedures, or care that is not medically necessary due to an injury or congenital defect
- Custodial care in an institution
- Electrolysis
- Expenses covered by the Dependent Daycare Spending Account
- Hair growth treatments
- Over-the-counter drugs used for general health (such as vitamins and fiber supplements)
- Services that are prepaid and prorated during the course of medical treatment
- Weight-loss programs, unless prescribed by a doctor for treatment of a specific disease

Two Important Notes

1. You cannot be reimbursed for an eligible expense under this program and deduct the same expense on your federal income tax return.

2. You cannot be reimbursed for any medical or dental expenses from your Health Care Spending Account if the expense has been or will be paid by your, or your spouse's, insurance plan(s).

For Additional Information on Health Care Spending Accounts

For additional information, refer to the instructions for filing Federal Income Tax Form 1040 and IRS Publication 502, available from the IRS. You can obtain a copy of such guidance by calling the IRS at 800-829-3676 or at www.irs.gov.

You can visit the Ceridian Web site at www.ceridian-benefits.com. A link to the site is also available from the Fidelity NetBenefits® Web site or by logging on to my.ti.com. (Under Health & Wellness, click Health Benefits Web Site, then Health Plans > Flexible Spending Accounts and the link "2009 Plan Administrator: Ceridian.")

Additionally, you can contact Ceridian's Service Center, the Health Care Spending Account Claims Administrator, at 877-799-8820.

Dependent Daycare Spending Account

How the Dependent Daycare Spending Account Works

During the plan year, you can contribute up to $5,000, in whole dollar amounts, to the Dependent Daycare Spending Account. If you choose to participate, the minimum annual contribution is $100. If you are married but file a separate federal income tax return, then you can only contribute up to $2,500. Contributions to your account are deducted from your pay before federal income taxes and Social Security (FICA) taxes. In some cases, state income taxes are withheld (See additional information in the Restrictions on Contribution Amounts section).

Your contributions are held for you in a special account. When you incur an eligible expense for dependent daycare, you must pay the bill and then submit a claim for the paid expense to the Dependent Daycare Spending Account Claims Administrator. You will be reimbursed from your account for eligible expenses submitted by the required deadline only up to the amount already deducted. This payment is not taxable.

TIers must stay enrolled for the full plan year, unless you have an appropriate qualified status change as described in the Introduction section. If you have an appropriate qualified status change, you cannot reduce your Dependent Daycare Spending Account election to an amount less than the contributions you have already made. However, if a change in coverage is consistent with a qualified status change, you may choose to increase your Dependent Daycare Spending Account election amount. Due to IRS regulations, the increased amount will be effective on the day following the qualified status change.

How to Put Money in the Dependent Daycare Spending Account — Enrollment

You will make contributions to your account over the course of the plan year through payroll deductions. **According to IRS regulations, any contributions placed in the Dependent Daycare Spending Account that are not used by the end of the plan year will be forfeited. No refunds or carryovers are allowed.** Your contributions should not exceed the total amount you expect to pay for eligible dependent daycare expenses during the plan year. Also, contributions to a Dependent Daycare Spending Account cannot be more than $5,000 or what you or your spouse earns during the year, if less.

If you go on paid leave of absence, your contributions for your Dependent Daycare Spending Account will continue to be deducted from your pay. While on an unpaid leave of absence or while receiving Long-

Term Disability benefits from the Disability Benefit Plan, your coverage will be stopped and you will not be billed for Dependent Daycare Spending Account coverage.

Contribution amounts must be set during annual enrollment or within 30 days of your date of hire or within 30 days of an appropriate qualified status change. You cannot stop, reduce or increase your contributions during the plan year unless an appropriate qualified status change occurs. **The IRS does not make an exception to this rule even if you make a mistake.** If you have an appropriate qualified status change, you cannot reduce your Dependent Daycare Spending Account election to an amount less than the contributions you have already made. However, if a change in coverage is consistent with a qualified status change, you may choose to increase your Dependent Daycare Spending Account election amount. Due to IRS regulations, the increased amount will be effective on the day following the qualified status change.

It is important to consider the amount of money you elect to contribute to your Dependent Daycare Spending Account carefully. Money cannot be transferred between the Health Care Spending Account and Dependent Daycare Spending Account.

Restrictions on Contribution Amounts

The amount you can contribute is limited to the amount of your earned income, or, if married, to the earned income of your spouse if such income is less than your earned income. For example, if you earn $25,000 and your spouse earns $4,000, you can put a maximum of only $4,000 into your Dependent Daycare Spending Account.

If your spouse is a full-time student or is mentally or physically disabled, IRS rules treat him or her as having earned income equal to $250 (if you have one dependent eligible for care) or $500 (if you have two or more dependents eligible for care), for each month your spouse is a full-time student or disabled during the year.

If both you and your spouse participate in Dependent Daycare Spending Accounts, your combined contributions cannot exceed $5,000 per year.

If you are married and want to participate in the Dependent Daycare Spending Account, your spouse must either:

- Work (full-time or part-time)
- Be a full-time student
- Be incapacitated (physically or mentally incapable of self-care)

Filing Claims

Dependent Daycare Spending Account claims must be filed by you**.** You can obtain a claim form on the Fidelity NetBenefits® Web site. From the "Home Page" tab, select the "Health & Insurance" tab. You can click on the "Forms" link in the View column or select "All Health & Insurance Forms" at the bottom of the benefit summary. You can also obtain a claim form online at benefits.ti.com (click Health Benefits Web Site > Forms) or by contacting the Ceridian Service Center directly at 877-799-8820 or through their Web site at www.ceridian-benefits.com. Claims should be sent to:

Ceridian FSA Services
P.O. Box 534134
St. Petersburg, FL 33747

or faxed to 866-717-3820

Please do not use a fax cover sheet when submitting claims by fax, as this can cause delays.

You'll need to include itemized receipts or other supporting documentation. Please refer to the Ceridian claim form for information regarding the details required on receipts and other forms of supporting documentation that may be required. If you've lost your receipt, contact the provider to request a copy.

Once your claim has been processed, you'll receive notification from Ceridian regarding the status of your claim. If your claim is approved for reimbursement, you'll receive either a check or an electronic funds transfer to your designated bank account. If you've already established direct deposit of your payroll check through TI, your spending account reimbursement will be deposited automatically to the same bank account that you have established for your net pay for TI payroll.

Deadlines for Submitting Claims

All claims must be mailed and postmarked or faxed to Ceridian **no later than three months after the end of the plan year (March 31)** in which the expenses were incurred; claims submitted after this deadline will be denied as untimely.

Receiving Reimbursement

Expenses incurred prior to enrollment in the plan are not eligible for reimbursement. Expenses will be reimbursed for the calendar year the participant incurs the cost of dependent daycare, not in the calendar year when the participant is billed, charged for or pays the dependent daycare expense.

If you submit a dependent care claim for an amount that is more than the amount you have in your account, partial payment will be made with the funds available. Remaining eligible expenses will automatically be reimbursed as additional contributions are credited to your account.

Dependent Daycare Spending Account Claim Denial and Appeal Information

If a Claim is Denied

A Dependent Daycare Spending Account claim for benefits under the Flexible Benefits Plan must be submitted to Ceridian, the Claims Administrator, at the time and in the manner prescribed by the Claims Administrator.

If Ceridian determines that you are not entitled to receive all or part of the benefits you claim in a post-service claim for benefits (other than a claim involving concurrent care), a notice will be provided to you within a reasonable period of time, but no later than 90 days from the day your claim was received by Ceridian. This notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will describe (i) the Claims Administrator's determination, (ii) the basis for the determination (along with appropriate references to pertinent Flexible Benefits Plan provisions on which the denial is based), and (iii) the procedure you must follow to obtain a review of the determination, including a description of the appeals procedure 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, Ceridian may not be able to make a determination within 90 days from the day your claim for benefits was submitted. In such situations, Ceridian, in its sole and absolute discretion, may extend the 90-day period for up to 90 days, as long as the Claims Administrator determines that the extension is necessary due to matters beyond the control of the Flexible Benefits Plan or the Claims Administrator and provides you with a written notice within the initial 90-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected. If the reason for the delay is due to your failure to provide information necessary to decide your claim, the above-mentioned notice will describe the information needed and afford you 45 days from the day you receive the notice to provide

the required information. However, a delay brought about by your failure to provide information necessary to decide your claim may result in a delay of the determination by Ceridian.

Dependent Daycare Spending Account Claim Appeals

If your claim for Dependent Daycare Spending Account benefits under the Flexible Benefits Plan is denied, you may appeal Ceridian's denial by requesting a review of your claim by the Plan Administrator. Your written request for an appeal must be received by the Plan Administrator within 180 days of the date you received your notification of Ceridian's denial. Your request for an appeal should be mailed to:

TI Flexible Benefits Plan
Plan Administrator
ATTN: Formal Appeals
P.O. Box 650311, MS 3905
Dallas, TX 75265

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim. 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. The review will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in Ceridian's initial determination of your claim. The Plan Administrator's review will also not afford any deference to the initial determination.

The claim will be given a full and fair review by the Plan Administrator at the Administration Committee meeting that follows receipt of the appeal if it is received more than 30 days in advance of the meeting. If the claim is received less than 30 days before the meeting, the appeal may be heard at the second meeting after such receipt. Such time period is referred to as the "benefit determination period."

If an extension of the review period is necessary, you will be notified in writing before the end of the benefit determination period of the reason additional time is required and the date by which the Administration Committee expects to make a decision. The time for making a final decision may be extended no later than the date of the third Administration Meeting following receipt of the appeal.

The Plan Administrator's decision on review of the claim will be communicated to you in writing within 5 days of the decision. This communication 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, and (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.

The Plan Administrator's decision shall be the final determination of the claim. If it is not furnished within the appropriate period described above, the claim should be considered denied on review.

If You Terminate Employment with TI

If your employment with TI terminates **before the end of the plan year (December 31)** while you are participating in the Dependent Daycare Spending Account, no additional contributions can be made to your Dependent Daycare Spending Account.

Only the expenses you incurred while working as a TIer are eligible for reimbursement.

Eligible Expenses

The following expenses qualify for reimbursement from your Dependent Daycare Spending Account after services have been rendered:

- Daycare for eligible dependent children under age 13 (in your home or elsewhere)
- Household services to care for a qualified dependent
- Nursery school daycare tuition (non-educational)
- Day Camp (if for childcare purpose)

Examples of Ineligible Expenses

Generally, ineligible expenses for reimbursement are those that don't qualify for the federal income tax credit or allow you to work. The following are examples of expenses that do **not** qualify for reimbursement from your account:

- Dependent health care
- Amounts paid to children or stepchildren under the age of 19 for care of a dependent
- Child care for an evening out
- Expenses covered by your Health Care Spending Account
- Expenses for overnight camp
- Kindergarten (which is primarily educational in nature or purpose)
- Nursing home care for dependents who don't spend at least 8 hours a day in your home
- Payments for schooling in first grade or higher grades
- Transportation expenses, unless furnished by the provider
- Amounts paid to someone you claim as a dependent on your federal income tax return

Definition of Dependent (Qualifying Individuals)

The expense incurred must be for the care of a qualifying individual. Qualifying individuals for reimbursement include persons who regularly spend at least eight hours a day in your home.

Qualifying individuals include:

- A child younger than age 13 who lives at your home and is claimed as a dependent on your federal income tax return
- A dependent who is mentally or physically disabled and incapable of self-care. This dependent must spend at least 8 hours a day in your home. He or she can be your spouse, parent, brother, sister, or any other family member, as long as you provide at least half of his or her financial support and claim him or her as a dependent on your federal income tax return

If you are divorced or separated and have a child whom you do not claim as a dependent for federal income tax purposes, the child must be in your custody for at least six months out of the year.

The dependent care expenses claimed for reimbursement must be incurred in order for you and your spouse to be able to work or attend school full-time. If your spouse is neither working nor a full-time student, he or she must be disabled and unable to provide for his or her own care.

Additional Internal Revenue Service Requirements

Be sure you consider these IRS rules:

- Amounts paid to a facility that cares for more than six children can only be reimbursed if the facility is properly licensed
- You must provide the name, address and taxpayer identification number of the care provider
- Reimbursement cannot be made until services have been rendered

Receipts

TIers who use the Dependent Daycare Spending Account should include receipts when filing for reimbursement and keep a copy for their personal records.

Tax Treatment

Under current federal tax laws, there are two types of dependent care tax advantages available: (i) the dependent care tax credit which permits you to deduct dependent care costs for purposes of preparing your federal income tax return and (ii) participation in a company-sponsored dependent daycare spending account. You may only use one type of dependent care tax advantage for an individual expense. The TI Flexible Benefits Plan offers a Dependent Daycare Spending Account that permits you to withhold up to $5,000 of earnings from your pay during the plan year which may be returned to you as a tax-free reimbursement of your dependent daycare costs.

For Additional Information on Dependent Daycare Spending Accounts

For additional information, refer to the instructions for filing Federal Income Tax Form 1040 and IRS Publication 503, available from the IRS. You can obtain a copy of such guidance by calling the IRS at 800-829-3676 or at www.irs.gov.

You can visit the Ceridian Web site at www.ceridian-benefits.com. A link to the site is also available from the Fidelity NetBenefits® Web site or by logging on to my.ti.com. (Under Health & Wellness, click Health Benefits Web Site, then Health Plans > Flexible Spending Accounts and the link “2009 Plan Administrator: Ceridian.”)

Additionally, you can contact the service center for Ceridian, the Dependent Daycare Spending Account Claims Administrator, at 877-799-8820.

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Health and Wellness

Medical— Blue Cross Blue Shield PPO and HMOs

ERISA PLAN, offered through the TI Employees Health Benefit Plan

A Quick Look

PPO

Key features of the Blue Cross Blue Shield Preferred Provider Organization (PPO) are highlighted below. You will find more detailed information on the following pages.

- TIers may choose from two Blue Cross Blue Shield PPO options: PPO A or PPO B. The difference between these options is the deductible amounts, out-of-pocket maximums and the cost for coverage. See page 30 for more details.
- Use of the Employee Assistance Program (EAP) is encouraged to ensure appropriate treatment and referral within the Behavioral Health Care Network
- 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.
- TIers can call Blue Cross Blue Shield through TI HR Connect at 888-660-1411 before incurring a medical expense to verify the following:
    - Whether the treatment is covered
    - When using a non-network doctor, whether your doctor's charges are within the reasonable and customary range. You will need the procedure (CPT) code and the amount the doctor will charge.

HMOs

- Key features of the HMOs available in your area can be viewed during enrollment on the Fidelity NetBenefits® Web site. You can also call the HMO directly.
- The list of available HMOs and contact information can be found in the Important Phone Numbers chart, following the Introduction section.

If You Do Not Enroll

If you do not make an election during your first 30 days of employment, you will automatically be enrolled in the Blue Cross Blue Shield PPO B option with employee only coverage. The design will be as follows:

- Annual medical/behavioral health deductible of $900 individual/$1,800 family with an associated in-network out-of-pocket maximum of $6,600 individual/$13,200 family.
- In-network physician coinsurance of 90% and in-network hospital coinsurance of 80%.
- Prescription drug coverage with no deductible and with an associated out-of-pocket maximum of $5,000 individual/$10,000 family.
- Prescription drug in-network retail generic coinsurance of 75%, in-network retail brand-name coinsurance of 60%, mail-order generic coinsurance of 80%, and mail-order brand-name coinsurance of 65%.

If you do not make an election during annual enrollment, you will automatically be enrolled in the coverage you had the previous plan year. If you had no coverage the previous plan year, you will be assigned no coverage for the new plan year.

If your medical plan is no longer available for the new plan year and you do not make an election, you will automatically be enrolled in the Blue Cross Blue Shield PPO B option at the level of coverage (for example, you + family) you had the previous plan year. The design will be as follows:

- Annual medical/behavioral health deductible of $900 individual/$1,800 family with an associated in-network out-of-pocket maximum of $6,600 individual/$13,200 family.
- In-network physician coinsurance of 90% and in-network hospital coinsurance of 80%.
- Prescription drug coverage with no deductible and with an associated out-of-pocket maximum of $5,000 individual/$10,000 family.
- Prescription drug in-network retail generic coinsurance of 75%, in-network retail brand-name coinsurance of 60%, mail-order generic coinsurance of 80%, and mail-order brand-name coinsurance of 65%.

NOTE: *If you are hospitalized at the end of a plan year and your hospital stay continues or will continue into the next year, you should contact your medical PPO/HMO to understand what process you should follow to be sure your medical expenses will be covered.*

Enrolling Yourself and Your Eligible Dependents for Medical Coverage

You and your eligible dependents can be covered by the Blue Cross Blue Shield PPO or an HMO (if available in your area) on your first day of work by making an election on the Fidelity NetBenefits® Web site or by contacting the TI Benefits Center. You must make an election on the Fidelity NetBenefits® Web site or contact the TI Benefits Center before coverage can begin.

Employees and spouses or same-gender domestic partners, if covered under TI benefits, are encouraged to complete the annual online Wellness Assessment to help manage personal risks and save money on TI medical benefit premiums. The Wellness Assessment is available at www.LiveHealthyAtTI.com. If you don't take the Wellness Assessment by the end of the annual enrollment period, you will see an increase of $120 on your upcoming annual TI medical benefit premium. If you cover your spouse or same-gender domestic partner and they do not take the Wellness Assessment, you will also pay an additional $120 for them. If neither you nor your spouse or same-gender domestic partner takes the Wellness Assessment, you will be charged an additional $240 (based on $10 per person per month charge). All employees, spouses or same-gender domestic partners who participate in a TI-sponsored medical plan – PPO or HMO – are eligible. You must complete this assessment **every** year to qualify for the savings. If the Wellness Assessment is completed after the end of the annual enrollment period, the savings become effective as soon as administratively practical after the date completed; no retroactive dollars will be issued.

New hire employees have 30 days from the date of employment to complete an online Wellness Assessment, available at www.LiveHealthyAtTI.com. The savings become effective as soon as administratively practical after the date completed; no retroactive dollars will be issued. If you don't take the Wellness Assessment, you will see an additional increase of $10 per month. If you cover your spouse or same-gender domestic partner and they do not take the Wellness Assessment, you will also pay an additional $10 per month for them. If neither you nor your spouse or same-gender domestic partner takes the Wellness Assessment, you will be charged an additional $20 per month. Employees, spouses or same-gender domestic partners who enroll in a TI-sponsored medical plan – PPO or HMO – are eligible. If the Wellness Assessment is completed after 30 days from the date of employment, the savings become effective as soon as administratively practical after the date completed; no retroactive dollars will be issued.

When You Can Make Changes

During the annual enrollment period or within 30 days of an appropriate qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance

program), you may make changes in medical coverage. Please see the Introduction section for information about qualified status changes.

Effective Date of Coverage

TIer

As a new employee, provided you enroll during your first 30 days of employment, your coverage takes effect retroactive to your first day at work.

If adding coverage subject to an appropriate qualified status change, provided you enroll within 30 days of the qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance program), coverage takes effect retroactive to the date of the qualified status change. The next opportunity to add coverage will be during annual enrollment.

Dependents

Coverage for your dependent(s), provided you enroll them during the first 30 days of employment, takes effect retroactive to your first day at work.

If adding coverage subject to an appropriate qualified status change, provided you enroll your eligible dependent within 30 days of the qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance program), coverage takes effect retroactive to the date of the qualified status change. The next opportunity to add coverage, absent a change in coverage consistent with a qualified status change, will be during annual enrollment.

Newborn or Adopted Children

To add coverage for a newborn or adopted child, coverage must be elected within 30 days from the date of birth, date of adoption or date adoption papers were filed. The next opportunity to add coverage, absent a change in coverage consistent with a qualified status change, will be during annual enrollment.

Cost – Who Pays

TI and the TIer share in the cost for medical coverage. The eligible TIer will pay their share of the plan cost through payroll deductions. The TIer will also be responsible for deductibles, copays and coinsurance payments.

TIers, covered spouses or same-gender 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, cigars, pipes or smokeless tobacco (snuff) at any time, even occasionally. 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 same-gender 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 may participate in the Live Tobacco Free Program (available on www.LiveHealthyAtTI.com) to avoid this additional cost. You can avoid paying the additional cost for as long as you participate in the Live Tobacco Free Program, regardless of whether you actually stop using tobacco products. To change your tobacco user status, contact the TI Benefits Center. The additional cost does not apply to residents of Kentucky.

All active TIers (including those on unpaid and paid leave of absence) and their spouses or same-gender domestic partners, if covered, are eligible to complete an online Wellness Assessment at

www.LiveHealthyAtTI.com. If you don't take the Wellness Assessment, you will see an additional increase of $120 (or $240, if you cover your spouse or same-gender domestic partner, based on $10 per person per month charge) added to the total annual cost of your medical benefit. This opportunity is not contingent on what medical plan is chosen; therefore, TIers, spouses or same-gender domestic partners in the BCBS PPO or in an HMO are eligible to participate. For more information, see the Wellness Assessment section.

Blue Cross Blue Shield PPO

Deductibles and Coinsurance

A deductible is the amount you must pay for eligible expenses each year before most benefits begin. Coinsurance is the percentage that TI contributes to your eligible medical expenses after you meet your deductible (unless otherwise noted). 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 Blue Cross Blue Shield through TI HR Connect at 888-660-1411. Your out-of-pocket expenses will be less if you use participating network providers. *Participating* providers have agreed to an allowable amount, which results in lower fees. By having an allowable amount, you and TI pay less for medical care.

If you have covered dependents, all charges used to apply toward each individual's deductible will be applied toward the family deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be satisfied for that calendar year. No individual will contribute more than the individual deductible amount to the family deductible amount.

The out-of-pocket maximum is the annual limit you will pay for most eligible expenses after the deductible is met. Deductibles as well as some additional expenses are not applied toward your out-of-pocket maximum. There are separate out-of-pocket maximums for medical (which includes behavioral health care) and pharmacy.

Networks

Blue Cross Blue Shield network providers offer care to TIers and covered family members at negotiated rates. 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:

- View the listing of network providers (including doctors, hospitals, and pharmacies) which can be found on the Fidelity NetBenefits® Web site. From the "Home Page" tab, select the "Health & Insurance" tab and then select the Plan's "Details" link and click the "Find a Provider" link on the left. You can search for a provider based on defined criteria or by the provider name.
- Call Blue Cross Blue Shield through TI HR Connect at 888-660-1411
- Contact the provider directly by phone or through their Web site which may be located by using www.bcbstx.com

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.).

No Access to Network

In Alaska, Hawaii, Maine and Wyoming, a no-access-to-network benefit (same as in-network benefit) will be offered. There will be no non-network penalty applied in these locations. However, this does not apply to prescription drug and behavioral health care benefits, as these networks are nationwide. You also have the choice of using a *participating* provider. *Participating* providers have agreed to an allowable amount, which results in lower fees. By having an allowable amount, you and TI pay less for medical care.

The listing of *participating* providers can be found on www.bcbstx.com.

Notes:

- "Provider" is defined as anyone who provides medical services—hospitals, doctors, and outpatient care centers.
- Network or negotiated rates apply to expenses that are covered under the Blue Cross Blue Shield PPO. Network or negotiated rates do not apply to non-covered expenses.

Your Benefits

What is Covered under the Blue Cross Blue Shield PPO

The plan covers 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 or supplies 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 Blue Cross Blue Shield to confirm an eligible expense.

Covered 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 Allowed Amount is the amount covered by the plan, as agreed to by the participating provider.

You or your provider can contact Blue Cross Blue Shield to confirm an eligible expense. 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 Blue Cross Blue Shield'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 Blue Cross Blue Shield's Case Management Department by calling Blue Cross Blue Shield through TI HR Connect at 888-660-1411.

Reasonable and Customary (Allowable) Charges

A reasonable and customary (you may also see this referred to on your Explanation of Benefits (EOB) as allowable) charge is the usual cost for comparable treatment in a local geographic area.

Network Doctor

Reasonable and customary limits do not apply if you use a network doctor.

Non-Network Doctor

Charges for non-network doctors fees, (medical/surgical services and supplies and non-network behavioral health care) covered under the plan are subject to reasonable and customary reimbursement limits. Reasonable and customary reimbursement limits also apply to non-network preventive health care, but deductibles and coinsurance amounts do not apply.

No Access

Reasonable and customary limits do not apply for TIers and dependents in areas (Alaska, Hawaii, Maine and Wyoming) without a network.

How Reasonable and Customary is Determined

The reasonable and customary reimbursement level is set at the 80th percentile of charges in a geographic area. For example, this means that if 80 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.

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
2) Call Blue Cross Blue Shield
    - Give each CPT Code and fee to the Blue Cross Blue Shield Benefits Representative
    - You will be told if the fees are within reasonable and customary reimbursement limits. If they are more than reasonable and customary, 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 reasonable and customary reimbursement limits, you will be responsible for the difference.

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 reasonable and customary reimbursement limits

Pre-Existing Conditions

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

Certificate of Group Health Plan Coverage

If you leave TI and are required by another employer to provide proof of your previous TI insurance coverage (certificate of group health plan coverage), contact the TI Benefits Center. This proof may be required to offset any pre-existing condition limitation that may be applied by your new employer. The TI Benefits Center will provide you with a certificate of group health plan coverage when you lose coverage under the plan.

Deductibles, Copays and Coinsurances in the Blue Cross Blue Shield PPO
TIers share the cost of coverage through deductibles, copays and coinsurance; the following chart highlights the coverage amounts.

Benefit	Network	Non-Network
Deductibles/Copays		
Annual Deductible — Medical/Behavioral Health Care	PPO A option: $300 individual / $600 family PPO B option: $900 individual / $1,800 family	
Annual Deductible — Pharmacy	No deductible	
Annual Hospital Copay	$0	$300
Coinsurance		
Doctor [2]	90%	50%
Professional Services[5]	90%	50%
Hospital/Facilities[7] (inpatient & outpatient)	80%	50%
Nutrition	90%	N/A
Behavioral Health Care (doctor/outpatient)	90%	50%[3]
Behavioral Health Care (hospital/inpatient)	80%	50%[3,4]
Annual Out-of-Pocket Maximum for Medical/Behavioral Health Care[1]	PPO A option: $2,200 individual / $4,400 family PPO B option: $6,600 individual / $13,200 family	PPO A option: $3,700 individual / $7,400 family PPO B option: $11,000 individual /$22,000 family
Annual Out-of-Pocket Maximum for Pharmacy[6]	$5,000 per individual / $10,000 per family	

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

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

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

[4] Non-network behavioral health care must be provided by a licensed M.D. or Ph.D. psychologist.

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

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

[7] Facilities include, but are not limited to, hospitals, emergency rooms, independent lab/radiology facilities, skilled nursing facilities and hospice.

Maximum Benefits

Below are the amounts that will be payable under the Blue Cross Blue Shield PPO per individual covered by the Blue Cross Blue Shield PPO.

Benefit	Lifetime Limit
Behavioral Health Care – Inpatient [1] – Outpatient [2]	Included in Medical Limit
Medical [3]	$2,000,000 network $1,000,000 non-network

[1] Cases meeting specific criteria will be case-managed by Magellan Behavioral Health.

[2] Covered expenses include network and non-network expenses. .

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

Adult Preventive Health Care – PPO Participants
Preventive health care is designed to help TIers take an active role in managing their health and well-being. Targeted preventive care services help detect risks and health problems early when they are easiest to treat.

The periodic preventive health office visit, screening tests and immunizations recommended for your age and gender are covered at 100%. No copay, coinsurance or deductibles apply. **Coverage is limited to one preventive health office visit per year for adults enrolled in the Blue Cross Blue Shield PPO.** Preventive services by non-network providers are covered at 100% of reasonable and customary reimbursement limits. Preventive services and the recommended frequency are specified in the following chart.

Preventive Services Covered by the Blue Cross Blue Shield PPO

Recommendations are based on national preventive guidelines.

Preventive Health Office Visit	Ages Covered	Recommended Frequency	Gender	
			M	F
Health History & Lifestyle Counseling	18 and older	Annually	X	X
Blood Pressure Check	18 and older	Annually	X	X
Cancer Screen Exams (visual and/or Palpation)				
- Digital Rectal	40 and older	Annually	X	X
- Oral, Skin and Breast	18 and older	Annually	X	X
- Testicular	18 and older	Annually	X	
- Vaginal and Cervical	18 and older	Annually		X
Screening Tests	**Ages Covered**	**Recommended Frequency**	**Gender**	
			M	**F**
Breast Cancer Screen (screening mammogram)	35 and older	Annually		X
Colonoscopy*	50 and older	Every 5 years	X	X
EKG	35 and older	Once only	X	X
Fasting Glucose	18 and older	Annually	X	X
Flexible Sigmoidoscopy	50 and older	Every 5 years	X	X
Papanicolaou (Pap) Test (including Thin Prep™ and HPV testing)	18 and older	Annually		X
Prostate Specific Antigen (PSA)	50 and older	Annually	X	
Stool Blood Test	45 and older	Annually	X	X
Blood Count	18 and older	Annually	X	X
Lipid Panel (tests for Total, HDL and LDL Cholesterol and Triglycerides)	18 and older	Annually	X	X
Urinalysis	18 and older	Annually	X	X
Immunizations	**Ages Covered**	**Recommended Frequency**	**Gender**	
			M	**F**
Flu Vaccine	18 and older**	Annually	X	X
Gardasil® (HPV) vaccine	18 to 26	One series		X
Hepatitis A	18 and older	One series	X	X
Hepatitis B	18 and older	One series	X	X
Measles/Mumps/Rubella	18 and older	One series	X	X
Meningococcal	18 and older	One series	X	X
Pneumococcal	18 and older	One series	X	X
Rubella	18 and older	Once only	X	X
Shingles vaccine (Zostavax®, for example)	60 and older	Once only	X	X
Tetanus	18 and older	Every 10 years	X	X
Varicella Zoster (Chicken Pox)	18 and older	One series for those not previously immunized	X	X

* Colonoscopy considered diagnostic, not preventive, when performed within 5 years following Flexible Sigmoidoscopy screening.
** Flu vaccine provided for dependents ages 0 to 18 under the Well-Baby, Well-Child Care benefits.

Flu Vaccinations

At most sites, TI employees (regardless of what health plan they are participating in), and eligible spouses and dependents in the Blue Cross Blue Shield PPO, have the convenience of receiving a free on-site flu vaccination. Or, you, your spouse and dependents can receive your annual flu vaccination at your doctor's office or a TI-preferred health clinic. Children between the ages of 9 and 17 can receive a flu vaccination on-site with parental consent. Children under the age of 9 should receive the flu vaccination from their physician. The vaccination and accompanying office visit are covered at 100%. Services by non-network providers are covered at 100% of reasonable and customary fees. Spouses and dependents participating in an HMO should contact their HMO to obtain a flu vaccination under their HMO guidelines.

Well-Baby, Well-Child Care – PPO Participants

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

The following immunization schedule is a guide and represents the maximum number and type of immunizations and lab tests that are covered by the Blue Cross Blue Shield PPO. Your physician may prescribe an actual interval for immunizations, which, including initial and PKU office visits, provides approximately eight well-baby checkups for the baby's first year.

Well-Baby, Well-Child Care
Immunizations and Lab Tests Covered by the Blue Cross Blue Shield PPO

Immunizations	Ages Covered	Recommended Frequency
Diphtheria/Tetanus/Pertussis*	0 to 18	One series
Flu vaccine	0 to 18	Annually
Gardasil® (HPV) vaccine	9 to 18	One series
H. influenza type B*	0 to 18	One series
Hepatitis A	0 to 18	One series
Hepatitis B	0 to 18	One series
Measles/Mumps/Rubella	0 to 18	One series
Meningococcal	0 to 18	One series
Pneumococcal	0 to 18	One series
Polio	0 to 18	One series
Prevnar	0 to 18	One series
Tuberculosis Test (TB)	0 to 18	Once only
Varicella Zoster (Chicken Pox)	0 to 18	One series for those not previously immunized
Office Visit	Ages Covered	Recommended Frequency
Physical Development Assessment	0 to 18	Annually
Lab Tests	Ages Covered	Recommended Frequency
Cholesterol	0 to 18	Once only
Hematocrit	0 to 18	Annually
Hemoglobin	0 to 18	Annually
Lead Screening	2 to 6	Once only
Urinalysis	0 to 18	Annually

* If your doctor chooses, tetramune can be given instead of DTP and HiB

Reminder: To add coverage for a newborn child, coverage must be elected within 30 days from the date of birth.

Well-Baby, Well-Child Check-ups

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

Expenses for recommended immunizations and lab tests are covered at 100%. No copay, coinsurance or deductibles apply. Services by non-network providers are covered at 100% of reasonable and customary fees.

Inpatient Maternity Admissions

For mothers and their new babies, the Blue Cross Blue Shield 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 illness or injury requiring immediate care should be treated at the nearest provider (facility or doctor) that is able to provide the necessary care, regardless of whether that provider is in the network. For emergency/accident care received outside the network, eligible charges will be reimbursed at the in-network level of benefits. The participant may be held responsible for charges in excess of the BCBS allowable amount.

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

Behavioral Health Care

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

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

In order to receive appropriate referral and treatment, TIers covered under the Blue Cross Blue Shield PPO are encouraged to call the Employee Assistance Program (EAP) at 800-888-CARE (2273) before receiving behavioral health care**.** Failure to use a Behavioral Health Care Network provider will result in expenses being reimbursed as out-of-network benefits.

What Happens When You Call the EAP?

You will set up an appointment with an EAP counselor. In most cases, the EAP counselor will be able to provide short-term counseling at no cost. *If more care is needed and is medically necessary*, the EAP counselor will refer you to a provider in the Behavioral Health Care Network.

Behavioral Health Care Options	
Network Benefits	**Non-Network Benefits**
You may contact the EAP at 800-888-CARE (2273) or access an in-network provider on your own. If you contact the EAP, the EAP will assist you with your problem(s) and recommend a treatment plan at no charge to you. EAP help is: • Free short-term counseling • Referral for continued care The EAP will refer you to a Behavioral Health Care Network provider when other *medically necessary* care is needed. Coinsurance for doctor services is 90% and for hospital care is 80% of covered expenses, after the medical deductible (up to plan limits).	Select your own behavioral health care provider — Licensed M.D. or Ph.D. Psychologist. Coinsurance is 50% of average network negotiated rates for inpatient care and 50% of reasonable and customary reimbursement limits 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 Blue Cross Blue Shield PPO

Services are not covered under the Blue Cross Blue Shield PPO for the following:

- Stammering or stuttering
- Specific delays in mental development
- Mental retardation
- Education, custodial care, 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 Blue Cross Blue Shield through TI HR Connect at 888-660-1411 if you have any questions about treatment covered under the plan.

Second Surgical Opinion (Optional)

How a Second Opinion is Handled

TIers have the option of obtaining a second opinion for any surgical procedure. The plan pays 100% of the covered charges for the examination and second opinion. Charges by a non-network doctor are subject to reasonable and customary reimbursement limitations. This benefit is not subject to deductibles and coinsurance.

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 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 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 — Blue Cross Blue Shield PPO

Other covered expenses under the Blue Cross Blue Shield 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
- Up to 48 hours of hospitalization following a vaginal delivery and 96 hours following a Cesarean-section delivery
- Blood transfusions
- Birth control pills, injections or devices that are medically prescribed and not considered experimental or investigational (See Exclusions and Limitations)
- Physical therapy up to $2,000 per calendar year 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

Allergy Testing and Treatment

The Blue Cross Blue Shield PPO will reimburse up to $1,000 maximum per person per calendar year for allergy testing and treatment. This limit is based on the allowed amount.

Benefits for allergy testing and treatment:

- Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Chiropractic Services

The Blue Cross Blue Shield PPO will reimburse up to $1,000 maximum per person per calendar year for chiropractic treatment. This limit is based on the allowed amount. To be covered, visits must be for the treatment of:

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

Benefits for chiropractic services:

- Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Durable Medical Equipment

If you require durable medical equipment, the following applies:

- Network coinsurance is 90%, 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 Blue Cross Blue Shield to determine what durable medical equipment is covered under the plan.

Home Health Care

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

Conditions to Meet for Home Health Coverage

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

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

Benefits for Home Health Services

The benefits include:

- Part-time or intermittent home nursing care by an RN or LVN
- Part-time or intermittent home health-aide services that consist primarily of caring for the individual
- Physical, occupational 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 or prosthetic devices are covered by the plan
- Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

The maximum number of home health care visits covered in a calendar year is 120. Each visit of up to four hours by an RN, LVN, aide or therapist will be considered as one visit. Care must require skilled nursing interventions; otherwise, custodial care benefits are immediately applied.

Services Not Covered by Home Health Coverage

Home health care expenses not covered:

- Services or supplies not included in 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 family
- Services of a social worker
- Transportation services
- Expenses incurred for services provided by a nurse administering a treatment not covered under the program

Custodial Care Program

Custodial care may be appropriate for long-term care instead of hospitalization or once home health benefits have been exhausted.

Charges incurred for the care of a long-term or chronic physically disabled person (as the result of retarded development or bodily infirmity) in his or her home will be considered covered medical expenses. Blue Cross Blue Shield will cover 50% of a participant's custodial care charges after the deductible is met. Network benefits do not apply to the custodial care program. This program is subject to the following:

- Care must be obtained from a licensed nursing service, but is not limited to the services of an RN or LVN
- Care must be prescribed by the individual's physician
- Care cannot be provided by a person who is a member of your family or your spouse's family
- The 50% coinsurance does not apply toward out-of-pocket maximums under the plan
- Once care is determined to be custodial, reimbursement provisions will not change, unless there is a change in the individual's medical needs
- If home care does not require RN or LVN skilled nursing interventions, but does require aide care, custodial benefits are initiated immediately

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. You must use a Blue Cross Blue Shield network provider to receive network reimbursement. Contact Blue Cross Blue Shield for additional information.

Benefits for hospice care:

- Network coinsurance is 80%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met
- Combined annual or lifetime maximum inpatient and outpatient hospice benefit is $20,000

Benefits for Hospice Care Services

Benefits include:

- Room and board and other necessary services and supplies furnished to an individual while full-time inpatient for up to 30 days
- Part-time or intermittent outpatient nursing care by an RN or LVN

Services Not Covered under Hospice Care

Services not included under hospice care:

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

Note: Some of these excluded counseling services are available through the Employee Assistance Program (EAP).

Injuries to Teeth

- 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

Nutrition Benefits

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

Who is Eligible

For you or your covered family members to be eligible, you must be a Blue Cross Blue Shield 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

To determine eligibility, contact TI's nutrition network provider, Professional Nutrition Therapists, at 972-238-1811 in the Dallas area or 800-888-9560.

Nutrition Benefits Available

You may have up to four visits a 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.

To make an appointment with a dietitian in your area, call the network nutrition provider at 972-238-1811 in the Dallas area or 800-888-9560 and identify yourself as a TI Blue Cross Blue Shield PPO participant. When you call, you will be asked questions to establish your records and to determine if medical nutrition therapy is appropriate for you at this time. An assigned network dietitian will contact you to set an appointment time and location convenient for you.

During your initial visit, the dietitian will assess your food preferences and eating patterns. The dietitian 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 the dietitian will send your doctor a brief report.

Cost

The coinsurance is 90% of the cost after the deductible is met for benefits in the Nutrition Network. **Dietitian visits outside the network are not covered.**

Outpatient Physical Therapy Benefits

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

- Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Blue Cross Blue Shield will reimburse up to $2,000 maximum per person per calendar year for outpatient physical therapy. This limit is based on the allowed amount.

Skilled Nursing Facility

The Blue Cross Blue Shield PPO will reimburse up to 100 days per calendar year for a skilled nursing facility. Care must be non-custodial.

Benefits for a skilled nursing facility:

- Network coinsurance is 80%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met. The $300 annual hospital copay will also apply.

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.

Transplant Network

The Transplant Network is a subset of the Blue Cross Blue Shield PPO network. Providers in the Transplant Network have met specific credentialing requirements.

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 Blue Cross Blue Shield to determine whether you reside in a Transplant Network geographic area. Non-network coinsurance is 50%. The Blue Cross Blue Shield PPO will reimburse up to $10,000 for non-network services.

Human Organ or Tissue Transplants

Not all organ or tissue transplants are covered and certain limitations apply. Call Blue Cross Blue Shield for additional information.

Treatment for Loss or Impairment of Speech

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

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

Benefits for outpatient treatment for loss or impairment of speech:

- Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Exclusions and Limitations

Services that are Not Covered under the Plan

The plan does not cover:

- Treatment not prescribed by a licensed physician or dentist
- Experimental or investigational treatment
    - Experimental or investigational treatment includes procedures, treatments, care, services and supplies which do not represent a commonly accepted form of treatment; are not generally accepted by the medical community in the United States as effective, appropriate and essential for the treatment of a diagnosed condition; or are not proven effective in the treatment of an illness
- 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
    - reconstructive breast surgery following mastectomy as described in the Other Covered Expenses section
- Occupational illness or injuries
- Exercise programs or vitamins
- Routine health checkups and tests not specified in preventive care (See the Adult Preventive Health Care and Well-Baby, Well-Child Care sections for information about preventive health care.)
- Fitting or cost of eyeglasses, except when needed because of an injury to the eye
- Hearing aids and exams
- 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 that a covered individual is not legally obligated to pay
- Charges for education, special education or job training
- Non-network doctor fees above reasonable and customary reimbursement limits
- Sonograms during pregnancy, unless medically necessary
- Charges for, or related to hormonal and surgical sex reassignment
- Charges for, or associated with, artificial insemination, in-vitro fertilization, embryo transfer procedures, sexual dysfunction, promotion of fertility through extra-coital reproductive technologies or reversal of sterilization
- Charges for fertility and/or infertility medications
- Birth control devices which are experimental/investigational or can be 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
- Foot orthotics are not covered, unless prescribed for diabetes
- **Select** Specialty Medications (including self-administered and physician administered injectables, along with certain oral medications) are covered exclusively under the Pharmacy Network administered by CVS Caremark. These select Specialty Medications are not eligible for coverage by Blue Cross Blue Shield. For more information refer to the Specialty Medications part of the Pharmacy Network section.

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

Know Your Benefits

To get the most from your benefits:

- Call Blue Cross Blue Shield before care is received or to verify medical necessity
- Use a network provider
- Call the EAP first for behavioral health care

Claiming Benefits

When You Must File Your Claims

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

Payment of Hospital Expenses

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

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 Blue Cross Blue Shield. Call Blue Cross Blue Shield 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 Blue Cross Blue Shield. You will receive an Explanation of Benefits (EOB), showing the amount paid by the Blue Cross Blue Shield 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.

Blue Cross Blue Shield PPO claim forms can be found on the Fidelity NetBenefits® Web site. From the "Home Page" tab, select the "Health & Insurance" tab. You can click on the "Forms" link in the View column or select "All Health & Insurance Forms" at the bottom of the benefit summary. You can also obtain a claim form You can also obtain a claim form online at benefits.ti.com (click Health Benefits Web Site > Forms) or by contacting Blue Cross Blue Shield directly through TI HR Connect at 888-660-1411, or by going to www.bcbstx.com. Fill in the patient information section on the claim form. The completed form should be submitted directly to Blue Cross Blue Shield, along with your itemized bills, for reimbursement.

A separate claim form must be filled out once a year for each member of your family who is sick or injured.

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

Health Care Spending Account

If you have elected to decline automatic claim submissions for your Health Care Spending Account, you must complete, sign and submit a Health Care Spending Account claim form to receive reimbursement. (See Flexible Benefits Plan section for additional information.)

If You Need Help Filing a Claim

Call Blue Cross Blue Shield, the Claims Administrator, through TI HR Connect at 888-660-1411 if you have any questions concerning your claim or need help filing your claim.

Claims should be sent to:

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

You also may write to Blue Cross Blue Shield at the following address:

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

Claim Denial and Appeal Information

If a Claim is Denied

A claim for health benefits under the plan must be submitted to Blue Cross Blue Shield, the Claims Administrator, at the time and in the manner prescribed by the Claims Administrator.

If your claim for health benefits involves urgent care, Blue Cross Blue Shield will notify you as soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the urgent care claim. If Blue Cross Blue Shield requires additional information in order to render a decision, Blue Cross Blue Shield will notify you of the specific information necessary to complete the urgent care claim within 24 hours of receipt of the urgent care claim. You have 48 hours to provide more information. Blue Cross Blue Shield must render a decision on the urgent care claim that required additional information no

later than the earlier of 48 hours after receipt of the initial urgent care claim or by the end of the time period Blue Cross Blue Shield gave you to provide the additional information.

If Blue Cross Blue Shield determines that you are not entitled to receive all or part of the benefits you claim in a post-service claim for benefits (other than a claim involving concurrent care), a notice will be provided to you within a reasonable period of time, but no later than 30 days from the day your claim was received by Blue Cross Blue Shield. This notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will describe (i) the Claims Administrator's determination, (ii) the basis for the determination (along with appropriate references to pertinent plan provisions on which the denial is based), and (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, Blue Cross Blue Shield may not be able to make a determination within 30 days from the day your claim for benefits was submitted. In such situations, Blue Cross Blue Shield, in its sole and absolute discretion, may extend the 30-day period for up to 15 days, as long as Blue Cross Blue Shield determines that the extension is necessary due to matters beyond the control of the TI Employees Health Benefit Plan or the Claims Administrator and provides you with a written notice within the initial 30-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected. If the reason for the delay is due to your failure to provide information necessary to decide your claim, the above-mentioned notice will describe the information needed and afford you 45 days from the day you receive the notice to provide the required information. However, a delay brought about by your failure to provide information necessary to decide your claim may result in a delay of the determination by Blue Cross Blue Shield.

If your claim for group health 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 medical care (other than by a plan amendment or termination) before the end of the period of time or number of treatments constitutes an adverse benefit determination. Blue Cross Blue Shield will notify you of any such reduction or termination in time to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

If you request an extension of the course of treatment beyond the period of time or number of treatments, your claims will be decided as soon as possible, taking into account the medical exigencies. Blue Cross Blue Shield will notify you of the outcome of your claim (whether adverse or not) within 24 hours after the receipt of your claim by the plan (provided you made the claim at least 24 hours prior to the expiration of the prescribed period of time or number of treatments).

Blue Cross Blue Shield PPO 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 Blue Cross Blue Shield. Your written request for an appeal must be received by

Blue Cross Blue Shield within 180 days of the date you received your notice that Blue Cross Blue Shield denied your claim. Your request for an appeal should be mailed to:

Blue Cross Blue Shield
Attn: Claim Review Section
PO Box 660044
Dallas, TX 75266-0044

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits. You may also request reasonable access to, and copies of, all

documents, records, and other information relevant to your claim. You will not be charged for this information. Blue Cross Blue Shield's review will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in the initial determination of your claim. You will also be provided a review that does not afford deference to the initial adverse determination to be conducted by someone who is neither the individual who made the initial determination nor the subordinate of such individual.

If your appeal involves a determination based in whole or part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), Blue Cross Blue Shield will consult with a health care professional with the appropriate training and experience in the field of medicine at issue in your appeal. The health care professional consulted will be an individual who is neither an individual who was consulted in connection with the initial determination that is the subject of the appeal nor the subordinate of any such individual. When requested by you, Blue Cross Blue Shield will provide you with the name of any medical or vocational experts whose advice was sought in connection with your appeal.

If, after reviewing your appeal and any further information that you have submitted, Blue Cross Blue Shield denies your claim, either in whole or in part, a notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 60 days (72 hours for urgent care claims) from the day your request for a review was received by Blue Cross Blue Shield.

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

Medical Plan
Plan Administrator
ATTN: Formal Appeals
PO Box 650311, MS 3905
Dallas, TX 75265

If, after reviewing your appeal and any further information that you have submitted, the Plan Administrator denies your second-level appeal, either in whole or in part, a notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 30 days (72 hours for urgent care claims) from the day your request for a review was received by the Plan Administrator.

This notice will describe: (i) the specific reason or reasons for the decision, including any adverse determinations, (ii) references to the specific plan provisions on which the decision was based, (iii) your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (iv) your right to bring a cause of action for benefits under section 502(a) of ERISA. If you do not agree with any of the Claim or Plan Administrator’s decisions you must exhaust all levels of appeals provided by the plan before you can proceed to court.

Your notice will also describe, if applicable, any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or the availability of such internal rule, guideline, protocol or other similar criterion free of charge upon request). Also, if your appeal involved a question of medical necessity or the experimental nature of a treatment, or a similar exclusion or limit, the explanation of the scientific or clinical judgment for the determination (or the availability of such an explanation) will be provided to you.

The Plan Administrator’s decision shall be the final determination of the claim. If it is not furnished within the appropriate period described above, the claim should be considered denied on review.

Additional Information

Blue Cross Blue Shield PPO is 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 TIer 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 TIer or other covered individual.

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 TIer or other covered individual, or his or her estate, the plan has a right to collect health care-related expenses from the applicable third party. If payment has been made to the TIer or other covered individual, the plan has the right to collect any amount paid by the responsible third party or that responsible party's insurer to the TIer or other covered individual, any such amount being held by the TIer or other covered individual being held in a constructive trust on behalf of the plan with the plan being entitled to first reimbursement. This is the case, regardless of whether the TIer or other covered individual has been fully compensated or made whole, and regardless of the fault of the TIer or other covered individual.

In any event, the Plan will be made whole in the event that an injury or illness is caused by a third party, whether through direct payment from the responsible third party or that responsible party's insurer, by the TIer or other covered individual.

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

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

If You Have Other Medical or Dental Insurance

If you are married and both you and your spouse are working, it is possible that members of your family might be covered under more than one group medical and/or dental plan.

When a TI medical or 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 plan. **If the primary plan pays the same or more than TI's plan, the TI plan will not pay on the claim.**

If the TI plan is secondary in your case, examine benefits of both health plans to be sure the TI plan benefits are higher than the primary plan.

Each time a secondary claim is submitted, the plan annual and maximum benefit amounts will be reduced, whether or not the TI plan pays toward the claim.

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 the other plan does not have the birthday rule, the father's plan is primary.

When Covered Employee or Dependent Turn Age 65

If you are actively employed by TI and you and/or your covered dependents turn age 65, the Blue Cross Blue Shield PPO continues to be your primary coverage over Medicare.

Coverage During a Leave of Absence

If you are on a paid leave of absence, your coverage and that of your covered dependents will continue to be deducted from your pay.

If you are on an unpaid leave of absence (including while on LTD benefits), your coverage and that of your covered dependents can continue. You will be billed for these benefits. If you do not pay your bill, your coverage will be dropped effective your last paid through date.

In the case of military leave, your coverage and that of your covered dependents may be continued while on military leave.

Termination of Coverage

If You Terminate Employment with TI or Change Your Employment Status

Your medical plan coverage will end the earlier of the following:

- Date employment ends
- Date TI discontinues the plan
- Last date through which benefits are extended
- Last date for which payment was made for your coverage

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

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

Death

If you die while an employee of TI and you were eligible for TI Extended Health Benefits Coverage at the time of your death (service and age must satisfy the eligibility rules for TI Extended Health Benefits Coverage), coverage for your eligible dependents may be elected under TI Extended Health Benefits Coverage, as long as they continue to be eligible for dependent coverage. TI will bill the dependents for the cost of their coverage.

Death on or after January 1, 1998 -- TI Extended Health Benefits Coverage must be elected within 30 days of your death, by at least one survivor. If your survivors do not enroll in dental coverage through TI Extended Health Benefits Coverage within 30 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 Coverage. If none of your survivors enroll in medical coverage through TI Extended Health Benefits Coverage, 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 Coverage in the future.

Death prior to January 1, 1998 – Your survivors may defer election of TI Extended Health Benefits Coverage at the time of your death and remain eligible to re-enroll in the plan at any time 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 drug is filled in-network, out-of-network or through mail-order (CVS Caremark Home Delivery service).

The retail network includes both chain and independent pharmacies. The directory of nationwide participating pharmacies can be accessed on the Fidelity NetBenefits® Web site. From the “Home Page” tab, select the “Health & Insurance” tab and then select the Plan’s “Details” link and click the “Find a Provider” link on the left. You can search for a pharmacy based on defined criteria or by the provider name.

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.

See the next page for a table of prescription benefits.

Prescription Benefits

Type	In-Network Coinsurance	Out-of-Network Coinsurance	Mail-Order Program Coinsurance
Generic Drugs	75% of the total drug cost, for up to a 30-day supply	55% of the total drug cost, for up to a 30-day supply	80% of the total drug cost, for up to a 90-day supply
Brand-name Drugs (generic available)	60% of the total drug cost, for up to a 30-day supply. You also pay the cost difference between the brand-name and generic drug*	40% of the total drug cost, for up to a 30-day supply. You also pay the cost difference between the brand-name and generic drug*	65% of the total drug cost, for up to a 90-day supply. You also pay the cost difference between the brand-name and generic drug*
Brand-name Drugs (no generic available)	60% of the total drug cost, for up to a 30-day supply	40% of the total drug cost, for up to a 30-day supply	65% of the total drug cost, for up to a 90-day supply
Annual pharmacy out-of-pocket maximum**	$5,000 individual / $10,000 family		

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

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

You can receive the highest covered benefit from this program 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.

Covered Drugs Subject to Prior Authorization

Prior Authorization determines benefit coverage or the appropriateness of drug therapy based on strict FDA approved criteria for drugs that would otherwise not be covered by the plan. 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.

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 may be dispensed up to a 30-day supply quantity only. The coinsurance for specialty medications will be 90% 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 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 CaremarkConnect 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 CaremarkConnect 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 CaremarkConnect representative will contact your physician to obtain a new prescription.

Claiming Benefits

When You Must File Your Pharmacy Claims

TIers can use their BCBS/ CVS Caremark ID card when obtaining prescriptions at network pharmacies. Pharmacists can access the pharmacy eligibility and plan information through the information on the back of the ID cards.

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.

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

CVS Caremark claim forms can be found on the Fidelity NetBenefits® Web site. From the "Home Page" tab, select the "Health & Insurance" tab. You can click on the "Forms" link in the View column or select "All Health & Insurance Forms" at the bottom of the benefit summary. You can also obtain a claim form

online at benefits.ti.com (click Health Benefits Web Site > Forms) or by contacting CVS Caremark Customer Care through TI HR Connect at 888-660-1411 or you can go to the www.caremark.com Web site. The completed form should be submitted directly to CVS Caremark, along with your receipts, for reimbursement.

Health Care Spending Account

If you have elected to decline automatic claim submissions for your Health Care Spending Account, you must complete, sign and submit a Health Care Spending Account claim form to receive reimbursement (See Flexible Benefits Plan section for additional information).

If You Need Help Filing a Claim

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

Claims should be sent to:

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

Claim Denial and Appeal Information

If a Claim is Denied

A claim for pharmacy benefits under the plan must be submitted to CVS Caremark, the Claims Administrator, at the time and in the manner prescribed by the Claims Administrator.

If your claim for pharmacy benefits involves urgent care, CVS Caremark will notify you as soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the urgent care claim. If CVS Caremark requires additional information in order to render a decision, CVS Caremark will notify you of the specific information necessary to complete the urgent care claim within 24 hours of receipt of the urgent care claim. You have 48 hours to provide more information. CVS Caremark must render a decision on the urgent care claim that required additional information no later than the earlier of 48 hours after receipt of the initial urgent care claim or by the end of the time period CVS Caremark gave you to provide the additional information.

If CVS Caremark determines that you are not entitled to receive all or part of the benefits you claim in a post-service claim for benefits (other than a claim involving concurrent care), a notice will be provided to you within a reasonable period of time, but no later than 30 days from the day your claim was received by CVS Caremark. This notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will describe (i) the Claims Administrator's determination, (ii) the basis for the determination (along with appropriate references to pertinent plan provisions on which the denial is based), and (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, CVS Caremark may not be able to make a determination within 30 days from the day your claim for benefits was submitted. In such situations, CVS Caremark, in its sole and absolute discretion, may extend the 30-day period for up to 15 days, as long as the Claims Administrator determines that the extension is necessary due to matters beyond the control of the TI Employees Health Benefit Plan or the Claims Administrator and provides you with a written notice within the initial 30-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected. If the reason for the delay is due to your failure to provide information necessary to decide your claim, the above-mentioned notice will describe the information needed and afford you 45 days from the day you receive the notice to provide the required information. However, a delay brought about by your failure to

provide information necessary to decide your claim may result in a delay of the determination by CVS Caremark.

If your claim for pharmacy 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 medical care (other than by a plan amendment or termination) before the end of the period of time or number of treatments constitutes an adverse benefit determination. CVS Caremark will notify you of any such reduction or termination in time to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

If you request an extension of the course of treatment beyond the period of time or number of treatments, your claims will be decided as soon as possible, taking into account the medical exigencies. CVS Caremark will notify you of the outcome of your claim (whether adverse or not) within 24 hours after the receipt of your claim by the Plan (provided you made the claim at least 24 hours prior to the expiration of the prescribed period of time or number of treatments).

CVS Caremark Claim Appeals

If your claim for pharmacy benefits is denied, either in whole or in part, you must appeal the denial by requesting a review of your claim by CVS Caremark. Your written request for an appeal must be received by CVS Caremark within 180 days of the date you received your notice that CVS Caremark denied your claim. Your request for an appeal should be mailed to:

Prescription Claim Appeals MC 109
CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072-2084
or faxed to:
866-443-1172
ATTN: Prescription Claim Appeals

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits. You may also request reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You will not be charged for this information. CVS Caremark's review will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in the initial determination of your claim. You will also be provided a review that does not afford deference to the initial adverse determination to be conducted by someone who is neither the individual who made the initial determination nor the subordinate of such individual.

If your appeal involves a determination based in whole or part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), CVS Caremark will consult with a health care professional with the appropriate training and experience in the field of medicine at issue in your appeal. The health care professional consulted will be an individual who is neither an individual who was consulted in connection with the initial determination that is the subject of the appeal nor the subordinate of any such individual. When requested by you, CVS Caremark will provide you with the name of any medical or vocational experts whose advice was sought in connection with your appeal.

If, after reviewing your appeal and any further information that you have submitted, CVS Caremark denies your claim, either in whole or in part, a notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 30 days (72 hours for urgent care claims) from the day your request for a review was received by CVS Caremark.

If, after reviewing your appeal and any further information that you have submitted, CVS Caremark denies your appeal, either in whole or in part, you must appeal CVS Caremark's denial by requesting a review of your claim by the Plan Administrator. Your written request for an appeal must be received by the Plan Administrator within 90 days of the date you received your notice that CVS Caremark denied your claim.

The remainder of your second-level appeal will be handled as discussed above. Your request for a second-level appeal should be mailed to:

Pharmacy Network
Plan Administrator
ATTN: Formal Appeals
PO Box 650311, MS 3905
Dallas, TX 75265

If, after reviewing your appeal and any further information that you have submitted, the Plan Administrator denies your second-level appeal, either in whole or in part, a notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 30 days (72 hours for urgent care claims) from the day your request for a review was received by the Plan Administrator.

This notice will describe: (i) the specific reason or reasons for the decision, including any adverse determinations, (ii) references to the specific plan provisions on which the decision was based, (iii) your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (iv) your right to bring a cause of action for benefits under section 502(a) of ERISA. If you do not agree with any of the Claim or Plan Administrator's decisions you must exhaust all levels of appeals provided by the Plan before you can proceed to court.

Your notice will also describe, if applicable, any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or the availability of such internal rule, guideline, protocol or other similar criterion free of charge upon request). Also, if your appeal involved a question of medical necessity or the experimental nature of a treatment, or a similar exclusion or limit, the explanation of the scientific or clinical judgment for the determination (or the availability of such an explanation) will be provided to you.

The Plan Administrator's decision shall be the final determination of the claim. If it is not furnished within the appropriate period described above, the claim should be considered denied on review.

Health Maintenance Organizations (HMOs)

Most TI employees can choose a Health Maintenance Organization (HMO) as an alternative to the Blue Cross Blue Shield PPO. Because TI offers different HMOs to employees across the U.S., this section offers an overview of the services that HMOs generally provide. Details about each HMO can be obtained on the Fidelity NetBenefits® Web site on the Plan's "Detail" link or directly from the HMO. Before choosing a medical plan, you should carefully weigh the quality of the health care options available to you, the accessibility of that care and the cost.

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

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

The HMOs vary on whether or not they impose any limitations on pre-existing conditions. Please contact your HMO to verify their policy.

The HMOs vary on guesting privilege coverage (i.e., coverage for dependent children who attend school in a different location). Specific HMO access information can be found on the Fidelity NetBenefits® Web site through the "Plan Compare" charts accessed in the Health Management Center. You can also call the HMO directly to find out what benefits, if any, are available.

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

If you are transferred by TI to a new location not covered by your HMO, there will be no pre-existing limitations if you enroll in another HMO or the Blue Cross Blue Shield PPO. **Otherwise, you cannot change HMOs or enroll in the Blue Cross Blue Shield PPO except during annual enrollment, or in the event of an appropriate qualified status change.**

Adding Newborn or Adopted Children

The Health Maintenance Organizations (HMOs) require each newborn or adopted child to be enrolled within 30 days from the date of birth, date of adoption or date adoption papers were filed. You must enroll your child on the Fidelity NetBenefits® Web site or contact the TI Benefits Center.

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.

Wellness Assessment

Every U.S. employee (including those on unpaid and paid leave of absence) and spouse or same-gender domestic partner participating in a TI-sponsored medical plan (PPO or HMO) is encouraged to take the annual online Wellness Assessment. This brief assessment will help you learn more about your health and provide customized information to help you get healthy and stay healthy.

If you don't take the Wellness Assessment within the annual enrollment period, you will see an increase of $120 on your upcoming annual TI medical benefit premium. If you cover your spouse or same-gender domestic partner and they do not take the Wellness Assessment, you will also pay an additional $120 for coverage. If neither you nor your spouse or same-gender domestic partner takes the Wellness Assessment, you will be charged an additional $240 (based on $10 per person per month) and this will be added to the total annual cost of your medical benefit. The Wellness Assessment is available through single sign-on via my.ti.com under "My Tools" or directly at www.LiveHealthyAtTI.com. During new hire or annual enrollment, you can also go to the Health & Insurance tab on Fidelity NetBenefits® and click on "Your Lifestyle and Wellness Program" under "More Benefits Resources" for a link to the "Wellness Assessment". You must complete the Wellness Assessment by the end of annual enrollment to qualify for the full savings in the upcoming year. This opportunity to save is available regardless of what medical plan you choose – the BCBS PPO or an HMO. If the Wellness Assessment is completed after the end of the annual enrollment period, the savings become effective as soon as administratively practical after the date completed; no retroactive dollars will be issued.

If you opt out of medical coverage through TI, you can still take the Wellness Assessment for information and education, but will not receive the savings since you will not incur medical benefit cost.

Completion of the Wellness Assessment will be verified by Alere* and prices reflected on Fidelity NetBenefits® may be adjusted based on this verification. Your enrollment confirmation letter will be sent after the end of Annual Enrollment and will reflect the verified prices.

New hire employees also have an opportunity to participate. If you are participating in a TI-sponsored medical plan (PPO or HMO), you should complete the Wellness Assessment within 30 days of employment. The savings become effective as soon as administratively practical after the date completed; no retroactive dollars will be issued. If you don't take the Wellness Assessment, you will see an additional increase of $10 per month. If you cover your spouse or same-gender domestic partner and they do not take the Wellness Assessment, you will also pay an additional $10 per month for them. If neither you nor your spouse or same-gender domestic partner takes the Wellness Assessment, you will be charged an additional $20 per month. If the Wellness Assessment is completed after 30 days from the date of employment, the savings become effective as soon as administratively practical after the date completed; no retroactive dollars will be issued.

**Texas Instruments has contracted Alere (formerly Matria Healthcare), a corporate wellness company, to provide the Wellness Assessment to TI employees. In completing the Wellness Assessment, you will be disclosing personal health information that is protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).*

Continuation of Benefits (COBRA)

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

TI Extended Health Benefits Coverage (Medical)

TI Extended Health Benefits Coverage provides access to medical and/or dental coverage after leaving TI. When you terminate employment from TI, you may be eligible for TI Extended Health Benefits Coverage. TI Extended Health Benefits Coverage is offered through the TI Employees Health Benefit Plan.

Eligibility for TI Extended Health Benefits Coverage

If you were hired prior to January 1, 1998, and you terminate from TI prior to January 1, 2013, you must meet one of the following requirements to be eligible for TI Extended Health Benefits Coverage:

- 20 years of TI service
- At least age 60 and have five years of TI service
- At least age 65 and have one year of TI service

If you were hired on or after January 1, 1998; or you were hired prior to January 1, 1998 and you terminate from TI on or after January 1, 2013, you are eligible for TI Extended Health Benefits Coverage if you have 20 years of service with TI, regardless of your age, when you terminate.

For purposes of eligibility for TI Extended Health Benefits Coverage, your service date (employment date) is the date used to compute the length of service.

- For a rehire that was *not eligible* for TI Extended Health Benefits Coverage upon their most recent termination, the service date will be the rehire date unless the TIer is entitled to prior service credit. Prior service credit is available if the break in service is less than two years, in which case the TIer will be given an adjusted service date to recognize the full calendar years of prior service time (this only applies for TI Extended Health Benefits Coverage). The retirement status (such as codes R1, R2, etc.) associated with rehires falling under this category will be updated to reflect the most current applicable retirement status based upon the most recent rehire date regardless of the break in service period.
- For a rehire that was *eligible* for TI Extended Health Benefits Coverage upon their most recent termination, prior service credit for TI Extended Health Benefits Coverage will be given using an adjusted service date to recognize the full prior service time (this only applies for TI Extended Health Benefits Coverage). The same retirement status (such as codes R1, R2, etc.) applies to previous terminations and rehires who fall under this category, even if you have had more than one termination and rehire (See Re-employment After Termination and Enrollment in TI Extended Health Benefits Coverage below in this section.).

Eligibility and plan rules for the TI Employees Health Benefit Plan may differ from the eligibility and plan rules for the TI Employees Pension Plan. Therefore, eligibility under the TI Employees Pension Plan will not automatically provide eligibility under TI Extended Health Benefits Coverage offered through the TI Employees Health Benefit Plan.

Enrollment and Maintaining Your Coverage

If you are eligible for TI Extended Health Benefits Coverage, you and your dependents can be covered by the Blue Cross Blue Shield PPO or a TI-sponsored HMO on your first day of retirement. To cover yourself and your eligible dependents, you must make an election on the Fidelity NetBenefits® Web site or contact the TI Benefits Center within 30 days of your retirement date.

If you terminate employment on or after January 1, 1998, to have medical coverage through the TI Employees Health Benefit Plan, you must elect TI Extended Health Benefits Coverage prior to or within 30 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 Coverage; once you elect it, you must continue paying costs without lapse in order to maintain coverage. If you don't enroll in dental coverage through TI Extended Health Benefits Coverage prior to or within 30 days from the date you terminated, you'll be eligible to enroll for coverage later (during annual enrollment or in the event of an appropriate qualified status change) as long as you're enrolled in medical coverage through TI Extended Health Benefits Coverage.

If you terminated employment prior to January 1, 1998, you remain under the enrollment rules in effect when you terminated. You may defer election of TI Extended Health Benefits Coverage at the time of your termination and remain eligible to re-enroll in the plan during annual enrollment or in the event of an appropriate qualified status change.

Regardless of your termination date, 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 Coverage. You may also add a dependent during any annual enrollment period.

Employees who terminate from TI and are eligible for TI Extended Health Benefits Coverage, may also enroll eligible same-gender domestic partners unless they are eligible for coverage under another health plan. However, the TIer ***must*** choose to retain the coverage at the time of termination.

Medicare Prescription Drug Coverage Information

Medicare began offering prescription drug coverage in 2006. This coverage is only available to individuals who are enrolled in Medicare Part A and/or Part B. **It is important to note that you may obtain medical coverage through the TI Employees Health Benefit Plan (the "TI Plan") or Medicare Prescription Drug Coverage, but not both.**

If you decide to enroll in Medicare Prescription Drug Coverage, be aware that this will affect your TI Plan coverage. Your current coverage under the TI Plan pays for other health expenses in addition to prescription drug coverage. Detailed below is more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

- **If you terminated employment on or after January 1, 1998:**
    - If **you** choose to enroll in Medicare Prescription Drug Coverage, you and any covered family members will lose coverage under the TI Plan, and WILL NOT be eligible to re-enroll at any time. *This means medical and prescription drug coverage under the TI Plan ends for you and any covered family members. Once coverage ends, it cannot be reinstated.* Please plan carefully, because if you enroll for Medicare Prescription Drug Coverage, your family members will be left without medical and prescription drug coverage if they don't have coverage elsewhere.
    - If **any of your covered family members** choose to enroll in Medicare Prescription Drug Coverage, they will lose their coverage under the TI Plan. *This means their medical and prescription drug coverage under the TI Plan ends.* If they drop their Medicare Prescription Drug Coverage, you will be able to re-enroll them for prescription drug coverage through the TI Plan during any annual enrollment period or within 30 days of an appropriate qualified status change (provided that you notify TI through the Fidelity NetBenefits® Web site or the TI Benefits Center within the same thirty day period of the

status change), as long as you remain enrolled in the TI Plan. If you drop coverage under the TI Plan, neither you nor your dependents can re-enroll in the TI Plan.

If you terminated employment prior to January 1, 1998:

- If **you** choose to enroll in Medicare Prescription Drug Coverage, you and any covered family members will lose coverage under the TI Plan. *This means medical and prescription drug coverage under the TI Plan ends for you and any covered family members.* Please plan carefully because if you enroll for Medicare Prescription Drug Coverage, your family members will be left without medical and prescription drug coverage if they don't have coverage elsewhere. However, under the current provisions of the TI Plan, you will be able to re-enroll yourself and any eligible family members for coverage under the TI Plan at the next annual enrollment if Medicare Prescription Drug Coverage is dropped.
- If **any of your covered family members** choose to enroll in Medicare Prescription Drug Coverage, they will lose their coverage under the TI Plan. *This means their medical and prescription drug coverage under the TI Plan ends.* However, under the current provisions of the TI Plan, you will be able to re-enroll them in the TI Plan if they drop Medicare Prescription Drug Coverage. You can re-enroll your family members in the TI Plan during any annual enrollment period or within 30 days of an appropriate qualified status change (provided that you notify TI through the Fidelity NetBenefits® Web site or the TI Benefits Center within the same thirty day period of the status change), as long as you are enrolled in the TI Plan.

IMPORTANT NOTE: If you elect Medicare Prescription Drug Coverage, you cannot elect medical coverage through the TI Plan. If you elect Medicare Prescription Drug Coverage and you terminated employment on or after January 1, 1998, you WILL NOT be eligible to re-enroll in medical coverage through the TI Plan.

Creditable Prescription Drug Coverage Notices

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 it, you can request one through the TI Benefits Center. Call TI HR Connect, 888-660-1411, and select option 1 to speak to a representative.

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 new prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription 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 plan 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.**

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep your TI Employee Health Benefits Coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15 through December 31. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan, your TI coverage will be dropped and your dependents will be offered COBRA: be aware that you and your dependents may not be able get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

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.

- BCBS PPO
- TI-sponsored HMOs

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare Prescription Drug Coverage in your area.

- If **you** choose to join a Medicare prescription drug plan, you and any covered family members will lose coverage under the TI Plan, and WILL NOT be eligible to re-enroll at any time (unless you terminated employment prior to January 1, 1998). **This means medical and prescription drug coverage under the TI Plan ends for you and any covered family members.** Please plan carefully, because if you join a Medicare prescription drug plan, your family members will be left without medical and prescription drug coverage if they don't have coverage elsewhere. You will be able to enroll for TI coverage at the next annual enrollment or within 30 days of an appropriate qualified status change (provided that you notify TI through Fidelity NetBenefits® or the TI Benefits Center within the same thirty day period of the status change), if Medicare prescription drug coverage is dropped, unless you terminated employment on or after January 1, 1998, in which case **once TI coverage ends, it cannot be reinstated.**

- If **any of your covered family members** choose to join a Medicare prescription drug plan, they will lose their coverage under the TI Plan. This means their medical and prescription drug coverage under the TI Plan ends. If they drop their Medicare prescription drug coverage, you will be able to re-enroll them for prescription drug coverage through the TI Plan during any annual enrollment period or within 30 days of an appropriate qualified status change (provided that you notify TI through Fidelity NetBenefits or the TI Benefits Center within the same thirty day period of the status change), as long as you remain enrolled in the TI Plan. If you drop coverage under the TI Plan, neither you nor your dependents can re-enroll in the TI Plan (unless you terminated employment prior to January 1, 1998).

You should also know that if you drop or lose your coverage with TI and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month after your initial enrollment period that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the next November to enroll.

For more information about this notice or your current prescription drug coverage …

Please call the TI Benefits Center toll-free at 888-660-1411, Monday through Friday (excluding New York Stock Exchange holidays) between 8:30 a.m. and 8:30 p.m. Eastern time to speak with a customer service associate. **Note:** You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

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 prescription drug plans. You can also get more information about Medicare prescription drug plans from the following:

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

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at **www.socialsecurity.gov**, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may need to give a copy of this notice when you join to show that you are not required to pay a higher premium amount.

Cost — Who Pays

If you terminated employment on or before January 4, 1993 – TI pays part of the cost for TIers who terminated on or before January 4, 1993 with five or more years of service and 50 percent of the cost for their covered dependents. Retirees with less than five years of service pay the full cost for themselves and their dependents.

If you terminate employment after January 4, 1993 and were hired before January 1, 2001 – If you have less than 15 years of service at the time you terminated, you pay the entire cost for TI Extended Health Benefits Coverage. 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 with 30 years of service or more will receive the largest TI contribution. Covered dependents pay 100 percent of the cost.

If you were hired on or after January 1, 2001 – TIers hired on or after January 1, 2001 will have access to TI Extended Health Benefits Coverage after 20 years of service to TI. You will pay the total cost for your coverage and coverage for your eligible dependents. TI will not make any financial contribution toward plan prices.

For the above to apply, you must be eligible for and elect TI Extended Health Benefits Coverage.

This cost-sharing policy may change at any time.

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

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

Health Maintenance Organization (HMO) Coverage

TI-sponsored HMOs may allow you to remain a member of your present HMO when you terminate your TI employment. The TI Benefits Center will bill you directly for cost of your coverage. If your HMO discontinues your coverage at your termination date, you will be eligible to transfer to another medical plan without pre-existing condition limitations.

Medicare Coverage at Age 65

When you or your spouse reach age 65, your TI benefits become secondary to those benefits you receive – or are eligible to receive – from Medicare. You are responsible for any Medicare premium charges for yourself and your dependents after you terminate.

Even if you do not enroll in Medicare Part B, the Blue Cross Blue Shield PPO Plan will continue to pay secondary and will estimate the portion that would have been paid by Medicare.

When Coverage Ends

Your coverage ends at the earliest to occur of the following:

- Your date of termination if you fail to elect TI Extended Health Benefits Coverage prior to or within the 30-day period following termination of employment (unless you terminated employment prior to January 1, 1998; see above).

- At the end of the applicable plan year, for employees who terminated prior to January 1, 1998, and elected to discontinue TI Extended Health Benefits Coverage during annual enrollment.
- 30 days following the due date of a required cost, if any, if it remains unpaid.
- The date the plan is discontinued or amended to eliminate TI Extended Health Benefits Coverage.

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

If you are rehired as an employee eligible for active benefits after you terminated and elected TI Extended Health Benefits Coverage, you will no longer be eligible for TI Extended Health Benefits Coverage, effective immediately upon the date of your rehire. You will again be eligible for TI Extended Health Benefits Coverage when you terminate again. You may resume TI Extended Health Benefits Coverage for yourself and your eligible dependents by making the election to be covered prior to or within 30 days following your subsequent termination. The retirement status (such as codes R1, R2, etc.) in effect at the date of your original termination will apply to your subsequent termination. You may qualify for additional years of service.

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

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

Dental — MetLife Dental (Basic and Plus) and Dental Health Maintenance Organization (DHMO)

ERISA PLAN, offered through the TI Employees Health Benefit Plan

A Quick Look

MetLife Dental

TIers may choose from two MetLife Dental options with different costs and coverage:

- Dental Basic
- Dental Plus

The major coverage difference between these options is the coinsurance amounts paid for services. Types of services covered:

- Preventive and diagnostic — Periodic oral exams, cleanings and preventive x-rays
- Basic Services – Fillings, routine extractions, root canals and minor periodontics
- Major Services — Crowns, dentures, surgical periodontics, implants and other oral surgery
- Orthodontics — Braces and other services to straighten teeth

DHMO

Key features of the DHMO, available in your area, can be viewed on the Fidelity NetBenefits® Web site on the Plan's "Detail" link. The list of available DHMOs and contact information can be found in the Important Phone Numbers chart following the Introduction section.

Enrolling Yourself and Your Eligible Dependents for Dental Coverage

You and your eligible dependents can be covered by the MetLife Dental (Basic or Plus) or a DHMO (if available in your area) on your first day of work by making an election on the Fidelity NetBenefits® Web site or by contacting the TI Benefits Center. You must make an election on the Fidelity NetBenefits® Web site or contact the TI Benefits Center before coverage can begin. Eligible dependents must be enrolled for the same coverage that the TIer is enrolled in — family members cannot have coverage under different options.

If You Do Not Enroll

If you do not make an election during your first 30 days of employment, you will automatically be enrolled in MetLife Dental Basic with employee only coverage.

If you do not make an election during annual enrollment, you will automatically be enrolled in the coverage you had the previous plan year. If you had no coverage the previous plan year, you will be assigned no coverage for the new plan year.

When You Can Make Changes

During the annual enrollment period or within 30 days of an appropriate qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance program), you may make changes in dental coverage. Please see the Introduction section for information about qualified status changes.

Effective Date of Coverage

TIer

As a new employee, provided you enroll during your first 30 days of employment, your coverage takes effect retroactive to your first day at work.

If adding coverage subject to an appropriate qualified status change, provided you enroll within 30 days of the qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance program), coverage takes effect retroactive to the date of the qualified status change.

Dependents

Coverage for your dependent(s), provided you enroll them during the first 30 days of employment, takes effect retroactive to your first day at work.

If adding coverage subject to an appropriate qualified status change, provided you enroll your eligible dependent within 30 days of the qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance program), coverage takes effect retroactive to the date of the qualified status change.

Newborn or Adopted Children

To add coverage for a newborn or adopted child, coverage must be elected within 30 days from the date of birth, date of adoption or date adoption papers were filed. The next opportunity to add coverage will be during annual enrollment.

Cost — Who Pays

TIers

TI and the TIer share in the cost for dental coverage. The TIer will pay their share of the plan cost through payroll deductions. The TIer will also be responsible for deductibles, copays and coinsurance payments.

Dependents

TI also pays part of the cost for each option if you elect dependent coverage; you contribute the remainder through payroll deductions.

Your Benefits (MetLife Dental Basic and Dental Plus)

Pre-Existing Condition Limitations

The initial installation of any prosthesis including a denture, bridge or implant to replace one or more natural teeth lost before coverage began under the Dental Plan or as a replacement for congenitally missing natural teeth are not covered under the Dental Plan.

What is Covered

This chart provides an overview of the types of services covered:

Preventive and Diagnostic	Basic Services	Major Services	Orthodontics
Periodic oral exams Cleanings Preventive x-rays	Fillings Routine extractions Root canals Minor periodontics	Crowns Dentures Oral surgery Surgical periodontics Implants	Braces Other services to straighten teeth

Network Providers You can choose any dentist to obtain dental services. There is not a penalty if you do not use a MetLife network dentist, but reasonable and customary reimbursement limits apply. Dentists in the MetLife network must negotiate their rates, resulting in lower fees. By having network prices, you and TI pay less for dental care. Reasonable and customary reimbursement limits do not apply if you use network providers.

The list of network dentists can be found on the Fidelity NetBenefits® Web site. From the "Home Page" tab, select the "Health & Insurance" tab and then select the Plan's "Details" link and click the "Find a Provider" link on the left. You can search for a provider based on defined criteria or by the provider name.

How the Plan Pays

The following chart shows the amount of reimbursement available.

Benefits	Dental Basic	Dental Plus
Annual deductible*	$50	$50
Annual maximum**	$1,000	$1,500
Preventive care		
- Oral exam, preventive x-rays, cleanings	100%	100%
Basic services		
- Fillings	50%	80%
- Routine extractions	50%	80%
- Endodontics (root canal therapy)	50%	60%
- Minor periodontics (non surgical)	50%	80%
Major services		
- Crowns	50%	60%
- Dentures	50%	60%
- Oral surgery	50%	60%
- Surgical Periodontics	50%	60%
- Implants (requires review by dental consultant)	50%	60%
Orthodontia services (adult and children)	50%	50%
Orthodontic lifetime maximum**	$1,000	$1,500

* Annual deductible applies to Basic and Major services only

** This is the maximum amount the plan will pay

Benefits for orthodontia treatment (for you or your covered dependents), are paid as a one-time lump sum benefit, once treatment begins. The lump sum payment is subject to the applicable coinsurance level and lifetime maximum amount, shown in the chart above.

Orthodontia Lifetime Maximum: If you are enrolled in Dental Basic when orthodontia treatment begins, the $1,000 lifetime maximum is the maximum reimbursement amount that you and/or your covered dependents are entitled to. If you move to Dental Plus after being enrolled in Dental Basic and you and/or your covered dependents are receiving orthodontia treatment, you and/or your covered dependents are NOT entitled to the additional orthodontia lifetime maximum benefits.

Reasonable and Customary Charges (applies to non-network providers only)

A reasonable and customary charge is the usual cost for comparable treatment in a local geographic area. Reasonable and customary limits will apply to all non-network dental services.

How Reasonable and Customary is Determined

The reasonable and customary reimbursement level is set at the 90th percentile of charges in a geographic area. For example, this means that if 90 out of 100 charges in this area are lower than or equal to $900 for a procedure, $900 would be the most that would be reimbursed for that procedure. You would be responsible for charges over $900, in addition to your deductible and coinsurance.

It's not always possible to plan dental expenses, but you can estimate expenses by calling your doctor's office and MetLife before receiving dental care.

Limitations and Exclusions (Dental Basic/Dental Plus)

The following are limitations:

- Preventive/diagnostic exams – two per calendar year
- Cleanings – two per calendar year
- Periodontal cleanings – combined limit of four per calendar year, including two routine cleanings
- Periodontal scaling and root planing – once per quadrant in 24 consecutive months
- Periodontal surgery – once per quadrant in 36 consecutive months
- Bitewing x-rays – one set during any period of 12 consecutive months
- Topical application of fluoride – for children through age 17; limited to two per calendar year
- Sealants – for children through age 13, applies only to permanent premolars/molars, replacement limit of once every 60 consecutive months
- Complete intraoral x-ray series (including bitewings) OR panoramic film (without bitewings) – once during a period of 60 consecutive months
- Denture relining – covered if more than six months after installation; one per denture during any period of 36 consecutive months
- Denture adjustments – covered if more than six months after installation
- Temporomandibular joint dysfunction (TMJ) – maximum benefit per person is $750. Surgical expenses associated with TMJ are not paid under the dental plan; however, they may be covered under your 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 Dental Plan did not exist, or expenses that you are not required to pay
- Treatment or service covered under Workers' Compensation or a similar program
- Replacement of an existing denture or fixed bridgework that was installed less than five years ago
- Replacement of an existing crown/inlay/onlay that was installed less than five years ago
- Dental expenses that are covered under the Blue Cross Blue Shield PPO (or HMO)
- 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
- Services or supplies received by a covered person before the 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 Dental Plan benefits for the covered person are in effect
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride for children through age 17
- Periodontal splinting
- Temporary or provisional restorations
- Temporary or provisional appliances
- Services or supplies furnished by a family member
- Accidents to sound, natural teeth (may be covered under medical)

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

Alternate Benefits (Dental Basic/Dental Plus)

Sometimes there are several ways to treat a particular dental problem. During the dental necessity review of the submitted documentation, MetLife may determine that a more cost-effective treatment is available that is adequate and meets generally accepted standards of dental care. If so, MetLife will provide benefits based upon that alternate treatment. You and your dentist may choose the more costly treatment, but you will be responsible for the difference in charges. This applies even if you don't get a pretreatment estimate (see below for more information on a pretreatment estimate). It is recommended

that a pretreatment estimate of benefits is obtained for all services in excess of $300 so that you are aware of what the 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)
- How much 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® Web site, or benefits.ti.com (click Health Benefits Web Site > Forms) or MetLife, and take it to your dentist.
Your Dentist	2. Fills in the description of the proposed treatment and its cost. (Be sure the dentist does not sign the section that certifies that the treatment has been completed.)
	3. Submits the form to MetLife for review.
MetLife	4. Reviews the proposed treatment and costs.
	5. Tells you and your dentist approximately how much the plan will cover.

Once you have the dental work done, your dentist must fill in the date of service, sign the form and submit it to MetLife.

As the 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 Benefits

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

MetLife claim forms can be found on the Fidelity NetBenefits® Web site. From the "Home Page" tab, select the "Health & Insurance" tab. You can click on the "Forms" link in the View column or select "All Health & Insurance Forms" at the bottom of the benefit summary. You can also obtain a claim form online at benefits.ti.com (click Health Benefits Web Site > Forms) or by contacting MetLife through TI HR Connect at 888-660-1411 or you can go to the www.metlife.com/dental Web site. Fill in the patient information section on the claim form. Be sure to include your Social Security number and sign the form. Your dentist should complete the dentist's section of the form or provide an itemized bill for you to submit.

Claims should be sent to:

MetLife Dental Claims
PO Box 981282
El Paso, TX 79998-1282

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

Any additional itemized bills must include the TIer's Social Security number, name of patient, and service provided.

Health Care Spending Account

If you have elected to decline automatic claim submissions for your Health Care Spending account, you must complete, sign and submit a Health Care Spending Account Claim form to receive reimbursement (See Flexible Benefits Plan section for additional information).

Claim Denial and Appeal Information

If a Claim is Denied

A claim for dental benefits under the plan must be submitted to MetLife, the Claims Administrator, at the time and in the manner prescribed by the Claims Administrator.

If your claim for dental benefits involves urgent care, MetLife will notify you as soon as possible taking into account the medical exigencies, but no later than 72 hours after receipt of the urgent care claim. If MetLife requires additional information in order to render a decision, MetLife will notify you of the specific information necessary to complete the urgent care claim within 24 hours of receipt of the urgent care claim. You have 48 hours to provide more information. MetLife must render a decision on the urgent care claim that required additional information no later than the earlier of 48 hours after receipt of the initial urgent care claim or by the end of the time period MetLife gave you to provide the additional information.

If MetLife determines that you are not entitled to receive all or part of the benefits you claim in a post-service claim for benefits (other than a claim involving concurrent care), a notice will be provided to you within a reasonable period of time, but no later than 30 days from the day your claim was received by MetLife. This notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will describe (i) the Claims Administrator's determination, (ii) the basis for the determination (along with appropriate references to pertinent plan provisions on which the denial is based), and (iii) the procedure you must follow to obtain a review of the determination, including a description of the appeals procedure, and (iv) your right to bring a cause of action for benefits under section 502(a) of ERISA. This notice will also explain, if appropriate, how you may properly complete your claim and why the submission of additional information may be necessary.

In certain instances, MetLife may not be able to make a determination within 30 days from the day your claim for benefits was submitted. In such situations, MetLife, in its sole and absolute discretion, may extend the 30-day period for up to 15 days, as long as MetLife determines that the extension is necessary due to matters beyond the control of the TI Employees Health Benefit Plan or the Claims Administrator and provides you with a written notice within the initial 30-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected. If the reason for the delay is due to your failure to provide information necessary to decide your claim, the above-mentioned notice will describe the information needed and afford you 45 days from the day you receive the notice to provide the required information. However, a delay brought about by your failure to provide information necessary to decide your claim may result in a delay of the determination by MetLife.

If your claim for dental benefits involves an ongoing course of treatment to be provided over a period of time or number of treatments (also known as concurrent care), any reduction or termination of such dental care (other than by a plan amendment or termination) before the end of the period of time or number of treatments constitutes an adverse benefit determination. MetLife will notify you of any such reduction or termination in time to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

If you request an extension of the course of treatment beyond the period of time or number of treatments, your claims will be decided as soon as possible, taking into account the medical exigencies. MetLife will notify you of the outcome of your claim (whether adverse or not) within 24 hours after the receipt of your claim by the Plan (provided you made the claim at least 24 hours prior to the expiration of the prescribed period of time or number of treatments).

MetLife Dental Basic and Dental Plus Plan Claim Appeals

If your claim for benefits is denied, either in whole or in part, you must appeal the denial by requesting a review of your claim by MetLife. Your written request for an appeal must be received by MetLife within 180 days of the date you received your notice that MetLife denied your claim. Your request for an appeal should be mailed to:

MetLife
PO Box 14589
Lexington, KY 40512

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits. You may also request reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You will not be charged for this information. MetLife's review will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in the initial determination of your claim. You will also be provided a review that does not afford deference to the initial adverse determination to be conducted by someone who is neither the individual who made the initial determination nor the subordinate of such individual.

If your appeal involves a determination based in whole or part on a dental judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), MetLife will consult with a dental health care professional with the appropriate training and experience in the field of medicine at issue in your appeal. The dental health care professional consulted will be an individual who is neither an individual who was consulted in connection with the initial determination that is the subject of the appeal nor the subordinate of any such individual. When requested by you, MetLife will provide you with the name of any dental or vocational experts whose advice was sought in connection with your appeal.

If, after reviewing your appeal and any further information that you have submitted, MetLife denies your claim, either in whole or in part, a notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 60 days from the day your request for a review was received by MetLife.

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

Dental Plan
Plan Administrator
ATTN: Formal Appeals
P. O. Box 650311, MS 3905
Dallas, TX 75265

If, after reviewing your appeal and any further information that you have submitted, the Plan Administrator denies your second-level appeal, either in whole or in part, a notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 30 days from the day your request for a review was received by the Plan Administrator.

This notice will describe: (i) the specific reason or reasons for the decision, including any adverse determinations, (ii) references to the specific plan provisions on which the decision was based, (iii) your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (iv) your right to bring a cause of action for benefits under section 502(a) of ERISA. If you do not agree with any of the Claims or Plan Administrators' decisions you must exhaust all levels of appeals provided by the Plan before you can proceed to court.

Your notice will also describe, if applicable, any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or the availability of such internal rule, guideline, protocol or other similar criterion free of charge upon request). Also, if your appeal involved a question of medical necessity or the experimental nature of a treatment, or a similar exclusion or limit, the explanation of the scientific or clinical judgment for the determination (or the availability of such an explanation) will be provided to you.

The Plan Administrator's decision shall be the final determination of the claim. If it is not furnished within the appropriate period described above, the claim should be considered denied on review.

Coordination of Benefits

For information on Coordination of Benefits (COB), see Medical Plan Section.

Coverage During a Leave of Absence

If you are on a paid leave of absence, your coverage and that of your covered dependents will continue to be deducted from your pay.

If you are on an unpaid leave of absence (including while on LTD benefits), your coverage and that of your covered dependents can continue. You will be billed for these benefits. If you do not pay your bill, your coverage will be dropped effective your last paid through date.

In the case of military leave, your coverage and that of your covered dependents may be continued while on military leave.

Termination of Coverage

If You Terminate Employment with TI or Change Your Employment Status

Your dental coverage will end the earlier of the following:

- Date employment ends

- Date TI discontinues the plan
- Last date through which benefits are extended

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

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

Death

If you die while an employee of TI and you were eligible for TI Extended Health Benefits Coverage at the time of your death (service and age must satisfy the eligibility rules for TI Extended Health Benefit Coverage), coverage for your eligible dependents may be elected under TI Extended Health Benefits Coverage, as long as they continue to be eligible for dependent coverage. TI will bill the dependents for the cost of their coverage.

Death on or after January 1, 1998 -- TI Extended Health Benefits Coverage must be elected within 30 days of your death, by at least one survivor. If your survivors do not enroll in dental coverage through TI Extended Health Benefits Coverage within 30 days of your death, they will only be eligible to enroll for 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 Coverage. If none of your survivors enroll in medical coverage through TI Extended Health Benefits Coverage, 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 Coverage in the future.

Death prior to January 1, 1998 – Your survivors may defer election of TI Extended Health Benefits Coverage at the time of your death and remain eligible to re-enroll in the plan at any time in the future.

When Benefits Change

If you terminate employment, dental coverage ends. However, expenses incurred for dentures, fixed bridgework and crowns will be covered if all of the following conditions are met:

- Final impressions were taken before coverage ended
- Teeth had been fully prepared to receive the item before coverage ended
- The item is delivered or installed no more than 30 days after your coverage ends

Dental Health Maintenance Organization (DHMO)

Most TI employees can choose a Dental Health Maintenance Organization (DHMO) as an alternative to Dental Basic / Dental Plus. This section offers an overview of the services that DHMOs generally provide. Details about the DHMO can be obtained on the Fidelity NetBenefits® Web site on the Plan's "Detail" link or directly from the DHMO.

A DHMO is an organization that provides benefits for most dental care needs, with no claim forms, to its members who generally live within its geographic service area. You need to choose a dentist from a list of providers in the service area when you enroll. You typically pay a copay for services.

You must receive care from your selected dentist, or be referred by your dentist to another in-network provider, to receive benefits from a DHMO. If you receive care from a dentist not approved by the DHMO, you won't receive benefit coverage.

The DHMO will provide you with information about its benefits, services, and claim procedures.

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 in the event of an appropriate qualified status change.

Adding Newborn or Adopted Children

DHMOs require each newborn or adopted child to be enrolled within 30 days from the date of birth, date of adoption or date adoption papers were filed. You must enroll your child on the Fidelity NetBenefits® Web site or contact the TI Benefits Center.

NOTE: All claims are administered by the 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 COBRA section.

TI Extended Health Benefits Coverage (Dental)

TI Extended Health Benefits Coverage provides access to medical and/or dental coverage after leaving TI. When you terminate employment from TI, you may be eligible for TI Extended Health Benefits Coverage. TI Extended Health Benefits Coverage is offered through the TI Employees Health Benefit Plan.

Eligibility for TI Extended Health Benefits Coverage

If you were hired prior to January 1, 1998, and you terminate from TI prior to January 1, 2013, you must meet one of the following requirements to be eligible for TI Extended Health Benefits Coverage:

- 20 years of TI service
- At least age 60 and have five years of TI service
- At least age 65 and have one year of TI service

If you were hired on or after January 1, 1998; or you were hired prior to January 1, 1998 and you terminate from TI on or after January 1, 2013, you are eligible for TI Extended Health Benefits Coverage if you have 20 years of service with TI, regardless of your age, when you terminate.

For purposes of eligibility for TI Extended Health Benefits Coverage, your service date (employment date) is the date used to compute the length of service.

- For a rehire that was *not eligible* for TI Extended Health Benefits Coverage upon their most recent termination, the service date will be the rehire date unless the TIer is entitled to prior service credit. Prior service credit is available if the break in service is less than two years, in which case the TIer will be given an adjusted service date to recognize the full calendar years of prior service time (this only applies for TI Extended Health Benefits Coverage). The retirement status (such as codes R1, R2, etc.) associated with rehires falling under this category will be updated to reflect the most current applicable retirement status based upon the most recent rehire date regardless of the break in service period.
- For a rehire that was *eligible* for TI Extended Health Benefits Coverage upon their most recent termination, prior service credit for TI Extended Health Benefits Coverage will be given using an adjusted service date to recognize the full prior service time (this only applies for TI Extended Health Benefits Coverage). The same retirement status (such as codes R1, R2, etc.) applies to previous terminations and rehires who fall under this category, even if you have had more than one termination and rehire.

Eligibility and plan rules for the TI Employees Health Benefit Plan may differ from the eligibility and plan rules for the TI Employees Pension Plan. Therefore, eligibility under the TI Employees Pension Plan will not automatically provide eligibility under TI Extended Health Benefits Coverage offered through the TI Employees Health Benefit Plan.

Enrollment and Maintaining Your Coverage

If you are eligible for TI Extended Health Benefits Coverage, you and your dependents can be covered by MetLife Dental (Basic or Plus) or a TI-sponsored DHMO on your first day of retirement. To cover yourself and your eligible dependents, you must make an election on the Fidelity NetBenefits® Web site or contact the TI Benefits Center prior to or within 30 days of your retirement date.

If you terminate employment on or after January 1, 1998, to have medical coverage through the TI Employees Health Benefit Plan, you must elect TI Extended Health Benefits Coverage prior to or within 30 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 Coverage; once you elect it, you must continue paying costs without lapse in order to maintain coverage. If you don't enroll in dental coverage through TI Extended Health Benefits Coverage prior to or within 30 days from the date you terminated, you'll be eligible to enroll for coverage later (during annual enrollment or in the event of an appropriate qualified status change) as long as you're enrolled in medical coverage through TI Extended Health Benefits Coverage.

If you terminated employment prior to January 1, 1998, you remain under the enrollment rules in effect when you terminated. You may defer election of TI Extended Health Benefits Coverage at the time of your termination and remain eligible to re-enroll in the plan during annual enrollment or in the event of an appropriate qualified status.

Regardless of your termination date, 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 Coverage. You may also add a dependent during any annual enrollment period.

Employees who terminate from TI and are eligible for TI Extended Health Benefits Coverage, may also enroll eligible same-gender domestic partners unless they are eligible for coverage under another health plan. However, the TIer ***must*** choose to retain the coverage at the time of termination.

Cost — Who Pays

You must pay the entire cost of dental coverage for both yourself and any dependents you cover. TI will bill you directly for the cost of the dental option in which you are enrolled.

For the above to apply, you must be eligible for and elect TI Extended Health Benefits Coverage.

IMPORTANT NOTE: Regardless of when you terminated from TI, if you fail to submit monthly payments within 30 days of the due date, your coverage will end retroactive to the last 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-sponsored health plan at any time.

When Coverage Ends

Your coverage ends at the earliest to occur of the following:

- Your date of termination if you fail to elect TI Extended Health Benefits Coverage prior to or within the 30-day period following termination of employment (unless you terminated employment prior to January 1, 1998; see above)
- For employees who terminated prior to January 1, 1998, the end of the applicable plan year if you elect to discontinue TI Extended Health Benefits Coverage during annual enrollment
- 30 days following the due date of a required cost, if any, if it remains unpaid
- The date the plan is discontinued or amended to eliminate TI Extended Health Benefits Coverage

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

If you are rehired as an employee eligible for active benefits after you terminated and elected TI Extended Health Benefits Coverage, you will no longer be eligible for TI Extended Health Benefits Coverage, effective immediately upon the date of your rehire. You will again be eligible for TI Extended Health Benefits Coverage when you terminate again. You may resume TI Extended Health Benefits Coverage for yourself and your eligible dependents by making the election to be covered prior to or within 30 days following your subsequent termination. The retirement status (such as codes R1, R2, etc.) in effect at the date of your original termination will apply to your subsequent termination. You may qualify for additional years of service.

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

TI Extended Health Benefits Coverage offered through the TI Employees Health Benefit Plan may be changed or discontinued in the future (See TI's Right to End or Change the Plans in the Introduction section).

Employee Assistance Program (EAP)

Offered through the TI Employees Health Benefit Plan

The Employee Assistance Program (“the EAP”) is a professional, confidential service you can use to get help whenever you need assistance in dealing with personal pressures, at no cost to you. TI has contracted with Magellan Behavioral Health ("Magellan"), an independent organization, to provide these services at no cost to you. TI pays the entire cost of the program.

Eligibility and Cost

If you are an employee or retiree, your coverage and coverage of your eligible household members is automatic; you do not need to take any steps to enroll.

Eligible household members include your:

- Spouse or same-gender domestic partner
- Unmarried dependent children (whether or not they reside with you)
- Members of your household

How to Obtain EAP Services

You can obtain EAP services by contacting Magellan Behavioral Health toll-free at 800-888-CARE (2273) any time of the day or night, 7 days a week, 365 days a year. When you call the EAP, a Magellan representative will:

- Ask you questions to help identify the problem and how it is affecting you,
- Find out what solutions you have tried and explore other solutions and resources, and
- Help you develop a plan to solve the problem.

Spanish-speaking representatives and counselors are available.

If you desire to work on your problem through in-person sessions with an EAP counselor or if it appears that your problem cannot be adequately addressed in a telephone consultation, the Magellan representative will refer you to an EAP counselor or another resource in your community, as appropriate.

You can also access information, self-help tools, and other resources through Magellan’s Web site. You can reach this Web site directly at www.magellanhealth.com, or you can reach the site through benefits.ti.com (click on Live Healthy Web Site, then Employee Assistance Program.)

Participation in the EAP is completely voluntary and strictly confidential. No information will be released unless you consent in writing, the law requires disclosure or if it is believed that life or safety would be threatened by a failure to disclose.

Voluntary Participation

The decision to seek or accept assistance through the EAP is your personal choice. It will not adversely affect your job security or advancement opportunities. However, participation in the EAP in no way relieves you of the responsibility to meet acceptable work performance and attendance standards.

TIers voluntarily requesting EAP assistance do not have to report this to the Department of Defense (DoD) under adverse information requirements. TIers having special access clearances should follow the guidelines explained in their clearance or orientation or consult the special access security administrator for more information. EAP files, at your request, may be released to the DoD as part of your security clearance.

Covered Services

The EAP provides confidential assessment and counseling services to help with issues or problems that could potentially affect your health, relationships, and job performance. You and each of your eligible household members are eligible to participate in up to 15 in-person sessions per problem each calendar year (as considered clinically necessary by the EAP). If you obtain in-person counseling for a problem together with an eligible household member, such as your spouse, the total number of in-persons sessions for which you and the other person are eligible for that problem is still 15. The number of sessions does not double simply because two persons participate in counseling or triple because three persons participate.

The EAP will help you develop solutions for problems such as:

- Marital and family problems (marital tension, parental concerns, etc.)
- Emotional concerns (anxiety, depression, stress, etc.)
- Substance abuse (drug, alcohol, prescription drugs, etc.)
- Adjusting to change, self-improvement
- Grief
- Work performance/career issues
- Elder Care concerns/issues

If you have questions or concerns about your EAP services, please call Magellan at 800-888-CARE (2273).

In-person EAP services are available only through Magellan's network of EAP counselors. The Magellan network of EAP counselors includes psychologists; clinical social workers; marriage, family, and child counselors; and other behavioral care professionals. For information about Magellan's network of EAP counselors, call Magellan at 800-888-CARE (2273) or access Magellan’s online provider directory at www.magellanhealth.com and enter "800-888-2273", followed by "Texas Instruments". You may select an EAP counselor (i) by calling Magellan at 800-888-CARE (2273) or (ii) through Magellan’s online EAP self-referral process.

Payment of Counselors
Magellan pays EAP counselors directly. You do not have to file claims for EAP services.

Coordination with Blue Cross Blue Shield PPO or Your HMO

If you initially elect to participate in EAP and require assistance beyond what the EAP can provide, the EAP will refer you to Blue Cross Blue Shield or your HMO for assistance with benefit coverage of your needed treatment.

EAP Exclusions and Limitations

The EAP will not pay for the following treatments, services, or supplies:

- Treatment by someone other than an EAP counselor to whom (i) a Magellan representative opened a case or (ii) you completed an electronic referral request through Magellan's online EAP self-referral process,
- Charge for failure to keep a scheduled visit,
- Charges for completing claim forms,
- Services or supplies not needed for treatment or not approved by your EAP counselor,
- Services or supplies required or paid for under any government law, including workers' compensation or other federal, state or local law,
- Services or supplies for which there is no charge,
- Services rendered before coverage became effective,
- Services rendered by a family member,
- Treatments, procedures or devices considered experimental or investigational in nature as determined by the EAP administrator,
- Treatment for any problem or condition that cannot be resolved in short-term counseling (for example, a psychosis or any other condition that requires inpatient treatment or more than 15 sessions),
- Psychiatric services or other medical care,
- Inpatient treatment,
- Treatment for any physical illness,
- Direct treatment for mental retardation, learning disabilities, or autism,
- More than 15 in-person EAP sessions per problem per calendar year,
- Psychological, psychiatric, neurological, educational, or IQ testing,
- Remedial education services, such as evaluation or treatment of learning disabilities, developmental and learning disorders, behavioral training, and cognitive rehabilitation,
- Medication, medication management, or treatment of any condition for which medication is required, unless you are seeing a doctor who prescribes medication for that condition and oversees your use of the medication,
- Evaluations for fitness for duty or excuses for leaves of absence or time off,
- Examinations and diagnostic services in connection with obtaining employment or a particular employment assignment, admission to or continuing in school, securing any kind of license (including professional licenses), obtaining any kind of insurance coverage,
- Court-mandated counseling, evaluations required by a state or federal judicial officer or other governmental agency or to be used in legal actions of any kind (for example, child custody proceedings),
- Testimony in legal proceedings or preparation for legal proceedings,
- Acupuncture,
- Aversion therapy,
- Biofeedback and hypnotherapy, and
- Sleep therapy.

Continuation of Benefits (COBRA)

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

Note: COBRA participants and retirees enrolled in the TI Employees Health Benefit Plan are automatically covered under the EAP.

Termination of Coverage

The benefit ceases when any of the following occurs:

- On discovery of fraud or deception on the part of the employee
- At termination of employment
- TI discontinues the program

Complaint Review

If you have a counselor you can't work with, call the EAP to request a different counselor.

The EAP Administrator realizes that employees may encounter situations where the performance of the program does not meet their expectations. The EAP Administrator will make every effort to resolve problems or complaints in a timely manner.

Vision

THIS BENEFIT IS PART OF AN ERISA PLAN

A Quick Look

The Vision benefit, administered by VSP® (formerly known as Vision Service Plan), has a network of ophthalmologists and optometrists – many in multiple retail locations – that provide vision care services at negotiated rates.

If you choose coverage, your benefits depend on whether you visit a VSP network provider or an out-of-network provider. You can seek vision care from any provider. However:

- If you obtain services from a VSP network provider, you receive the highest level of benefits coverage.
- If you obtain services from an out-of-network provider:
    - You receive limited benefits coverage according to a fixed schedule
    - You will need to file a claim with VSP to be reimbursed

Enrolling Yourself and Your Eligible Dependents for Vision Coverage

You and your eligible dependents can be covered by the Vision benefit on your first day of work by making an election on the Fidelity NetBenefits® Web site or by contacting the TI Benefits Center. You must make an election on the Fidelity NetBenefits® Web site or contact the TI Benefits Center before coverage can begin.

When You Can Make Changes

During the annual enrollment period or within 30 days of an appropriate qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance program), you may make changes in vision coverage. Please see the Introduction section for information about qualified status changes.

Effective Date of Coverage

TIer

As a new employee, provided you enroll during your first 30 days of employment, your coverage takes effect retroactive to your first day at work.

If adding coverage subject to an appropriate qualified status change, provided you enroll within 30 days of the qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance program), coverage takes effect retroactive to the date of the qualified status change.

Dependents

Coverage for your dependent(s), provided you enroll them during the first 30 days of employment, takes effect retroactive to your first day at work.

If adding coverage subject to an appropriate qualified status change, provided you enroll your eligible dependent within 30 days of the qualified status change (or within 60 days for your or your dependent's

change in eligibility for Medicaid or a State child health insurance program), coverage takes effect retroactive to the date of the qualified status change.

Newborn or Adopted Children

To add coverage for a newborn or adopted child, coverage must be elected within 30 days from the date of birth, date of adoption or date adoption papers were filed. The next opportunity to add coverage will be during annual enrollment.

Cost — Who Pays

If you enroll in the Vision benefit, you will be charged a cost. The cost will be deducted every payday.

Your Benefits

The amount the plan pays for expenses related to eye exams, glasses, and contacts depends on whether you visit a VSP network provider or an out-of-network provider.

If You Obtain Services from a VSP Network Provider

Here's what the plan pays for covered services:

Annual eye exams	The plan pays 100% after you pay a $10 copay
Lenses (single vision, lined bifocal, and lined trifocal lenses)*	The plan pays 100% after you pay a $25 copay
Frames*	The plan pays 100% after you pay a $25 copay, up to the plan allowance of $115 retail for covered frames every two calendar years. You receive 20% off any amount over the frame allowance
Contacts (elective)	The plan pays 100% up to $200. When you choose contacts instead of glasses, your $200 allowance applies to the cost of your contacts and the fitting and evaluation exam. This exam is in addition to your eye exam to ensure proper fit of contacts. If you choose contact lenses you will be eligible for a frame one calendar year from the date the contact lenses were obtained. Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your doctor or vsp.com.
Laser vision correction surgery	Discounted rates available**. The VSP doctor will coordinate referrals for qualified candidates to participating VSP Laser Surgery Centers. The maximum fee a member will pay is: $1,500 per eye for PRK $1,800 per eye for LASIK $2,300 per eye for Custom LASIK

* If you purchase frames and eyeglass lenses at the same time, only one $25 copay will apply.

** VSP has arranged for members to receive PRK, LASIK and Custom LASIK at a discounted fee, which could add up to hundreds of dollars in savings. Discounts vary by location, but will average 15 percent off of the contracted laser center's usual and customary price. Additionally, if the participating laser center is offering a temporary price reduction, VSP members will receive 5 percent off of the promotional price. After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor.

The plan will reimburse you for eyeglass lenses or contacts once every calendar year and frames once every two calendar years.

To find out which frames are covered, contact VSP at 800-877-7195 or through TI HR Connect at 888-660-1411.

The listing of VSP network providers can be found on the Fidelity NetBenefits® Web site. From the "Home Page" tab, select the "Health & Insurance" tab and then select the Plan's "Details" link and click the "Find a Provider" link on the left. You can search for a provider based on defined criteria or by the provider name. You can also obtain provider information by visiting the VSP Web site at www.vsp.com or by contacting VSP at 800-877-7195. VSP can also be reached through TI HR Connect at 888-660-1411.

Extra Discounts and Savings

When visiting a VSP network doctor, you'll receive:

- Average 35% - 40% savings on lens extras such as scratch resistant and anti-reflective coatings and progressives
- 30% off additional glasses and sunglasses (after your initial frame purchase), including lens options, from the same VSP doctor on the same day as your exam. Or get 20% off on glasses and sunglasses, including lens options, purchased from any VSP doctor within 12 months of your last exam.
- 15% discount off the cost of a contacts exam (fitting and evaluation)
- Exclusive pricing on annual supplies of popular brands of contacts
- Polycarbonate lenses for dependent children covered in full

If You Obtain Services from an Out-of-Network Provider

Here's what the plan pays for covered services:

Annual eye exams	The plan pays up to $40 after you pay a $10 copay.
Single vision lenses*	The plan pays up to $31 per pair after you pay a $25 copay.
Lined bifocal lenses*	The plan pays up to $47 per pair after you pay a $25 copay.
Lined trifocal lenses*	The plan pays up to $61 per pair after you pay a $25 copay.
Frames*	The plan pays up to $45 after you pay a $25 copay.
Contacts (elective)	The plan pays up to $200.
Laser vision correction surgery	Not covered

* If you purchase frames and eyeglass lenses at the same time, only one $25 copay will apply.

The plan will reimburse you for eyeglass lenses or contacts once every calendar year and frames once every two calendar years.

To find out which frames are covered, contact VSP at 800-877-7195 or through TI HR Connect at 888-660-1411.

You need to file a claim to be reimbursed for your covered out-of-network expenses.

Exclusions and Limitations

The Vision benefit is designed to cover *visual needs* rather than *cosmetic eyewear*. If you select any of the following options, the Plan will pay the basic cost of the allowed lenses, and you will be responsible for the additional costs for the options.

- Blended lenses
- Oversize lenses
- Photochromic lenses; tinted lenses except pink #1 or pink #2
- Progressive multifocal lenses
- The coating of a lens or lenses
- The laminating of a lens or lenses
- Cosmetic lenses
- Optional cosmetic processes
- UV (ultraviolet) protected lenses

Please contact VSP to determine coverage for medically necessary contact lenses (those used to correct extreme visual problems that eyeglass lenses can't correct and those used for conditions of anisometropia and keratoconus).

The following services/*eyewear* are not a covered benefit:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a +/- .50 diopter power); or two pairs of glasses used in lieu of bifocals
- Replacement of lenses and frames furnished under this Vision benefit which are lost or broken, except at the normal intervals when services are otherwise eligible
- Medical or surgical treatment of the eyes (may be covered under Blue Cross Blue Shield PPO or an HMO)
- Corrective vision treatment of an experimental nature
- Costs for services and/or eyewear above Vision benefit allowances
- Services/eyewear not indicated as covered Vision benefits

Coverage During a Leave of Absence

If you are on a paid leave of absence, your coverage and that of your covered dependents will continue to be deducted from your pay.

If you are on an unpaid leave of absence (including while on LTD benefits), your coverage and that of your covered dependents can continue. You will be billed for these benefits. If you do not pay your bill, your coverage will be dropped effective your last paid through date.

In the case of military leave, your coverage and that of your covered dependents may be continued while on military leave.

Termination of Coverage

If You Terminate Employment with TI or Change Your Employment Status

Your vision coverage will end the earlier of the following:

- Date employment ends
- Date TI discontinues the plan
- Last date through which benefits are extended

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

- Date a dependent becomes covered as a TIer
- Date the dependent does not meet the definition of an eligible dependent
- Date your TI coverage ends
- Date dependent coverage is no longer offered under the plan
- Last date for which payment was made for dependent coverage

Continuation of Benefits (COBRA)

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

Claiming Benefits

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

How to File a Claim

For VSP Network Provider Expenses

When visiting a VSP network provider, you do not need to file claim forms. Simply make an appointment and tell the doctor you are a VSP member. Your doctor and VSP will handle the rest.

For Out-of-Network Expenses

When you incur out-of-network vision care expenses, you need to pay the entire bill at the time of your appointment and then file a claim to VSP for reimbursement. Claims must be submitted to VSP and postmarked within 6 months from your date of service, claims submitted after this deadline will be denied as untimely.

You can get a claim form and filing instructions online at benefits.ti.com (click Health Benefits Web Site > Forms) or on the VSP Web site at www.vsp.com, or by calling VSP through TI HR Connect at 888-660-1411.

Health Care Spending Account

To receive reimbursement from your Health Care Spending account, you must complete, sign and submit a Health Care Spending Account Claim form (See Flexible Benefits Plan section.).

Claim Denial and Appeal Information

If a Claim is Denied

A claim for vision benefits must be submitted to VSP, the Claims Administrator, at the time and in the manner prescribed by the Claims Administrator.

If VSP determines that you are not entitled to receive all or part of the benefits you claim in a post-service claim for benefits (other than a claim involving concurrent care), a notice will be provided to you within a reasonable period of time, but no later than 30 days from the day your claim was received by VSP. This notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will describe (i) the Claims Administrator's determination, (ii) the basis for the determination (along with appropriate references to pertinent benefit provisions on which the denial is based), and (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, VSP may not be able to make a determination within 30 days from the day your claim for benefits was submitted. In such situations, VSP, in its sole and absolute discretion, may extend the 30-day period for up to 15 days, as long as VSP determines that the extension is necessary due to matters beyond the control of the Texas Instruments Incorporated Welfare Benefits Plan or the Claims Administrator and provides you with a written notice within the initial 30-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected. If the reason for the delay is due to your failure to provide information necessary to decide your claim, the above-mentioned notice will describe the information needed and afford you 45 days from the day you receive the notice to provide the required information. However, a delay brought about by your failure to provide information necessary to decide your claim may result in a delay of the determination by VSP.

If your claim for vision 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 vision care (other than by a plan amendment or termination) before the end of the period of time or number of treatments constitutes an adverse benefit determination. VSP will notify you of any such reduction or termination in time to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

If you request an extension of the course of treatment beyond the period of time or number of treatments, your claims will be decided as soon as possible, taking into account the medical exigencies. VSP will notify you of the outcome of your claim (whether adverse or not) within 24 hours after the receipt of your claim by the plan (provided you made the claim at least 24 hours prior to the expiration of the prescribed period of time or number of treatments).

VSP 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 VSP. Your written request for an appeal must be received by VSP within 180 days of the date you received your notification of VSP's denial. Your request for an appeal should be mailed to:

VSP
Claims Administrator
PO Box 997100
Sacramento, CA 95899-7100

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim. 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. VSP's review will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in VSP's initial determination of your claim. You will also be provided a review that does not afford deference to the initial adverse determination to be conducted by someone who is neither the individual who made the initial determination nor the subordinate of such individual.

If your appeal involves a determination based in whole or part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), VSP will consult with a health care professional with the appropriate training and experience in the field of medicine at issue in your appeal. The health care professional consulted will be an individual who is neither an individual who was consulted in

connection with the initial determination that is the subject of the appeal nor the subordinate of any such individual. When requested by you, VSP will provide you with the name of any medical or vocational experts whose advice was sought in connection with your appeal.

If, after reviewing your appeal and any additional information that you have submitted, VSP denies your claim, either in whole or part, a notice will be provided to you within a reasonable period of time, but not later than 60 days from the day your request for a review was received by VSP.

This notice will describe: (i) the specific reason or reasons for the decision, including any adverse determinations, (ii) references to the specific plan provisions on which the decision was based, (iii) your right to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim, and (iv) your right to bring a cause of action for benefits under section 502(a) of ERISA. If you do not agree with any of VSP's decisions, you must exhaust all levels of appeals provided by the Plan before you can proceed to court.

Your notice will also describe, if applicable, any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or the availability of such internal rule, guideline, protocol or other similar criterion free of charge upon request). Also, if your appeal involved a question of medical necessity or the experimental nature of a treatment, or a similar exclusion or limit, the explanation of the scientific or clinical judgment for the determination (or the availability of such an explanation) will be provided to you.

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 statement gives you advice required by law. This Notice is effective as of April 14, 2003, and applies to health information the Texas Instruments Incorporated Welfare Benefits Plan (the "Plan") receives about you. 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"). This statement is not a consent or an authorization form. This form will not be used to release or to use your health care information in any manner that is not permitted by the Privacy Regulations. This notice is for participants and beneficiaries in the Plan. 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 (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 Secretary of HHS 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:

1. 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, are medically necessary, experimental or investigational, and disclosures to obtain reimbursement under insurance, reinsurance, stop loss or excessive 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 who sponsors the Plan for any of the purposes described above, if the Plan is part of an organized health care arrangement with the other Plan.

2. 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.

3. 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, and other activities that are related to creating, renewing, or replacing the contract of health insurance or health benefits 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 quality improvement activities, and customer service and resolution of internal grievances.

4. The Plan may also be required to disclose or use your Protected Health Information for certain other purposes. These purposes include uses or disclosures that are required by law. For example, if the Plan receives a court order requiring disclosure of your 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.

5. The Plan may disclose your Protected Health Information as authorized by you or your

representative and to the extent necessary to comply with laws relating to workers' compensation and similar programs providing benefits for work-related injuries or illnesses if either (1) the health care provider provides health care to the individual at the request of the employer to determine if the individual has a work-related illness or injury or to provide medical surveillance of the workplace and the health care provider is employed by the employer, or (2) if the employer is a health care provider and the health care provider is a member of the employer's work force, or (3) you authorize the disclosure. You must authorize the disclosure in writing and you will receive a copy of any authorization you sign.

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.

6. 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, 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. 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.

7. The Plan may disclose your Protected Health Information for purposes of referring you to case management or a pharmacy benefit manager.

8. The Plan may disclose your Protected Health Information to vendors who may work with the Plan regarding other types of products that are available for marketing purposes. This type of disclosure may only be made with your authorization.

9. The Plan may also disclose your information for the purpose of underwriting, premium rating and other activities with respect to creating, renewing and replacing the health insurance contract or health benefit coverage, including creating, renewing and replacing stop loss or excess loss insurance coverage.

Rights You May Exercise

1. You have the right to request restrictions on certain uses and disclosures of your protected health information in writing. However, the Plan is not required to agree to any restriction you may request.

2. You have the right to receive confidential communication of your Protected Health Information.

3. You have the right to request access to your Protected Health Information and to inspect and copy your Protected Health Information under the policies and procedures established by the Plan.

4. You have the right to request an amendment to your Protected Health Information under the policies established by the Plan.

5. 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.

6. You have a right to receive this notice electronically and to obtain a paper copy from the group health plan upon request.

7. You have the right to receive confidential communications of your Protected Health Information confidentially. 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.

8. You have the right to request to inspect a copy of your Protected Health Information, other than 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. Psychotherapy notes are separately filed notes about your conversations with your mental health professional during a counseling session. Psychotherapy notes do not include summary information about your mental health treatment.

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 is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and

- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

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:

(1) When required by law.

(2) 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.

(3) 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. Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's Protected Health Information.

(4) 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).

(5) 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.

(6) When required for law enforcement purposes (for example, to report certain types of wounds).

(7) For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. 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. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement, and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

(8) 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.

(9) The Plan may use or disclose Protected Health Information for research, subject to certain conditions.

(10) 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.

(11) When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

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.

Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request.

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 Asarene Watts, Privacy Official, Texas Instruments Incorporated, 7839 Churchill Way, MS 3905, Dallas, Texas 75251 or (972) 917-7721.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI.

"Designated Record Set" includes the medical records and billing records about individuals

maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for the Plan; or other information used in whole or in part by or for the Plan to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is excluded.

The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

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 Asarene Watts, Privacy Official, Texas Instruments Incorporated, 7839 Churchill Way, MS 3905, Dallas, Texas 75251, or (972) 917-7721, or via email at hipaa_privacy_official@list.ti.com.

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 Secretary of the U.S. Department of Health and Human Services.

Right to Amend

You have the right to request the Plan to amend your Protected Health Information or a record about you in a designated record set for as long as the Protected Health Information is maintained in the designated record set.

The Plan has 60 days after the request is made to act on the request. A single 30-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 Asarene Watts, Privacy Official.

You or your personal representative will be required to complete a form to request amendment of the Protected Health Information in your designated record set.

[The Plan requires that you make requests for amendment in writing and to provide a reason to support a requested amendment.]

The Right to Receive an Accounting of Protected Health Information Disclosures

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 on April 14, 2003.

If the accounting cannot be provided within 60 days, an additional 30 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.

The Right to Receive a Paper Copy of This Notice Upon Request

To obtain a paper copy of this Notice, contact Asarene Watts, Privacy Official, Texas Instruments Incorporated, 7839 Churchill Way, MS 3905, Dallas, Texas 75251, or (972) 917-7721, or via email at hipaa_privacy_official@list.ti.com.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your Protected Health Information or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a 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.

You have a right to request an amendment to your Protected Health Information; however the Plan may deny your request and you may appeal any denial.

You have the right to receive an accounting of any disclosures made of your Protected Health Information excluding those disclosures or uses for payment, treatment or health care operations.

You have a right to receive a copy of this notice in paper format. The Plan is required by law to maintain the privacy of Protected Health Information and provide individuals with notice of its legal duties and privacy practices with respect to the Protected Health Information.

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 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, taking into consideration practical and technological limitations.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;

- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for the Plan's compliance with legal regulations; and
- 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.

In addition, 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.

In addition, 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.

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with Kristy Rorschach, Complaint Official, at Texas Instruments Incorporated, 7839 Churchill Way, MS 3999, Dallas, Texas 75251, or via email @ hipaa_complaint_official@list.ti.com, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

You may also file a complaint with the Office of Civil Rights of the Department of Health and Human Services at Winston A. Wilkinson, Director, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington, DC 20201, or at the appropriate regional office of the Office of Civil Rights of the U.S. Department of Health and Human Services, within 180 days of any alleged violation. If you would like to receive further information, you should contact Asarene Watts, the Privacy Official, or Kristy Rorschach, the privacy Complaint Official, for the Plan. This notice will first be in effect on April 14, 2003, and shall remain in effect until you are notified of any changes, modifications or amendments.

Eye-Care Discount Program

(Note: This plan does not apply to COBRA participants)

You and your family members may use the EyeMed Eye-Care Discount Program ("Discount Program") to receive discounts on glasses and contacts. This program is administered by EyeMed Vision Care. You must show your TI badge or a TI Medical ID card to receive discounts at the time of purchase. There is no membership cost. Vision care expenses are not reimbursable under the Blue Cross Blue Shield PPO. However, most eye care expenses are eligible for reimbursement in the Health Care Spending Account.

Discounts are good at participating LensCrafters, Sears Optical, Target Optical, JCPenney Optical, most Pearle Vision locations and independent participating providers. To locate the nearest participating provider, call 866-723-0391 or access the program's Web site at www.eyemedvisioncare.com. The provider network is Select.

You may bring your own prescription or have your eyes examined at a participating provider and receive $5 off the exam fee for glasses or $10 off the exam fee for contacts, at the time of service. You may have your prescription filled at a participating provider or anywhere you wish, but keep in mind that discounts listed below are only available at participating providers.

The discount program includes the following savings:

Summary of Discounts

Vision Care Services	**TIer Cost**
Exam with Dilation as Necessary:	$5 off routine exam $10 off contact lens exam
Complete Pair of Glasses Purchase*: frame, lenses and lens options must be purchased in the same transaction to receive full discount.	
Standard Plastic Lenses:	
Single Vision	$50
Bifocal	$70
Trifocal	$105
Frames:	
Any frame available at provider location	40% off retail price
Lens Options:	
Ultraviolet (UV) Coating	$15
Tint (Solid and Gradient)	$15
Standard Scratch-Resistance	$15
Standard Polycarbonate	$40
Standard Progressive (Add-on to Bifocal)	$65
Standard Anti-Reflective Coating	$45
Other Add-Ons and Services	20% discount
Contact Lens Materials (Discount applied to materials only)	
Disposable	0% off retail price
Conventional	15% off retail price
Laser Vision Correction:**	
Lasik or PRK	15% off retail price - or - 5% off promotional price
Frequency:	
Examination	Unlimited
Frame	Unlimited
Lenses	Unlimited
Contact Lenses	Unlimited

***** Items purchased separately will be discounted 20% off of the retail price.

**Since Lasik or PRK vision correction is an elective procedure performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a participating provider near you and the discount authorization, please call l-877-5LASER6.

You will receive a 20% discount on items purchased at participating providers that are not specifically covered by this Discount Program. The 20% discount may not be combined with any other discounts or promotional offers, and the discount does not apply to EyeMed provider's professional services, or contact lenses. Retail prices may vary by location.

Prices are subject to change without notice.

Limitations/ Exclusions:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing
- Medical and/or surgical treatment of the eye, eyes, or supporting structures
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under this Discount Program
- Services provided as a result of any Workers' Compensation law
- Discount is not available on those frames where the manufacturer prohibits a discount

Pricing

Prices are subject to change.

Example of Program Savings

	REGULAR RETAIL	**DISCOUNTED COST**
Frame	$100	$ 60
Single vision lenses	$ 56	$ 50
Lens options		
• Ultraviolet (UV) coating	$ 20	$ 15
• Scratch resistant coating	$ 20	$ 15
Total	$196	$140 **You Save $56**

Choice Dollars and Opt-Out Credits

(Note: This does not apply to COBRA participants) Offered through the Texas Instruments Incorporated Flexible Benefits Plan

During annual enrollment, you receive "Choice Dollars" as an addition to your taxable pay. Dollars may be used to:

- Buy increased health or income protection coverage
- Offset the cost of plan prices
- Deposit in Health Care or Dependent Daycare Spending Accounts

Any portion of your Choice Dollars not used to offset any of the above will be considered taxable pay.

Choice Dollars are spread out equally throughout the year, depending on your pay frequency. Choice Dollars are prorated for newly eligible or newly hired employees based on the number of full paychecks from the date of eligibility or hire until the end of that year. Note: If you were hired or became newly eligible after January 1 you will not be eligible to receive the full Choice Dollars amount until the following year.

If you are a full-time TIer, you will receive $250 Choice Dollars in addition to your taxable pay.

If you are on an alternative work schedule (minimum 20-hours-a-week schedule), you will receive reduced Choice Dollars based on the number of hours you work:

Scheduled hours per week	**Choice Dollars**
20 — 29.9 hours	$125.06
30 — 39.9 hours	$187.72

Opt-Out Credits

You may receive Opt-Out Credits for declining medical coverage. The amount of dollars you receive depends on your work schedule. The Wellness Assessment credit is not considered part of the Opt-Out Credits you receive when declining coverage.

If You Decline:	**You will receive the following Opt-Out Credits per year:**		
	Full-Time	**30 - 39.9 hrs per wk**	**20 - 29.9 hrs per wk**
Medical	$500	$500	$500

Opt-Out Credits are taxable pay and are spread out equally throughout the year, depending on your pay frequency. Opt-Out Credits are prorated for newly eligible or newly hired employees based on the number of full paychecks from the date of eligibility or hire until the end of that year. Note: If you were hired or became newly eligible after January 1 you will not be eligible to receive the full Opt-Out Credits amount until the following year.

What to Consider Before Declining Medical or Dental Coverage

If your TI employment ends or you become ineligible for TI benefits, COBRA coverage will only be available for those benefits you were covered under prior to becoming COBRA eligible. Thus, if you were covered under the medical plan and/or dental plan during employment, you may elect the same coverage under COBRA. If you decline any portion of the benefits coverage offered during employment, you are not

entitled to elect such coverage when you become initially eligible for COBRA. However, during annual enrollment following your initial COBRA election, you may elect COBRA coverage previously unavailable provided you did not decline COBRA coverage in its entirety during your initial election period. (COBRA stands for the Consolidated Omnibus Budget Reconciliation Act.)

Qualified Status Change

If you decline TI medical and/or dental coverage for the year, but have a qualified status change that causes you to lose any other non-TI coverage you elected for the year, you may enroll in TI medical and/or dental coverage within 30 days of the qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance program). Please see the Introduction section for information about qualified status changes. Within 30 days of a qualified status change (or within 60 days for your or your dependent's change in eligibility for Medicaid or a State child health insurance program), you may make appropriate changes to coverage by processing the Life Event change on the Fidelity NetBenefits® Web site (click on the "What To Do When Life Events…" link on the "Health & Insurance" tab) or by contacting the TI Benefits Center. You should print your "Confirmation of Benefit Election" page for your records, as this will serve as your confirmation.

Choice Dollars and Opt-Out Credits While on Unpaid Leave of Absence

While you're on an unpaid leave of absence, the value of your Choice Dollars and Opt-Out Credits will be applied to the cost of the coverage you choose to continue, in this order:

- Medical
- Dental
- Vision
- Disability pay continuance
- Long-term disability
- Employee life insurance
- Spouse life insurance
- Child life insurance
- Accidental death and dismemberment insurance

During your leave, if your Choice Dollars and Opt-Out Credits cover or exceed the cost of your benefits, you won't receive a bill.

You won't receive excess cash if the value exceeds the cost of your benefits. Excess credits can't be applied toward your Health Care Spending Account or Dependent Daycare Spending Account.

If your cost for coverage during your leave is **more** than your available Choice Dollars and Opt-Out Credits, you will be billed directly for the remaining cost. You will receive a bill by mail from the TI Benefits Center around the 15th of each month for your coverage for the next month. Payment for the month is due on the 1st of each month. If you do not pay your bill, your coverage will be dropped.

The billing you receive will only show the costs for benefits that you owe, not for benefits covered by your Choice Dollars and Opt-Out Credits. If a benefit is fully covered by the credits, it will not appear on the bill.

If you have questions about your bill, contact the TI Benefits Center.

Continuation of Medical, Dental, Vision and/or Health Care Spending Account Benefits (COBRA Benefits)

COBRA Continuation Coverage

TI, in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, allows you, your spouse and your eligible dependent children to elect to continue medical, dental, and/or vision benefits offered under the TI Employees Health Benefit Plan, and/or health care spending account benefits offered under the Texas Instruments Incorporated Flexible Benefits Plan beyond the date coverage is otherwise scheduled to end because of the occurrence of certain events known as “qualifying events.” Specific qualifying events are described later in this notice. When a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a "qualified individual." You, your spouse, and your dependent children could become qualified individuals if coverage under one of the plans described above is lost because of the qualifying event. However, same-gender domestic partners and their dependent(s) cannot become qualified individuals eligible to receive continuation benefits. Qualified individuals who elect COBRA continuation coverage must pay for COBRA continuation coverage.

Qualified individuals may elect to continue one or more of medical, dental, vision and/or health care spending account benefits in any combination; however, if medical coverage is elected, the EAP benefit is automatically included at no additional cost. Each qualified individual will have an independent right to elect COBRA continuation coverage. Additionally, covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their dependent children.

People electing to receive COBRA benefits have all the rights of employees and dependent(s) covered under the medical, dental, vision and/or health care spending account benefits, including the right to add newborn children, children placed for adoption, and other dependent(s) within 60 days following the appropriate qualified status change. Dependent(s) not covered when COBRA benefits began may also be added during annual enrollment.

Qualifying Events

If you are an employee, you will become a qualified individual if you lose your coverage because either one of the following qualifying events happens:

- Your hours of employment are reduced, resulting in a loss of medical, dental, vision and/or health care spending account benefits; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified individual if you lose your coverage because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced, resulting in the loss of medical, dental, vision and/or health care spending account benefits;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified individuals if they lose coverage under the plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced, resulting in the loss of medical, dental, vision and/or health spending account benefits;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Texas Instruments Incorporated, and that bankruptcy results in the loss of coverage of any retired employee covered under the TI Employees Health Benefit Plan, the retired employee will become a qualified individual with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified individuals if bankruptcy results in the loss of their coverage.

Finally, an individual who receives a certification indicating that they qualify for benefits under the Trade Adjustment Act (“TAA”) within six months of his/her employment termination may be provided with a second opportunity to elect COBRA continuation coverage, provided that they notify the TI Benefits Center, at the address specified below, of their TAA certification within the same six-month period. A copy of your TAA certification is required for enrollment.

Notice Requirements for COBRA Continuation Coverage

COBRA continuation coverage will be available to qualified individuals only after the TI Benefits Center has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), TI will make sure that the TI Benefits Center is notified of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (such as the divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage, as a dependent child), you must notify the TI Benefits Center within 60 days after the qualifying event occurs. You can provide notice by logging onto Fidelity NetBenefits®, by calling the TI Benefits Center through TI HR Connect at 888-660-1411 or you can provide this notice by mail to:

TI Benefits Center
PO Box 770003
Cincinnati, OH 45277

You must also notify the TI Benefits Center of any change in your address.

Electing COBRA Coverage

Once the TI Benefits Center has been notified of the occurrence of a qualifying event, you will be provided with instructions on how to elect COBRA continuation coverage. You must elect COBRA continuation coverage by the date specified in the enrollment notice. If you decline COBRA continuation

coverage, you may obtain coverage if you then decide to elect COBRA continuation coverage provided such election is made before the date specified in the enrollment notice. However, in no event can you elect COBRA continuation coverage after the date specified in the enrollment notice.

Special One-Time COBRA Election and Subsidy

If you were involuntarily terminated on or after September 1, 2008, and before February 17, 2009, and did not elect COBRA or had COBRA continuation coverage in effect on February 17, 2009, you had a one-time opportunity to elect COBRA continuation coverage a second time, within 60 days after receiving appropriate notice from TI.

You may be entitled to a subsidy if you were involuntarily terminated between September 1, 2008, and December 31, 2009 (or such later deadline if the duration is extended by legislation). The subsidy of your COBRA continuation coverage, if you are eligible, will continue for the lesser of: (i) 9 months, (ii) until the date the COBRA continuation coverage would have expired had you elected COBRA continuation coverage at the time of your original COBRA election period, or (iii) until the occurrence of an event specified in the Early Termination of COBRA Continuation Coverage section below.

Maximum Periods of Coverage

The maximum length of COBRA continuation coverage available for loss of medical, dental, and/or vision benefits will vary depending on which qualifying event occurs. COBRA continuation coverage for loss of medical, dental and/or vision benefits is available for up to 18, 29 or 36 months as outlined below. COBRA continuation coverage under the health care spending account continues through the end of the current plan year only.

Note: COBRA benefits are not available for same-gender domestic partners and their dependent(s).

18-Month COBRA Continuation Coverage Period

If coverage for you or your covered dependent(s) ends because your employment ends (other than your involuntary termination for gross misconduct) or because your hours of employment are reduced, then you and your covered dependent(s) may elect to extend medical, dental and/or vision benefits until the earliest of:

- 18 months from the date your COBRA benefits began;
- The last day for which you have paid the required premium;
- The date of cancellation of the plan if the plan is canceled for all employees; or
- The date after you elect COBRA continuation coverage on which you or your covered dependent(s) first become covered under another group health plan that does not include any limitation or exclusion on a pre-existing condition that applies to you or your covered dependent(s), or you or your covered dependent(s) become entitled to Medicare.

Potential Extensions of COBRA Continuation Coverage Period

There are two circumstances when the 18-month COBRA continuation period for medical, dental, and/or vision may be extended for a qualified individual.

Disability Extension

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled within 60 days of the time of your termination of employment or reduction in hours, and you

provide the TI Benefits Center with a copy of the Social Security Administration's letter providing evidence of the disability determination before your initial 18 months of COBRA continuation coverage expires, you and your eligible dependent(s) may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. If you receive a disability extension and the Social Security Administration determines that you or your dependent (whomever triggered the 11-month extension) is no longer disabled, the TI Benefits Center must be notified within 30 days of such determination.

If you receive a disability extension for your COBRA continuation coverage, COBRA continuation coverage for medical, dental and/or vision benefits will continue until the earliest of:

- 29 months from the date COBRA benefits began;
- The last day for which the required premium was paid;
- The date of cancellation of the plan if the plan is canceled for all employees;
- The date you or your covered dependent(s) first become covered under another group health plan that does not include any limitation or exclusion on a pre-existing condition that applies to you or your covered dependent(s), or you or your covered dependent(s) become entitled to Medicare; or
- The first day of the month that begins more than 30 days after the date Social Security makes a final determination that you or your covered dependent (whomever triggered the 11-month extension) is no longer disabled.

Second Qualifying Event Extension

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the TI Benefits Center. This extension may be available to your spouse and any dependent children receiving COBRA continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or get divorced or legally separated, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the plan had the first qualifying event not occurred.

If you receive extension for your COBRA continuation coverage because of the occurrence of a second qualifying event, COBRA continuation coverage for medical, dental and/or vision benefits will continue until the earliest of:

- 36 months from the date COBRA benefits began;
- The last day for which the required premium was paid;
- The date of cancellation of the plan if the plan is canceled for all employees; or
- The date you or your covered dependent(s) first become covered under another group health plan that does not include any limitation or exclusion on a pre-existing condition that applies to you or your covered dependent(s), or you or your covered dependent(s) become entitled to Medicare.

36-Month COBRA Continuation Coverage Period

Upon the occurrence of one of the following qualifying events, COBRA continuation coverage for medical, dental, and/or vision benefits will be available to your spouse and your eligible children**:**

- Loss of coverage for your eligible dependent(s) under the medical, dental and/or vision plans because of your death, or your divorce or legal separation from your lawful spouse;

- A dependent child ceasing to be a dependent child under the terms of the plan; and
- Loss of coverage under the plan because of your entitlement to Medicare. But, if you also experience a termination of employment or reduction in hours within 18 months following your entitlement to Medicare, your dependent(s) will be entitled to coverage until the later of (i) 18 months from your termination or reduction in hours (or 29 months of coverage if there is a disability extension) or (ii) 36 months from the date you become entitled to Medicare.

In these circumstances, your eligible dependent(s) may elect to continue coverage until the earliest of:

- 36 months from the date COBRA benefits began, except in certain circumstances involving your termination or reduction in hours within 18 months following your entitlement to Medicare;
- The last day for which the required premium was paid;
- The date of cancellation of the plan if the plan is canceled for all employees; or
- The date after you elect COBRA continuation coverage on which your covered dependent(s) first become covered under another group health plan that does not include any limitation or exclusion on a pre-existing condition that applies to your covered dependent(s), or you or your dependent(s) become entitled to Medicare (for additional information, see the Important Note in Premiums section).

Early Termination of COBRA Continuation Coverage

COBRA continuation coverage may be terminated before the maximum period described above for any of the following reasons:

- Texas Instruments no longer provides group health coverage to any of its employees;
- The premium for continuation coverage is not paid in a timely manner;
- The employee, spouse or dependent(s) first becomes covered after electing COBRA continuation coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition;
- The employee or spouse first becomes entitled to Medicare;
- The employee, spouse or dependent(s) received extended continuation coverage up to 29 months due to a Social Security disability and a final determination has been made that he or she is no longer disabled; or
- The employee, spouse or dependent(s) notifies the TI Benefits Center that they wish to cancel continuation coverage.

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

Premiums

An employee, spouse or dependent(s) does not have to show they are insurable in order to choose continuation coverage. But an employee, spouse or dependent(s) must have been actually covered under the medical, dental, and/or vision benefits offered under the TI Employees Health Benefit Plan, and/or health care spending account benefits offered under the Texas Instruments Incorporated Flexible Benefits Plan the day before the qualifying event in order to qualify for COBRA coverage.

An employee, spouse or dependent(s) may have to pay all of the applicable premiums, which generally cannot exceed 102% of the plan costs for a 12-month period. An exception exists for coverage of employees with disabilities during the extension from the 19th month to the 29th month. During that time, 150% of the plan costs may be charged. Because the cost of COBRA continuation coverage is based on

the amount of the applicable premium, the cost for COBRA continuation coverage will increase if the cost of premiums for medical, dental, and/or vision benefits offered under the TI Employees Health Benefit Plan increase.

You must make your first premium payment for COBRA continuation coverage not later than 45 days after the date of your election.

After you make your first payment for COBRA continuance coverage, you will be required to make periodic premium payments. There is a 30-day grace period following the date regularly scheduled monthly premiums are due.

Important Note: Coverage can be terminated before the 18-, 29- or 36-month period if you or your eligible dependent(s) are covered under another group health plan with no pre-existing condition limitation that applies to you or your eligible dependents (other than a pre-existing condition limitation which is satisfied by the employee or dependent by reason of the group health plan portability and access requirements of the Health Insurance Portability and Accountability Act of 1996). You must notify the Plan Administrator within 30-days of your loss of coverage in order to prevent being charged a monthly premium after loss of eligibility. You may not receive a refund for any premium paid for coverage after you lose eligibility if you fail to notify the Plan Administrator within this 30-day period.

Coverage for Eligible Employees in California Enrolled in an HMO

There are two types of coverage extensions available to persons living in California who are enrolled in a California HMO, one is for certain seniors and the other applies to individuals who are otherwise on federal COBRA continuation coverage after July 1, 2003.

Please examine your options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

California Senior COBRA (only applies to participants who qualified on or before January 1, 2005)

If you are a California TI employee and you are enrolled in an HMO in California and meet the following eligibility criteria, you may be eligible for an extension under the California Senior COBRA extension plan for up to five years or until you become entitled to Medicare. To be eligible you must:

- Reside in California;
- Terminate employment with five or more years of service prior to January 1, 2005;
- Be between the ages of 60 and 65 on the date employment ended;
- Be entitled to and elected COBRA under a TI-sponsored California HMO; and
- Be enrolled in a TI-sponsored California HMO at the end of the COBRA period.

Your spouse is also eligible if he or she also elected COBRA. A former spouse covered by COBRA is also eligible for this coverage.

Extensions for Eligible Employees in California

The California Senior COBRA extension allowed eligible seniors to extend continuation coverage with a California HMO from the end of the COBRA period until the earliest of the:

- End of the period for which you have paid premiums;
- Date you attain age 65;
- Date you begin coverage under a health plan not sponsored by TI;
- Date you become entitled to Medicare;
- Date TI terminates the plan or terminates the California HMO as a benefit option under the plan;
- (For your spouse) five years after the date on which his or her COBRA coverage was scheduled to end;
- The date on which you commit fraud or deception in the use of the HMOs services; or
- The date on which you move outside of the California HMO's service area.

The premium for the California Senior COBRA extension period is set by the Plan Administrator each year. For additional information, call the TI Benefits Center through TI HR Connect at 888-660-1411.

California's COBRA Extension for Persons in Insured Plans or HMOs in California

If you are a California TI employee and you are enrolled in an HMO in California and meet the following eligibility criteria, you may be eligible for an extension under the California COBRA extension plan for up to thirty-six months of total COBRA coverage including the COBRA coverage period available under the federal COBRA law. In order to be eligible you must:

- Reside in California;
- Be entitled to and elected COBRA; and
- Be enrolled in a TI-sponsored California HMO at the end of the COBRA period.

Your spouse is also eligible if he or she also elected COBRA. A former spouse covered by COBRA is also eligible for this coverage.

Extensions for Eligible Employees in California

The California COBRA extension allows you extended continuation coverage with a California HMO from the end of the COBRA period until the earliest of the:

- End of the period for which you have paid premiums;
- Date you begin coverage under a health plan not sponsored by TI;
- Date you become entitled to Medicare; or
- The date that is 36 months after your federal COBRA continuation coverage began.

Termination of coverage will occur earlier if TI terminates the plan or the California HMO as a health benefit option available to employees, if you move out of the HMO's service area, or if you commit fraud or deception in the use of the HMO's services. The premium for the California COBRA extension period is set by the Plan Administrator each year. For additional information, call the TI Benefits Center through TI HR Connect at 888-660-1411.

If, while you are on COBRA coverage, you change from coverage under the California HMO benefit option to the self-insured PPO benefit option, you will lose all rights to the California COBRA extension and will only be entitled to the federal COBRA continuation coverage period explained above. You must be covered by a California HMO and be living in California at the time your federal COBRA continuation coverage expires in order to be eligible for the California COBRA extension.

You should review your certificate of coverage from your California HMO regarding the availability of any conversion coverage after the expiration of California COBRA.

Conversion Information for the Blue Cross Blue Shield PPO

Conversion to an Individual Policy

Individuals whose Blue Cross Blue Shield PPO COBRA coverage has terminated can apply to convert to an individual medical policy subject to medical underwriting and an application fee charge. If you or your dependent(s) wish to convert, contact Blue Cross Blue Shield, Individual Department at 800-531-4456 within 31 days after COBRA coverage terminates.

Plan Contact Information

If you need additional information, access the Plan's "Detail" link on the Fidelity NetBenefits® Web site at netbenefits.fidelity.com or call the TI Benefits Center through TI HR Connect at 888-660-1411. When calling the TI Benefits Center please be prepared to provide your Social Security number and Fidelity password. TI Benefits Center Representatives are available between 8:30 a.m. and 8:30 p.m., Eastern time, Monday through Friday (excluding New York Stock Exchange holidays). The Web site is available virtually 7 days per week, 24 hours per day, except for scheduled maintenance windows.

If You Have Questions

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep the TI Benefits Center Informed of Address Changes

In order to protect your family's rights, you should keep the TI Benefits Center informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the TI Benefits Center.

Income Protection

Time Off Benefits

(Note: This does not apply to COBRA participants)

A Quick Look

Key features of Time Off benefits are:

- Time Bank that provides all TIers with a set number of hours each year which can be used for leisure, vacation, personal time, short-term non-occupational (in some instances occupational) illness or injury, and funeral or bereavement time off
- Nine paid holidays (only active employees)
- Time off for jury duty
- Military leave

Eligibility for Time Off Benefits

You are eligible to participate in the Time Off benefits if you are a full-time TIer or a part-time TIer on an alternative work schedule (minimum 20-hours-a-week schedule). If you are in a co-op program (minimum 20-hours-a-week schedule), you are eligible. You are not eligible for coverage if:

- You (regardless of how you are characterized for wage withholding purposes or any other purpose by the IRS, or any other agency, court, authority, individual or entity) are an employee who is classified by TI, acting in its sole absolute discretion, as a TIer on an alternative work schedule for less than 20 hours a week
- You are an employee who is a leased employee as defined by federal tax law
- Your compensation is reported to the IRS on a form other than a Form W-2, regardless of whether you are treated as an employee for federal income tax purposes
- You have agreed in writing that you are not an employee or are not otherwise eligible to participate

You are eligible for paid holidays if you are an active TI employee.

Time Bank

Accrual Rate

Your Time Bank accrual rate is based on the number of full years of service that you have completed before the first day of each month. Your Time Bank account will be credited with Time Bank hours for each month on the first day of that month.

Time Bank Accrual During Leave of Absence

If you are on a leave of absence (LOA) due to workers' compensation, medical, maternity, military or the Family and Medical Leave Act (FMLA), you will continue to earn monthly Time Bank accruals at the same rate you had before going on leave for up to 6 months.

Time Bank Accrual for Alternative Work Schedule

If you are on an alternative work schedule of 20 to 29.9 hours a week, you will earn Time Bank hours at a rate of 50 percent of the regular accrual rate.

If you are on an alternative work schedule of 30 to 39.9 hours a week, you will earn Time Bank hours at a rate of 75 percent of the regular accrual rate.

Time Bank Accrual for New Hires

If you are a new TIer, you will begin earning Time Bank on the first day of the month following the month in which you are hired.

Time Bank Accrual Chart

Full Years Of Service	Hours Accrued Per Month	Approximate Days Accrued Per Year	Carry-Forward Limit — Hours
0	10.0	15.0	180.0
1	10.7	16.0	192.6
2	11.0	16.5	198.0
3	11.4	17.0	205.2
4	11.7	17.5	210.6
5	13.8	20.5	248.4
6	14.1	21.0	253.8
7	14.4	21.5	259.2
8	14.8	22.0	266.4
9	15.1	22.5	271.8
10	15.4	23.0	277.2
11	15.8	23.5	284.4
12	16.1	24.0	289.8
13	16.4	24.5	295.2
14	16.8	25.0	302.4
15	17.1	25.5	307.8
16	17.4	26.0	313.2
17	17.8	26.5	320.4
18	18.1	27.0	325.8
19	18.4	27.5	331.2
20+	18.8	28.0	338.4

Time Bank Usage

Nonexempt TIers may use Time Bank hours in increments of tenths of an hour. The time need not be deducted if the TIer works the additional time over the same scheduled workweek (when business conditions permit).

Exempt TIers should use Time Bank hours only when they are away from work at least one-half of a scheduled workday. The time away from work need not be deducted from the Time Bank if the TIer works a period of time equal to the number of hours normally scheduled in that TIer's pay period (when business conditions permit).

Illness or Injury

The first 40 consecutive hours (or three complete consecutive scheduled shifts for those on compressed shift work schedules or the equivalent of a full consecutive work week for those on an alternative work schedule) of scheduled work time missed due to any non-occupational illness or injury will be taken from the Time Bank.

Family and Medical Leave Act (FMLA) Usage

TIers **must** use Time Bank hours for approved Family and Medical Leave Act (FMLA) absences for the TIer's own serious health condition if the absences are not covered under the Disability Benefit Plan, Workers' Compensation, or other paid leave benefits. TIers **may** elect to use Time Bank hours for approved FMLA absences for reasons other than the TIer's own serious health condition. Once the employee's Time Bank balance is zero, the TIer will not be paid for their time off.

Funeral or Bereavement Time Off

Time Bank allows TIers to make personal decisions about taking time off for funerals. TIers may determine how much time off they need following the death of a significant person in their lives.

Holidays

TIers who are scheduled to work on holidays may use Time Bank hours for a planned or unplanned absence, when business conditions permit.

Carry-Forward Limit

There is a carry-forward limit on the Time Bank account. This carry-forward limit is the number of Time Bank hours you will be allowed to carry forward from one year to another.

The carry-forward limit is 18 times the December 1 accrual rate (about 150 percent of your annual accrual days). It is applied once a year, on Dec. 31.

Cash-Out

Any earned Time Bank hours that are more than your carry-forward limit will be cashed out annually at 75 percent (may vary based on state mandates) of your regular rate of pay as of Dec. 31. Payment will be included in your first full pay period's paycheck in January.

Cash-out dollars are not considered eligible earnings for the TI 401(k) plan, pension plan, deferred compensation plan or any other benefits that are based on your rate of pay.

If You Terminate Employment with TI

For any termination from TI, you will receive a 100 percent cash-out of your Time Bank balance in your final paycheck based on your base pay on your last day worked.

Absence Notification Periods

Absence notification periods are business-unit specific (See the Family and Medical Leave Act section below for FMLA notification requirements.). In general, you should provide as much advance notice as possible to allow your supervisor to plan for your absence, except for unplanned events such as funerals, illnesses or injuries.

Time Bank Management

All TIers are expected to manage their Time Bank at or above a zero balance.

Negative Balance

In certain circumstances you may be allowed up to 24 hours of negative Time Bank for approved unplanned absences. Any negative balance will be carried to the following month and offset by the monthly accruals. If the 24 hours are used and more time away from work is needed, then you will need to work with your HR manager to determine what unpaid options are available.

A negative balance could be a performance issue. TIers will not be allowed to go below a zero balance in their Time Bank for planned events.

Holidays

TI provides specified paid holidays to all employed TIers on active status. These holidays are:

New Year's Day
Spring Holiday/Good Friday
Memorial Day
Independence Day
Labor Day
Thanksgiving Day
Friday after Thanksgiving
Winter Holiday/Christmas Day
Floating Holiday
(usually observed at Christmas)

When a holiday falls on Saturday or Sunday, it is observed on the preceding Friday or the following Monday. This observance will be announced in advance. When a holiday falls within your time off period and you were scheduled to work that day, you will reduce your Time Bank for only non-holiday days taken for time off.

Jury Duty and Legal Proceedings

TIers required to be absent from work in order to serve on a jury or as a subpoenaed witness will be given an excused absence until released from such service.

You will receive your hourly pay for any of your regularly-scheduled hours that you spend on jury duty or when you are subpoenaed as a witness. To qualify for Jury Duty allowance, you must present the summons or subpoena to your supervisor prior to reporting for your scheduled duty.

Your TI pay is in addition to any pay you may receive from the court.

The payment for jury duty and time spent as a witness pursuant to a subpoena does not reduce your Time Bank hours.

You will not receive pay if you are a principal (a plaintiff or defendant) in a legal proceeding. You must use your Time Bank hours to be paid for this type of service.

Military Leave

Full-Time, Active Service

TIers who leave to satisfy a full-time, active military obligation will be placed on military leave.

Temporary Service

TIers who are temporarily absent to participate in annual military reserve or National Guard training for 16 calendar days or less will be given an excused absence.

Special Pay

TIers on annual military reserve or National Guard training are entitled to special TI pay (covering up to 16 calendar days annually). The sum of their special pay and their military reserve or National Guard training pay will equal their TI base rate of pay.

The military reserve or National Guard gross base pay for the period will be used to calculate the special TI pay. Allowances for room and board and food are excluded. For an exempt TIer, base pay is defined as monthly salary. For a nonexempt TIer, base pay is defined as hourly rate times scheduled hours per week.

Exempt TIers on military training will be taken off the active payroll effective the first workday missed. Nonexempt TIers should enter the unpaid absence code “MIL” in the time system for the days missed.

All TIers returning to work upon completion of military training must provide their supervisors with pay documents regarding the pay they received for the training period. Supervisors will arrange for the special TI pay. Special TI military pay will not exceed 16 calendar days per year.

Other Leaves of Absence (LOA)

Leave of absence may also be granted for:

- Formal education to improve one's opportunities at TI
- At the request of TI, special assignment to another company which will compensate the individual
- Extended campaigning for election or appointment to a paid public office
- Essential personal reasons that require absence from work
- A "bridge to retirement" at the end of an individual's period of active employment
- Special conditions similar to the above or which are of mutual advantage to the TIer and TI

Benefits During a Leave of Absence

An approved leave of absence is considered continuous employment with respect to eligibility for most of your TI benefits. See the eligibility section of each plan for more information.

Your medical, dental, vision and life insurance (Life and AD&D) benefits remain in effect during your leave of absence period, and you will be billed for coverage prices on an after-tax basis.

If you have a child who is a dependent student who takes a medically necessary leave of absence from school, your child may continue coverage for up to 12 months, or, if earlier, until such coverage would otherwise terminate under the terms of the health insurance coverage. You must provide TI with a doctor’s certificate of the need for such leave to qualify for the continuation of coverage. A “medically necessary leave of absence” is a leave of absence from a post secondary educational institution or any change in enrollment at such institution that commences while your child is suffering from a serious illness or injury, is medically necessary and causes your child to lose dependent status for purposes of health insurance coverage.

In the case of military leave, medical, dental and vision coverage may be continued (as long as you pay the associated premiums) for you or your dependents. Life insurance coverage may be continued for you and your dependents while on military leave. TIers on military leave are not eligible for DPC or LTD coverage. AD&D coverage for TIers on military leave is discontinued, based on the exclusion of benefits

during military service. However, TIers on military leave may continue AD&D coverage on spouses and children at group rates following the military leave of absence start date.

If you are enrolled in the Disability Benefit Plan, your current Disability income coverage will be continued during a medical or Workers' Compensation leave of absence or a leave of absence authorized under the Family and Medical Leave Act (FMLA). To apply for leave under FMLA, call Time Loss Management Services (TLMS) through TI HR Connect at 888-660-1411.

If you are on an unpaid LOA other than FMLA, all disability coverages and price deductions stop. Also, while on an unpaid LOA or while receiving Long-Term Disability benefits from the Disability Benefit Plan, your Dependent Daycare Spending Account coverage will be stopped and you will not be billed for such coverage. You will receive a billing statement for your medical, dental, vision, life and AD&D coverage. The bill must be paid each month or all coverages are subject to cancellation effective your last paid through date.

If you return to work and have an outstanding amount due, this must be paid in addition to the current deduction for coverage on your paycheck.

Family and Medical Leave Act (FMLA)

(Note: This does not apply to COBRA participants)

To be eligible for leave under the Family and Medical Leave Act (FMLA), TIers must have a minimum of one year of service and have worked 1,250 hours in the past 12 months, and must work at a location where at least 50 employees are employed within 75 miles of the location.* TI must approve and certify all FMLA leaves. TIers must consult with a TI Occupational Health Nurse Consultant (OHNC) in order to determine if an absence qualifies under FMLA. To find the contact information for TI OHNCs, visit my.ti.com. Under Health & Wellness, select Occupational Health & Time Loss Management Web Site, then Find Your Occupational Health Nurse Consultant. To apply for FMLA leave, call Time Loss Management Services (TLMS) through TI HR Connect at 888-660-1411.

* For TIers who do not meet the geographical requirement that they work at a location where at least 50 employees are employed within 75 miles, TI will still consider a request for FMLA leave and will grant an equivalent leave when possible. However, if TI determines that its business needs would preclude such a leave, the request may be denied within TI's sole discretion.

The following requirements apply to FMLA leaves of absence:

- Eligible TIers are entitled to up to 12 weeks of unpaid FMLA leave during a 12-month period for the following reasons: for a TIer's own serious health condition, or to care for a parent, spouse or child with a serious health condition, or in the event of a birth (including through a surrogate), adoption or placement of a child in foster care, or because of certain "qualifying exigencies" arising out of the fact that the TIer's spouse, child, or parent is a covered military member on active duty (or called to active duty) in the National Guard or Reserves in support of a contingency operation. The 12-month period is calculated as a rolling 12-month period measured backward from the date of any FMLA leave usage.
- An eligible TIer who is the spouse, child, parent, or next of kin of a covered servicemember who is undergoing treatment for a serious illness or injury sustained during active duty in the Armed Forces is entitled to up to 26 weeks of unpaid FMLA leave in a single 12-month period to care for the servicemember ("military caregiver leave"). This single 12-month period will commence on the date the TIer first begins leave to care for the covered servicemember.
- Each period of approved FMLA leave will reduce the TIer's 12- or 26-week FMLA leave entitlement in the applicable 12-month period. Additionally, the maximum amount of leave that may be taken in the single 12-month period for military caregiver leave is 26 weeks, even if some of the leave taken during the single 12-month period is for an FMLA-qualifying reason other than military caregiver leave.
- If a TIer's need for FMLA leave is foreseeable, the TIer must provide notice to the supervisor and make a request for leave through TLMS at least 30 days in advance of the date the TIer intends to begin the leave. If the TIer is unable to foresee the need for leave 30 days in advance, the notice/request must be made to the supervisor and TLMS as soon as practicable.
- When making a request for leave, a TIer must provide sufficient information for the OHNC to determine whether the leave qualifies for FMLA and the anticipated timing and duration of the leave. Failure to timely provide requested certifications that support the need for FMLA leave may result in denial of leave.
- If leave is requested for planned medical treatment, the TIer must consult with his or her supervisor and make a reasonable effort to work out a treatment schedule that best suits the needs of TI and the TIer and does not unduly disrupt TI's operations.
- TIers returning to work after approved FMLA leave will be placed in the same or an equivalent position with the same pay, benefits and terms and conditions of employment. (If the leave extends beyond the end of a TIer's FMLA entitlement, there are no return rights under FMLA.)
- Leave for the birth of a child must be completed within 12 months of the birth of the child. Leave for adoption or foster placement of a child into an employee's immediate family must be taken within 12 months of the date of placement or adoption of the child, unless the employee needs to be absent from work to proceed with adoption or foster care arrangements. Intermittent FMLA leave is not allowed for the birth, adoption or foster placement of a child.

- If both spouses are TIers, their combined FMLA leave may be limited to the amount normally available to one employee (12 weeks in a rolling 12-month period, or 26 weeks in a single 12-month period for military caregiver leave) for any leave taken for the birth, adoption or foster care placement of a child, care of a TIer's parent with a serious health condition, or care of a covered servicemember with a serious injury or illness.
- Health benefits while on FMLA leave:
    - TIers' health benefits will be maintained by TI during any period of FMLA leave under the same conditions as when the TIer continued to work.
    - TIers must keep payments for health benefits current while on FMLA leave.
    - A TIer who is receiving pay from TI while on FMLA leave (e.g., Time Bank or DPC) will have the cost of health benefits deducted from the TIer's paycheck. If the TIer is not receiving pay from TI while on FMLA leave, the TIer will be billed on a monthly basis. There is a minimum 30-day grace period in which to make premium payments. If payment is not made timely, group health insurance may be cancelled (TI will provide written notice at least 15 days before the date that health coverage will lapse), or, at TI's option, TI may pay the TIer's share of the premiums during FMLA leave, and recover these payments upon the TIer's return to work.
    - If health plan coverage for a TIer and/or his/her dependents is canceled for non-payment before termination of employment, the TIer and/or dependents will not be eligible for COBRA continuation coverage.
    - If a TIer does not return to work following FMLA leave for a reason other than: (i) the continuation, recurrence, or onset of a serious health condition which would entitle the TIer to FMLA leave; (ii) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle the TIer to FMLA leave; or (iii) other circumstances beyond the TIer's control, the TIer may be required to reimburse TI for TI's share of health insurance premiums paid on the TIer behalf during FMLA leave.
- Concurrent Leave/Substitution of Paid Leave
    - TIers who are approved for a Disability Pay Continuation (DPC), Workers' Compensation, Paternity/Adoption paid leave of absence, or a leave of absence under applicable state law, will have their leave concurrently designated FMLA leave and counted against the TIer's FMLA leave entitlement.
    - If a TIer's FMLA leave is for the TIer's own serious health condition, the TIer is required to use available Time Bank for any time the TIer is not receiving DPC, Workers' Compensation, or other paid leave benefits.
    - If a TIer's FMLA leave is for a reason other then the TIer's own serious health condition, the TIer may choose to use Time Bank but is not required to do so.
    - If a TIer chooses not to use Time Bank (for an FMLA leave taken for a reason other than the TIer's own serious health condition), or if Time Bank has already been exhausted, a TIer may take any remaining leave as unpaid time off.

The policies and guidelines stated herein shall be subject to the provisions of the Family Medical Leave Act of 1993 and applicable state leave laws.

Paid Family Leave for California Employees Only

(Note: This does not apply to COBRA participants)

If you are a TI employee in California, you are eligible for Paid Family Leave (PFL) benefits.

PFL benefits may be claimed for the following reasons: to care for a seriously ill child, spouse, parent, or state-registered domestic partner; to bond with the employee's new child or the new child of the employee's spouse or state-registered domestic partner; or to bond with a child in connection with the adoption or foster care placement of the child with the employee or the employee's spouse or state-registered domestic partner.

PFL benefits are for a maximum of 6 weeks within a 12-month period. The weekly benefit amounts that are paid for PFL are the same as those paid for SDI (See TI policy on Disability Coverage for California Employees Only for more information). Like SDI, there is a 7-day unpaid waiting period for PFL benefits.

Employees who have been on pregnancy disability leave may apply for PFL benefits to bond with their new baby as soon as they have recovered from their pregnancy-related disability and are no longer receiving SDI. PFL taken for the purpose of bonding with a new baby or a new adoptive or foster child must be taken within the 12-month period immediately after the child’s birth, adoption, or foster care placement. PFL runs concurrent with FMLA and CFRA (California Family Rights Act) leave.

Paid Leave for Paternity, Surrogate Birth and Adoption

(Note: This does not apply to COBRA participants)

TI provides up to two weeks of paid time off for TIers who are fathers of newborns, who have a child through a surrogate, or who adopt a child. (Additional unpaid time off is available under the Family and Medical Leave Act (FMLA) for these reasons as well.)

For births

- Father: up to two weeks paid leave

For births through a surrogate

- Both parents: up to two weeks paid leave

For adoptions

- Both parents: up to two weeks paid leave
- Up to $4,000 reimbursement of expenses

Additional details:

- Must be a TI employee at the time of the birth or placement for adoption and be in active work status.
- Can be used only once per calendar year.
- Leave must be taken within 60 days of the birth or placement of the child for adoption. It must be taken all at once, not intermittently.
- The benefit does not apply to the adoption of a spouse or partner's child or children.
- No minimum years of service are required.
- Taking this leave does not reduce your Time Bank in any way. If you don't take this leave, you will not have the days added to your Time Bank.
- The two weeks paid leave will be concurrently designated as FMLA leave, and notification and certification requirements for FMLA leave must be followed.
- If the need for Paternity/Surrogate Birth/Adoption Leave is foreseeable, the TIer must notify his or her supervisor and request leave by calling Time Loss Management Services (TLMS) through TI HR Connect @ 888-660-1411 at least 30 days in advance of the date the TIer intends to begin leave. If the TIer is unable to foresee the need for leave 30 days in advance, the notice/request must be made to the supervisor and TLMS as soon as practicable.
- TIers applying for paid Paternity/Surrogate Birth/Adoption Leave in the event of a birth or adoption must provide documentation to support the request.

When paid Paternity/Surrogate Birth/Adoption Leave is approved and begins, time off will be entered in the TI Time system with a specific code for adoption or paternity leave. The type of leave is ABP and the codes are PAT for paternity leave and ADP for adoption leave.

For more information, please go to benefits.ti.com > Work-Life Programs > Adoption.

Disability Benefit Plan – Disability Pay Continuance (DPC) Benefits

(Note: This plan does not apply to COBRA participants)
ERISA PLAN, offered through the Disability Benefit Plan of Texas Instruments Incorporated

A Quick Look

Key features of the DPC benefits offered by the Disability Benefit Plan are:

- Provides you with income protection for up to 26 weeks of disability for illnesses/injuries and 8 weeks for maternity leave including time paid from Time Bank. The plan covers you for illnesses, injuries, or pregnancy for the period of time you are disabled.
- DPC benefits are paid after you have been absent from work for 40 consecutive scheduled hours (or three complete consecutive scheduled shifts for those on compressed shift work schedules or the equivalent of a full consecutive work week for those on an alternative work schedule) due to a non-occupational illness or injury or leave of absence for the birth of a child. *Partial days missed are not covered by the 40-hour or 3-schedule shift requirement. Partial days may be taken as Time Bank (if available) or as unpaid time.*
- All DPC payments made after the first 40 consecutive scheduled hours (or three complete consecutive scheduled shifts for those on compressed shift work schedules or the equivalent of a full consecutive work week for those on an alternative work schedule) of an absence from work are contingent upon an examination by a health care provider and medical documentation that a disabling condition exists which prevents you from performing the essential functions of your job or a modified job.
- TIers approved for Disability Pay Continuance (DPC) benefits will also be certified concurrently for FMLA. The required time bank period for approved DPC leave will be coded as FMLA leave.
- A disability week is defined as any week in which a TIer receives a disability benefit.

When Coverage Begins

You must be actively working on the date your coverage begins. If you are not in active service, your coverage will begin on the date you return to work for one full shift.

You are in active service if you are performing all the regular duties of your employment. The work you are performing must be on a regular scheduled workday.

How to Enroll

DPC Basic

- All eligible employees are automatically enrolled for DPC Basic coverage.

DPC Plus

- You may enroll during the first 30 days of your employment without evidence of insurability (EOI). Coverage begins on the day you enroll. After your first 30 days of employment, you must have an approved EOI to enroll in the LTD benefits offered by the Disability Benefit Plan.
- Active TIers may enroll in DPC Plus during the annual enrollment period. An Evidence of Insurability (EOI) form must be submitted and approved for a coverage change to become effective. Coverage begins on the first day of the year following annual enrollment, if your EOI is approved. Qualified status changes, as defined in the Introduction section, do not allow you to change your DPC coverage.
- TIers on disability leave during annual enrollment may not increase their coverage from DPC Basic to DPC Plus for the following year.

- If a TIer is on a medical leave of absence when a coverage change is scheduled to become effective, the TIer must return to work for 90 days before the change will be effective.
- If a TIer is on another type of leave when a coverage change is scheduled to be effective, the TIer must return to work for one full shift before the change will be effective.

Cost — Who Pays

TI pays the full cost for DPC Basic coverage. You share the cost if you elect DPC Plus. Costs are waived when benefit payments begin under the Long-Term Disability benefits of the Disability Benefit Plan.

Your Benefits

DPC income protection benefits are calculated:

- For non-exempt TIers, based on your base rate of pay, including base pay and group leader or working supervisor allowance. Overtime and shift premiums are not included
- For exempt TIers, based on your base rate of pay, or if you are on an alternative work schedule, your adjusted base rate of pay
- For TI sales representatives, your base rate of pay may include your sales bonus agreement amount.

DPC income protection benefits equal:

- 100 percent of base rate of pay for the first 13 weeks of disability
- DPC Basic — 75 percent of base rate of pay for weeks 14 through 26
- DPC Plus — 100 percent of base rate of pay for weeks 14 through 26
- Taxes are automatically withheld from the benefit payments

Your benefit will be reduced by any of the following benefits you are eligible to receive:

- Social Security Disability Income benefits and/or other Social Security benefits
- Workers' Compensation or other occupational disease benefits
- Disability pay from other sources
- Time Bank
- Other governmental disability income programs
- Automobile No Fault (if required by law)
- Third Party Liabilities (effective for disabilities occurring on or after January 1, 1994)
- California State Disability Insurance Program benefits

Disability Coverage for California Employees Only

If you are a TI employee in California, you are eligible for short-term disability benefits through the California State Disability Insurance (SDI) program. Benefits from the SDI program vary according to the wages that you earned in your base period, which is a period of 12 consecutive months that was approximately 5-17 months before your SDI claim begins. In general, SDI pays about 55% of your base period wages for up to 52 weeks after a 7-day waiting period (in which no benefits are paid). The maximum SDI benefit is currently $959.00 per week. However, SDI will not pay more than your total base period wages that were subject to SDI tax.

Any benefits you receive from the California SDI program may be supplemented (if your medical disability qualifies) by the TI DPC and LTD programs for a period of 52 weeks.

Criteria for Certification

To start receiving DPC after the first 40 consecutive scheduled hours (or three complete consecutive scheduled shifts for those on compressed shift work schedules or the equivalent of a full consecutive work week for those on an alternative work schedule) of your disability, you must meet all six of the following conditions:

- Be in active work status
- Have an illness, injury, or a pregnancy which totally disables you from performing the essential functions of your job or a modified job
- Provide (with assistance from your physician) information needed to approve your medical leave of absence request
- Be under the care of a licensed physician or chiropractor. If the disability is the result of a mental health condition, you must be under the care of a licensed psychiatrist or psychologist
- Receive examinations and treatment from health care providers, as required
- A Release of Information (ROI) form must be signed by you and returned to TI Time Loss Management Services (TLMS)

Note: Medical-related absences extending beyond the first 40 consecutive scheduled hours (or three complete consecutive scheduled shifts for those on compressed shift work schedules or the equivalent of a full consecutive work week for those on an alternative work schedule) must be certified by TI to continue to receive DPC benefits. All DPC benefits after the initial first 40 consecutive scheduled hours (or three complete consecutive scheduled shifts for those on compressed shift work schedules or the equivalent of a full consecutive work week for those on an alternative work schedule) of disability are contingent upon an examination by a health care provider and medical documentation that a disabling condition exists which prevents you from performing the essential functions of your job or a modified job. *Partial days missed are not covered by the 40-hour or 3-schedule shift requirement. Partial days may be taken as Time Bank (if available) or as unpaid time.* You must work with a TI Occupational Health Nurse Consultant to obtain the required certification.

Maternity Leave

Leave of absence for the birth of a child is eight work weeks including the date of delivery. The length of benefit duration must be supported in the same manner as any disability. Other requirements are the same as for DPC benefits.

More Than One Disabling Illness or Injury

DPC provides coverage for more than one disability resulting from ***unrelated causes***. Disabilities must be separated by a return to work of at least one full shift to be considered as separate claims. New Medical Leave of Absence/Disability information must be provided for new claims. If you have two or more injuries or illnesses at the same time, they will be considered one disability for your DPC benefits.

If a second disability results from the same or a related cause, a new DPC benefit period will start if you returned to your regularly assigned work schedule for a period of 90 or more consecutive days.

Continuation of Other Benefits

While you are receiving DPC benefits, your coverage under the following plans may continue (as long as you pay the associated costs):

- Blue Cross Blue Shield PPO or HMO
- MetLife Dental (Basic/Plus)/DHMOs
- Group Life Insurance
- AD&D Insurance
- Vision
- LTD
- Flexible Benefits Plan
  - Health Care Spending Account
  - Dependent Daycare Spending Account

Coverage under these plans for your enrolled dependents also continues. Current plan prices will be deducted from your DPC check. If you are on an unpaid leave of absence, TI will bill you for benefit costs. If you do not pay your bill, your coverage will be dropped effective your last paid through date.

You will continue to earn service credit for the TI Employees Pension plan and TI's 401(k) Savings plans.

Application and Payment

- Call TI Time Loss Management Services (TLMS) through TI HR Connect at 888-660-1411. If you have questions about DPC, contact the TI Occupational Health Nurse Consultant (OHNC) assigned to your business. For contact information, visit my.ti.com. Under Health & Wellness, select Occupational Health & Time Loss Management Web Site, then Find Your Occupational Health Nurse Consultant.
- A TI Occupational Health Nurse Consultant (OHNC) will contact you and your physician to obtain medical information for disability certification, determine medical qualification and set approval of the disability period
- You and your supervisor will be notified of approval dates for the disability period. If an extension is needed, you must contact the TI Occupational Health Nurse Consultant (OHNC) assigned to your claim
- DPC benefits are paid after you have received 40 consecutive scheduled hours (or three complete consecutive scheduled shifts for those on compressed shift work schedules or the equivalent of a full consecutive work week for those on an alternative work schedule) of Time Bank. This requirement is waived if partial disability follows an approved DPC leave

Returning to Work from Leave (DPC)

You must notify your supervisor and the TI Occupational Health Nurse Consultant (OHNC) of your availability to return to work at least one week before your leave of absence expires or if you are able to return to work sooner. You must inform your supervisor and the TI OHNC if you will have any health-related limitations which affect your ability to perform your job. When applicable, the TI OHNC may help facilitate your return to work after you are released to return to work by your treating physician.

On the day you return to work, you must call the TI OHNC assigned to your claim to be returned to active status.

Partial Disability

This program is available for instances of intermittent and partial disability. Intermittent absences are defined as absences for regularly scheduled treatments/special tests for a specific period of time. Partial disability is defined as when you are unable to work at least one half of your normal shift.

Coverage

- A full-time TIer with DPC coverage is eligible to obtain intermittent and partial disability benefits
- With the facilitation of the TI Occupational Health Nurse Consultant (OHNC) and the approval of the employee's supervisor, a TIer may be accommodated to work partial hours with the intent to transition back to a full-time job within TI
- Partial disability may be approved in 30-day increments, not to exceed a cumulative total of 90 days

Criteria for Certification

- Intermittent absences for regularly scheduled treatments/special tests for a specific period of time
- Partial hours as part of a work strengthening care plan to rehabilitate the TIer back to his/her full work schedule
- The weeks on partial disability apply toward long-term disability eligibility
- Partial disability days apply toward FMLA time
- Other requirements are the same as for regular DPC benefits

Application and Payment

- Call TI Time Loss Management Services (TLMS) through TI HR Connect at 888-660-1411. If you have questions about DPC, contact the TI Occupational Health Nurse Consultant (OHNC) assigned to your business. For contact information, visit my.ti.com. Under Health & Wellness, select Occupational Health & Time Loss Management Web Site, then Find Your Occupational Health Nurse Consultant.
- A TI Occupational Health Nurse Consultant (OHNC) will contact you and your physician to obtain medical information for partial disability certification, determine medical qualification and set approval of the disability period
- You and your supervisor will be notified of approval dates for the partial disability period. If an extension is needed, you must contact the TI Occupational Health Nurse Consultant (OHNC) assigned to your claim
- Partial DPC benefits are paid after you have received 40 consecutive scheduled hours (or three complete consecutive scheduled shifts for those on compressed shift work schedules or the equivalent of a full consecutive work week for those on an alternative work schedule) of Time Bank. This requirement is waived if partial disability follows an approved DPC leave. Partial DPC benefits equal 100 percent of base rate of pay for hours missed due to partial disability up to one-half of your normal shift.

Exclusions and Limitations

The Disability Benefit Plan does not cover disability contributed to or caused by:

- Intentionally self-inflicted injuries, suicide or attempted suicide, while sane or insane
- War, declared or undeclared, or any act or hazard of war
- Any period of total disability during which you are not under the care of a legally qualified physician
- Your committing or attempting to commit, an assault, battery (or similar unlawful act) or felony
- Alcoholism or chemical dependency unless you are in an alcoholism or chemical abuse rehabilitation program which is approved by the case manager or claims administrator
- Accidental injury or occupational disease incurred or commenced in the course of employment with a company other than TI
- Accidental injury or occupational disease warranting workers' compensation, which is due to your lack of due care for your or your fellow workers safety or lack of compliance with any TI safety regulation, as determined by the administrator in its sole and absolute discretion
- Insurrection, rebellion or taking part in a riot or similar civil commotion
- Cosmetic surgery
- Days worked for pay or profit outside of TI
- Procedures not covered under the Blue Cross Blue Shield PPO or TI sponsored HMOs.

Claiming Your DPC Benefits

If you believe you are eligible for DPC benefits, these are the steps you must follow:

1. Notify your supervisor immediately on any day you are absent.
2. Call TI Time Loss Management Services (TLMS) through TI HR Connect at 888-660-1411 to provide Medical Leave of Absence/Disability information after your first work day missed if you will miss more than 40 consecutive scheduled hours (or three complete consecutive scheduled shifts for those on compressed shift work schedules or the equivalent of a full consecutive work week for those on an alternative work schedule). *Partial days missed are not covered by the 40-hour or 3-schedule shift requirement. Partial days may be taken as Time Bank (if available) or as unpaid time.*
3. TLMS must approve or deny your request for medical leave of absence (MLOA) after you have missed 40 consecutive scheduled hours (or three complete consecutive scheduled shifts for those on compressed shift work schedules or the equivalent of a full consecutive work week for those on an alternative work schedule). You will be required to work with a TI Occupational Health Nurse Consultant. For contact information, visit my.ti.com. Under Health & Wellness, select Occupational Health & Time Loss Management Web Site, then Find Your Occupational Health Nurse Consultant.
4. You will be required to submit medical information that supports your continuing disability.
5. You may be required to undergo an examination by a physician chosen by TI.

Deadline for Filing Claims

The deadline for filing any DPC claim is 90 days after the end of the period for which you are claiming benefits. Any claim(s) filed after the 90-day period will be denied as untimely.

Claim Denial and Appeal Information

If a Claim is Denied

If the Claim Administrator denies your claim for disability benefits, either in whole or part, a notice will be provided to you within a reasonable period of time, but no later than 45 days from the day your claim was received by the Claim Administrator. This notice will describe (i) the Claim Administrator's determination,

(ii) the basis for the determination (along with appropriate references to pertinent plan provisions on which the denial is based), (iii) the procedure you must follow to obtain a review, including a description of the appeal procedure and (iv) your right to bring a cause of action for benefits under section 502(a) of ERISA, and (iv) the specific rule, guideline, protocol or other similar criterion, if any, on which the Claim Administrator relied (or a statement that a copy of any such rule, guideline, protocol or other similar criterion, if any, will be provided free of charge upon request) in making the determination of your claim.

In certain instances, the Claim Administrator may not be able to make a determination within 45 days from the day you submit your claim for disability benefits. In such situations, the Claim Administrator, in its sole discretion, may extend the 45-day period for up to 30 days as long as the Claim Administrator, in its sole and absolute discretion, determines that the extension is needed because of matters beyond the Plan's control and provides you with a written notice within the initial 45-day period that explains (i) the reason for the extension, (ii) the date on which a decision is expected, (iii) the unresolved issues preventing a decision, and (iv) the information needed to make a determination. If, before the end of the first 30-day extension period, the Claim Administrator, in its sole and absolute discretion, determines that a determination cannot be made due to matters beyond the control of the Plan, the Claim Administrator, in its sole and absolute discretion, may extend the initial 30-day extension for up to 30 additional days, as long as the Claim Administrator provides you with a written notice within the 30-day extension period that explains (i) the reason for the extension, (ii) the date on which a decision is expected, (iii) the unresolved issues preventing a decision, and (iv) the information needed to make a Disability determination.

If the time needed by the Claim Administrator to determine your claim for disability benefits is extended because of your failure to submit information necessary to make the determination, the period during which the Claim Administrator has to decide the claim will be suspended on the date on which the Claim Administrator sends the notification to you until you properly respond. You will have 45 days in which to respond. If you fail to respond within the 45-day period, the Claim Administrator will make the determination based upon the information then available and within the remaining time left in which to make a determination.

Disability Benefit Plan Claim Appeals (DPC/LTD)

If your claim that you are entitled to disability benefits according to the terms of the Disability Benefit Plan is denied, you must appeal the Claim Administrator's denial by requesting a review of your claim by the Plan Administrator. Your written request for an appeal must be received by the Plan Administrator within 180 days of the date you received your notification of the Claim Administrator's denial. Your request for an appeal should be mailed to:

TI Disability Benefit Plan
Plan Administrator
ATTN: Formal Appeals
PO Box 650311, MS 3938
Dallas, TX 75265

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim that you are entitled to disability benefits. You may also request reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You will not be charged for this information. The Plan Administrator’s review will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in the Claim Administrator's initial determination of your claim. The Plan Administrator's review will also not afford any deference to the initial determination and, to the extent that the determination of whether you are disabled involves medical judgment, the Plan Administrator will consult with a health care professional (one who was not involved in the initial determination or the subordinate of a medical professional involved in the initial determination) with the appropriate training and experience. When requested by you, Plan Administrator will provide you with the name of any medical or vocational experts whose advice was sought in connection with your appeal.

If, after reviewing your appeal and any additional information that you have submitted, the Plan Administrator denies your claim to disability benefits, a notice will be provided to you within a reasonable period of time, but not later than 45 days from the day your request for a review was received by the Plan Administrator. In certain instances, the Plan Administrator may not be able to make a determination within 45 days after the day your request for a review was received. In such situations, the Plan Administrator, in its sole and absolute discretion, may extend the 45-day period for up to 45 additional days, as long as the Plan Administrator provides you with a written notice within the initial 45-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

This 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 Plan Administrator based its determination, (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, (iv) your right to bring a cause of action for benefits under section 502(a) of ERISA, (v) the specific rule, guideline, protocol or other similar criterion, if any, on which the Claims Administrator relied (or a statement that a copy of any such rule, guideline, protocol or other similar criterion, if any, will be provided free of charge upon request) if you were determined by the Plan Administrator to not be disabled, and (vi) the following statement: You may contact your local U.S. Department of Labor office to see if alternative dispute resolution options, such as mediation, are available.

The Plan Administrator's decision shall be the final determination of the claim. If it is not furnished within the appropriate period described above, the claim should be considered denied on review.

Right to Recover Overpayment

If you receive a benefit payment greater than that which should have been paid per the TI Disability Benefit Plan, TI has the right to recover such overpayments, including the right to reduce future benefits and make payroll deductions.

When Benefit Payments Stop

Benefit payments and your period of total disability ends when:

- You are not totally disabled
- You fail to give proof that you are still totally disabled
- You refuse to be examined
- You die
- You work outside of TI for pay or profit

Termination of DPC Coverage

Your DPC benefit eligibility will terminate when any of the following conditions are met:

- The date you terminate or retire from TI. For employees in Hawaii and New Jersey, coverage continues for two weeks past termination date unless you will begin coverage immediately under another plan. Employees in New York have coverage for four weeks past termination date
- You are placed on a leave of absence for a reason other than disability
- You are no longer in an eligible class of covered TIers
- You have received 26 weeks of DPC benefits
- The date TI discontinues the DPC Plan

Disability Benefit Plan – Long-Term Disability (LTD) Benefits

(Note: This plan does not apply to COBRA participants)
ERISA PLAN, offered through the Disability Benefit Plan of Texas Instruments Incorporated

A Quick Look

Key features of the Long-Term Disability (LTD) benefits offered by the Disability Benefit Plan are highlighted below.

- If you are a full-time TIer or a part-time TIer on an alternative work schedule (minimum 20-hours-a-week schedule), you may enroll on your first day of employment
- Benefits are payable after 26 weeks of full, partial or intermittent disability. Partial disability is defined as when you are unable to work all of your normal shift
- There are two options for coverage:
    - LTD Basic — 50 percent of your basic monthly earnings less other income benefits such as income from TI or any government program
    - LTD Plus — 66 2/3 percent of your basic monthly earnings less other income benefits such as income from TI or any government program
- The maximum monthly benefit is $25,000

When Coverage Begins

You must be actively working on the date your coverage begins. If you are not in active service, your coverage will begin on the date you return to work for one full shift.

You are in active service if you are performing all the regular duties of your employment. The work you are performing must be on a regular scheduled workday.

How to Enroll

You may enroll during the first 30 days of your employment without evidence of insurability (EOI). After your first 30 days of employment, you must have an approved EOI to enroll in the LTD benefits offered by the Disability Benefit Plan.

You may enroll in LTD benefits or change from LTD Basic to LTD Plus during annual enrollment. An EOI form must be submitted and approved for a coverage change to become effective. You cannot change your Disability Benefit Plan enrollment when a qualified status change occurs.

If you are on a medical leave of absence when a coverage change is scheduled to become effective, you must return to work before being eligible for the newly elected benefits. If you are out on disability leave during annual enrollment, you will not be able to increase the prior year's selections for disability benefits.

Cost — Who Pays

You and TI share the plan costs. Your share of the cost will be deducted on an after-tax basis from your paycheck each pay period.

Plan costs will be waived when benefit payments begin under LTD benefits.

Your Benefits

Amount of Disability Income

Your disability income under LTD benefits will be a monthly benefit based on the option you elect:

- If you elect LTD Basic — your monthly benefit will be equal to 50 percent of your basic monthly earnings
- If you elect LTD Plus — your monthly benefit will be equal to 66 2/3 percent of your basic monthly earnings

Basic monthly earnings means:

- Nonexempt — straight-time hourly rate of pay multiplied by 173.3 hours
- Exempt — monthly salary

Your basic monthly earnings do not include overtime, shift premium or any other additional compensation. For TI sales representatives, your monthly salary may include your sales bonus agreement amount.

Your benefit will be reduced by any of the following benefits you are eligible to receive:

- Social Security Disability Income benefits and/or other Social Security benefits
- Workers' Compensation or other occupational disease benefits
- Disability Pay Continuance benefits or disability pay from other sources.
- Time Bank
- Other governmental disability income programs
- Automobile No Fault (if required by law)
- Third Party Liabilities (effective for disabilities occurring on or after January 1, 1994)
- California State Disability Insurance Program benefits

LTD benefits begin after you have been totally, partially or intermittently disabled for a total of 26 weeks.

A disability week is defined as any week in which a TIer receives a disability benefit. Your benefit will be based on your rate of pay in effect (on last day worked) when disability starts. Your LTD benefit will continue to pay a benefit to you as long as you remain totally disabled (See following definition) up to age 65 (and up to age 70 in some instances), or until you recover.

Once your LTD benefit amount is fixed, your benefit will not be reduced because of any increase in Social Security payments. If the LTD monthly benefit for any month is overpaid, TI has the right to recover the overpayment by deducting that amount from future payments.

Total Disability

You are considered totally disabled when you are unable to perform the essential functions of your job or any job for which you may qualify and cannot be reasonably accommodated.

Your LTD benefits will continue during the period you remain totally disabled (as defined above)]. It may be necessary to submit a doctor's certification of your continued total disability on request or your LTD benefits will stop.

Total and Permanent Disability

An employee may be considered totally and permanently disabled (TPD) with the appropriate medical documentation, Social Security disability income benefits award, and the inability to perform the essential functions or be reasonably accommodated for a job that pays a minimum of 75% of his or her base pay before the disability leave. **Once an employee has been on leave of absence for 48 months, his or her employment with TI will terminate.** *The 48 months begins with the commencement of the participant's disability.*

How Long Benefits are Payable

The Social Security Disability Insurance (SSDI) benefit must be approved by the end of 48 months (four years) from the onset of disability or long-term disability benefit payments will be terminated. At the discretion of the Plan Administrator, TI may continue the LTD benefit at the end of 48 months if a decision is pending at the next step in the SSDI appeal process, with resolution not to exceed six months.

LTD Benefits are payable through age 65 (or up to age 70 on a graduated basis if the disability began after age 60) if SSDI benefits have been awarded.

When LTD Benefit Payments Stop

Benefit payments and your period of total disability ends when:

- You are not totally disabled
- You fail to give proof that you are still totally disabled
- You refuse to be examined
- You become eligible for benefits under any other long-term disability benefits plan carried or sponsored by your employer as of the date this group policy terminates
- After 12 months, you have not filed for SSDI benefits
- At the end of 48 months, SSDI benefits have not been awarded
- You do not submit your SSDI renewal notice of benefits to TI annually
- You die
- You work outside TI for pay or profit

Return to Work

After you have received your LTD benefit and returned to work, a second disability resulting from the same or related causes will be considered a continuation of the first period of total disability, unless you return to work full-time for 90 or more consecutive days.

Once you have worked full-time for three consecutive months, any new disability will restart your DPC benefit eligibility.

Continuation of Other Benefits

While you are receiving LTD benefits, your coverage under the following plans will continue (as long as you pay the associated costs) for a maximum of 48 months (during LOA):

- Blue Cross Blue Shield PPO or HMO
- MetLife Dental (Basic/Plus)/DHMOs
- Group Life Insurance
- AD&D Insurance
- Vision
- Flexible Benefits Plan
  - Health Care Spending Account

Coverage under these plans for enrolled dependents also continues. Costs for these plans will be billed. If you do not pay your bill, your coverage will be dropped.

You will continue to earn service credit for the TI Employees Pension Plan and TI's 401(k) savings plan for a maximum of 48 months (during LOA).

Total and Permanent Disability (TPD) Termination Benefits

Once an employee has been on disability leave of absence for 48 months, his or her employment with TI will terminate and they will be determined to be TPD. If this occurs, you will be eligible for the following:

- Life insurance coverage conversion or portability for yourself and your dependents
- 29 months of COBRA coverage
- Medicare after 24 months of Social Security Disability Insurance (SSDI) benefits
- LTD benefits (if covered) up to age 65 (and up to age 70 in some instances)
- May bridge one year for retiree eligibility

Rehabilitation Program

LTD benefits allow you to take a job under any approved program of rehabilitation employment. This is a program of physical, mental or vocational rehabilitation that is:

- Expected to result in your return to your own occupation, or to a reasonable occupation, on a full-time basis
- Approved by a TI Occupational Health Nurse Consultant

A rehabilitation program will cease to be an approved rehabilitation program on the earliest date that:

- You are able to perform the essential functions of your own occupation or any job (including jobs outside of TI) that pays a minimum of 75% of base pay before the disability leave
- TI withdraws, in writing, its approval of the program

Your total income from this rehabilitation job (including your LTD benefit) cannot exceed 100 percent of your basic monthly earnings before you became totally disabled. TI will reduce or recover your LTD benefits in such cases to prevent overpayment.

Tax Treatment

According to U.S. federal income tax laws, the LTD benefits you receive under the Disability Benefit Plan (if costs are paid by TI) are taxable income and TI pays 50 percent of your basic coverage cost. LTD costs paid by you are paid on an after-tax basis. This avoids income tax on that portion of the benefit received that is derived from the cost paid by you.

Exclusions and Limitations

The Disability Benefit Plan does not cover disability contributed to or caused by:

- Intentionally self-inflicted injuries, suicide or attempted suicide, while sane or insane
- War, declared or undeclared, or any act or hazard of war
- Any period of total disability during which you are not under the care of a legally qualified physician
- Your committing or attempting to commit, an assault, battery (or similar unlawful act) or felony
- Alcoholism or chemical dependency unless you are in an alcoholism or chemical abuse rehabilitation program which is approved by the case manager or claims administrator
- Accidental injury or occupational disease incurred or commenced in the course of employment with a company other than TI
- Accidental injury or occupational disease warranting workers' compensation, which is due to your lack of due care for your or your fellow workers' safety or lack of compliance with any TI safety regulation, as determined by the administrator in its sole and absolute discretion
- Insurrection, rebellion or taking part in a riot or similar civil commotion
- Cosmetic surgery
- Days worked for pay or profit outside of TI
- Procedures not covered under the Blue Cross Blue Shield PPO or TI sponsored HMOs

Claiming Your Benefits

When to Submit a Claim

After you have been off work because of a disability for four continuous months, and you do not expect to return in the next two months, do the following:

You	Notify your supervisor and the TI Occupational Health Nurse Consultant (OHNC) assigned to your claim that you expect to be absent longer than six months. For OHNC contact information, visit my.ti.com. Under Health & Wellness, select Occupational Health & Time Loss Management Web Site, then Find Your Occupational Health Nurse Consultant.
Your Physician	Your physician will be asked to submit medical information which supports your continuing total disability. You may be required to submit to a physical examination by a doctor designated by TI. Prompt response by you and your physician to these requests will help avoid delays in receiving your benefit.

If your LTD claim is approved, LTD benefits will start after the end of 26 disability weeks.

Deadline for Filing Claims

The deadline for filing any LTD claim is 90 days after the end of the period for which you are claiming benefits. Any claim(s) filed after the 90-day period will be denied as untimely.

Claim Denial and Appeal Information

If a Claim is Denied

If the Claim Administrator denies your claim for disability benefits, either in whole or part, a notice will be provided to you within a reasonable period of time, but no later than 45 days from the day your claim was received by the Claim Administrator. This notice will describe (i) the Claim Administrator's determination, (ii) the basis for the determination (along with appropriate references to pertinent plan provisions on which the denial is based), (iii) the procedure you must follow to obtain a review, including a description of the appeal procedure and (iv) your right to bring a cause of action for benefits under section 502(a) of ERISA, and (iv) the specific rule, guideline, protocol or other similar criterion, if any, on which the Claim Administrator relied (or a statement that a copy of any such rule, guideline, protocol or other similar criterion, if any, will be provided free of charge upon request) in making the determination of your claim.

In certain instances, the Claim Administrator may not be able to make a determination within 45 days from the day you submit your claim for disability benefits. In such situations, the Claim Administrator, in its sole discretion, may extend the 45-day period for up to 30 days as long as the Claim Administrator, in its sole and absolute discretion, determines that the extension is needed because of matters beyond the plan's control and provides you with a written notice within the initial 45-day period that explains (i) the reason for the extension, (ii) the date on which a decision is expected, (iii) the unresolved issues preventing a decision, and (iv) the information needed to make a determination. If, before the end of the first 30-day extension period, the Claim Administrator, in its sole and absolute discretion, determines that a determination cannot be made due to matters beyond the control of the Plan, the Claim Administrator, in its sole and absolute discretion, may extend the initial 30-day extension for up to 30 additional days, as long as the Claim Administrator provides you with a written notice within the 30-day extension period that explains (i) the reason for the extension, (ii) the date on which a decision is expected, (iii) the unresolved issues preventing a decision, and (iv) the information needed to make a Disability determination.

If the time needed by the Claim Administrator to determine your claim for disability benefits is extended because of your failure to submit information necessary to make the determination, the period during which the Claim Administrator has to decide the claim will be suspended on the date on which the Claim Administrator sends the notification to you until you properly respond. You will have 45 days in which to respond. If you fail to respond within the 45-day period, the Claim Administrator will make the determination based upon the information then available and within the remaining time left in which to make a determination.

Disability Benefit Plan Claim Appeals (DPC/LTD)

If your claim that you are entitled to disability benefits according to the terms of the Disability Benefit Plan is denied, you must appeal the Claim Administrator's denial by requesting a review of your claim by the Plan Administrator. Your written request for an appeal must be received by the Plan Administrator within 180 days of the date you received your notification of the Claim Administrator's denial. Your request for an appeal should be mailed to:

TI Disability Benefit Plan
Plan Administrator
ATTN: Formal Appeals
PO Box 650311, MS 3938
Dallas, TX 75265

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim that you are entitled to disability benefits. You may also request reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You will not be charged for this information. The review will take into account all comments, documents, records and

other information you submitted, without regard to whether such information was submitted and considered in the Claim Administrator's initial determination of your claim. The Plan Administrator's review will also not afford any deference to the initial determination and, to the extent that the determination of whether you are disabled involves medical judgment, the Plan Administrator will consult with a health care professional (one who was not involved in the initial determination or the subordinate of a medical professional involved in the initial determination) with the appropriate training and experience. When requested by you, the Plan Administrator will provide you with the name of any medical or vocational experts whose advice was sought in connection with your appeal.

If, after reviewing your appeal and any additional information that you have submitted, the Plan Administrator denies your claim to disability benefits, a notice will be provided to you within a reasonable period of time, but not later than 45 days from the day your request for a review was received by the Plan Administrator. In certain instances, the Plan Administrator may not be able to make a determination within 45 days after the day your request for a review was received. In such situations, the Plan Administrator, in its sole and absolute discretion, may extend the 45-day period for up to 45 additional days, as long as the Plan Administrator provides you with a written notice within the initial 45-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

This 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 Plan Administrator based its determination, (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, (iv)your right to bring a cause of action for benefits under section 502(a) of ERISA, (v) the specific rule, guideline, protocol or other similar criterion, if any, on which the Plan Administrator relied (or a statement that a copy of any such rule, guideline, protocol or other similar criterion, if any, will be provided free of charge upon request) if you were determined by the Plan Administrator to not be disabled, and (vi) the following statement: You may contact your local U.S. Department of Labor office to see if alternative dispute resolution options, such as mediation, are available

Termination of Coverage

Your coverage under the Disability Benefit Plan ends the earliest of the following dates:

- The date you cease to qualify as a TIer (unless considered to be TPD)
  Examples: Termination or non-medical leave of absence (termination of active service will be considered termination of employment)
- The last day of the period for which you paid LTD costs
- The date the policy ends

Your retirement date (coverage ends, LTD benefits can continue).

Workers' Compensation

(Note: This plan does not apply to COBRA participants)

A Quick Look

Key features of Workers' Compensation are:

- Health care coverage for an illness or injury that is work-related
- Income protection for time missed from work due to a work-related illness or injury

Eligibility

You are covered by TI's Workers' Compensation program on your first day of employment as a full-time TIer or a part-time TIer on an alternative work schedule (minimum 20-hours-a-week schedule).

Your Benefits

If a claim is determined to be compensable by the Workers' Compensation insurance carrier, all medical care that is directly related to the occupational injury or illness is paid in full with no copay, coinsurance or deductible.

Depending on the state in which you reside, there is a waiting period from three to seven calendar days before Workers' Compensation wage replacement benefits begin. Payment for workdays missed during this waiting period following an on-the-job injury or illness is generated by the TI Payroll System and sent to the TIer through the normal payroll distribution process.

Following the waiting period, tax-free weekly benefits will be determined by the state in which you reside and are paid directly by TI's Workers' Compensation insurance carrier.

TIers receiving Workers' Compensation benefits must meet DPC/LTD criteria to be eligible for DPC/LTD.

During the first six months of a work-related disability, DPC benefits will be offset by Workers' Compensation benefits so that no more than the elected DPC coverage amount will be payable. DPC Basic coverage equals 100% of base pay for weeks 1-13 and 75 percent of base pay for weeks 14-26; DPC Plus equals 100 percent of base pay for 26 weeks.

After 26 weeks of lost time because of a compensable on-the-job injury, LTD benefits will be offset by Workers' Compensation benefits by elected coverage amounts if you are enrolled in the Disability Benefit Plan. LTD Basic coverage equals 50 percent of base pay; LTD Plus equals 66-2/3 percent of base pay (maximum monthly benefit is $25,000).

Claiming Your Benefits

If you are injured or become ill due to your work environment, notify your supervisor immediately. You must also call TI Time Loss Management Services (TLMS) through TI HR Connect at 888-660-1411. TLMS will notify the insurance carrier to begin the claim process review.

Contact the TI Occupational Health Nurse Consultant (OHNC) assigned to your business. For contact information, visit my.ti.com. Under Health & Wellness, select Occupational Health & Time Loss Management Web Site, then Find Your Occupational Health Nurse Consultant.

You will be contacted by the insurance carrier and/or a TI Occupational Health Nurse Consultant (OHNC) to gather more information if needed for review of your claim.

If your claim is denied, you must appeal to the Workers' Compensation Board of the state in which you live.

Life Insurance – Group Term

(Note: This benefit does not apply to COBRA participants)
THIS BENEFIT IS PART OF AN ERISA PLAN

A Quick Look

The plan has two parts:

- **TI-Paid Life Insurance (Basic Life):** TI will pay for coverage equal to one times your annual base salary up to $2.5 million in coverage, rounded to the nearest $1,000
- **TIer-Paid Additional Life Insurance:** You may also purchase additional life insurance coverage up to eight times your annual base salary, rounded to the nearest $1,000, to add to your basic life insurance coverage

Your combined coverage cannot exceed $2,500,000.

Enrollment

- TI enrolls you for the Basic Life coverage when you are first eligible. There is no cost to you. However, you must be actively at work on the date your coverage begins. Otherwise, coverage will begin the date you return to work
- To enroll in the TIer-paid additional life insurance when you are first eligible, make election on the Fidelity NetBenefits® Web site or contact the TI Benefits Center
- You are eligible for up to $250,000 of coverage on your date of hire without providing proof of insurability if you enroll within the first 30 days of your employment
- You will be required to provide proof of insurability if you enroll after 30 days of service for the TIer-paid portion of your life insurance
- You can make changes to your election if an appropriate qualified status change occurs. Please see the Introduction section for information about qualified status changes

Cost — Who Pays

Both you and TI share in the cost of your Group Term Life Insurance. Costs are shared in the following way:

- TI pays for one times your annual base salary in life insurance coverage
- You may purchase additional coverage at rates based on each $1,000 of coverage you have elected. Rates for additional coverage are based on your age and whether you use tobacco products

Your Benefits

The TI Group Term Life Insurance benefit provides insurance that is based on your annual base salary. Annual base salary is defined as follows:

- Nonexempt status — Your annual base salary is straight-time pay of 40 hours per week, multiplied by 52 weeks
- Exempt status — Your annual base salary is your annual wages, not counting bonuses or overtime

- TI Sales Representative — If you are covered by a sales bonus plan, your annual base salary may include your sales bonus agreement amount

You can choose the amount of life insurance coverage that best fits your needs, up to $2.5 million of combined TI-paid and TIer-paid coverage.

TI-Paid Insurance

TI will pay for your basic life insurance coverage up to one times your annual base salary, rounded to the nearest $1,000, up to $2.5 million.

TIer-Paid Insurance

You may purchase additional life insurance in an amount up to eight times your annual base salary, rounded to the nearest $1,000, up to $2.5 million.

Evidence of Insurability (EOI)

If you choose life insurance for the first time (other than the TI-paid portion), or you increase the coverages you have currently, you will be required to complete an EOI form. (This does not apply to new hires who are within 30 days of their date of employment and who select less than $250,000 in coverage.)

Completing an EOI form is not a guarantee of coverage. You can be denied life insurance coverage due to your medical history or a current medical condition.

When Coverage Amount Changes

Your coverage is based on your annual base salary. When your annual base salary changes, the new coverage will be effective immediately.

Imputed Income — An IRS-Required Tax

If your total group life insurance coverage is greater than $50,000, you may be subject to imputed income, which will be added to your W-2 Form and subject to tax.

The IRS sets the value of group term life insurance amounts more than $50,000. If the actual cost you pay is less than the value set by the IRS, the difference is considered "imputed income." You did not actually receive this amount but you must include it as income for tax purposes. This amount is based on your age, the amount of coverage more than $50,000 and your cost. The taxable amount is shown in the taxable benefits section of your paycheck

Additionally, if you choose spouse life insurance or life insurance for a domestic partner, the IRS also requires imputed income to be added to your W-2 form. Imputed income is based on the amount and the cost of coverage you choose.

Coverage During Disability

Life insurance benefits during a disability covered by the Disability Benefit Plan are discussed in the:

- Disability Pay Continuance benefits (DPC) section under Continuation of Other Benefits;
- Time Off Benefits section under Benefits During a Leave of Absence; and the
- Long-term Disability benefits (LTD) section under Continuation of Other Benefits.

Conversion or portability of coverage

If you terminate your employment with TI as a result of a disability, you are eligible to convert the basic or additional life insurance you have currently, plus any spouse or child life insurance you have currently, to personal policies. You are also eligible to continue your additional life insurance coverage and/or your dependent life insurance coverage through portability. No proof of insurability is required. You must have a permanent U.S. address for conversion or portability of coverage. Call MetLife at 877-275-6387 for conversion details; or 866-492-6983 for portability details.

Beneficiary Information

Designation of Beneficiaries

On your date of hire, you should make a beneficiary election on the "Your Profile" tab on the Home Page of the Fidelity NetBenefits® Web site. This allows you to name the beneficiaries you wish to receive your life insurance. Please be ready to provide your beneficiary(ies) complete name, Social Security number and date of birth. Later, if you wish to change your beneficiaries, you can change your election(s) on the "Your Profile" tab on the Fidelity NetBenefits® Web site or contact the TI Benefits Center. You can make changes to your beneficiaries at any time.

You may name specific individuals, a trust, a charitable organization, or your estate. MetLife will make payment directly to the named beneficiary unless a written notice of an adverse claim is received before MetLife makes a payment.

Beneficiary Succession

If more than one beneficiary is designated, the designated beneficiaries will share equally, unless otherwise specifically stated by you.

If any designated beneficiary predeceases you, their share, unless specified otherwise, will be payable equally to the remaining designated beneficiary or beneficiaries, if any, who survive you.

If no designated beneficiary survives you or if no beneficiary has been designated, payment will be made to your estate. However, MetLife has the option of making payment to any one or more of the following surviving relatives of the employee: spouse or same-gender domestic partner, child, parent, brother or sister.

Assignment of Coverage

Transferring Ownership

Subject to the approval of TI and the insurance company, you may assign your insurance ownership as a gift. Life benefits are also assignable by means of a viatical assignment.

Any such assignment will transfer all right, title, interest and incidents of ownership, both present and future, in such benefits, but not limited to 1) right to make contributions required to keep the benefits in force; 2) privilege of obtaining an individual life policy; and 3) right to change the beneficiary.

You make an assignment by completing an assignment form and sending three copies to MetLife for approval. You can request the assignment form by contacting MetLife at 800-233-4172. The assignment must be received and approved by MetLife to be valid.

Neither TI nor MetLife guarantees nor assumes any obligation for the validity or sufficiency of any assignment.

Spouse Life Insurance *

* The following may apply to coverage for a same-gender domestic partner.

You may also elect life insurance coverage for your legal spouse. You are the beneficiary of any spouse life insurance coverage you elect.

Coverage for your spouse includes options of $5,000, $10,000, $25,000, $50,000, $100,000, $150,000 or $200,000. Coverage is available for your spouse only if you have enrolled in life insurance for yourself. Maximum spouse coverage is the lesser of 7 times employee annual base salary or $200,000.

Provisions Applicable to Coverage on Your Spouse in Excess of $50,000

You must, at your expense, give MetLife evidence of the good health of your dependent spouse in order for your dependent spouse to:

- Become covered under this plan for an amount of dependent life benefits greater than $50,000
- Receive an increase in the amount of dependent life benefits if the amount of spouse life benefits is already equal to, or greater than, $50,000

Such amount of dependent life benefits or such increase in the amount of dependent life benefits will become effective for your dependent spouse on the later of:

- The date the evidence of the good health of your dependent spouse is accepted by MetLife as satisfactory
- The effective date of your personal benefits provided you are actively at work on that date. If you are not an active employee on that date, such amount of dependent life benefits will become effective on the date of your return to work

If you do not give MetLife evidence of the good health of your dependent spouse, or if such evidence of good health is not accepted by MetLife as satisfactory, the amount of dependent life benefits will not be more than the greater of:

- The amount of dependent life benefits in effect on your dependent spouse immediately prior to the date of which any such increase would have become effective
- $50,000

When You May Enroll

New employees have from 30 days of the date of their employment to choose spouse life insurance coverage. Other TIers may elect spouse life insurance during annual enrollment or within 30 days of an appropriate qualified status change.

Your Cost

Spouse life insurance costs are based on the amount of coverage elected, your spouse's age and whether he or she uses tobacco products.

Evidence of Insurability (EOI)

During annual enrollment, if you elect spouse life insurance of greater than $50,000, an EOI for your spouse will be required. If applicable, you will receive an EOI form from Fidelity. You can access a copy online on the Fidelity NetBenefits® Web site. From the "Home Page" tab, select the "Health & Insurance" tab. You can click on the "Forms" link in the View column or select "All Health & Insurance Forms" at the bottom of the benefit summary. You can also download the form by going to benefits.ti.com. Click on the Health Benefits Web Site, then “Forms”.

Imputed Income — An IRS-Required Tax

If you choose spouse life insurance, you will be subject to imputed income, which will be added to your W-2 Form and subject to tax.

Living Needs Benefit

If you, or your covered spouse, are terminally ill and are expected to die within 6 months, you may request an accelerated payment of life insurance under the Living Needs Benefit. All requests are subject to approval, as well as the minimum and maximum benefit amounts allowable.

You may request a Living Needs Benefit in an amount up to 50 percent of the amount of life insurance in force. Upon approval, the Living Needs Benefit will be paid in a lump sum. You can request a Living Needs Benefit by contacting MetLife at 800-638-6420.

The maximum amount payable under Basic and Additional life insurance combined is $250,000. No Living Needs Benefit will be payable if the amount of dependent spouse life benefits in effect is less than $10,000.

This option may be elected only once, and the amount of coverage cannot be changed after your election is made. You will continue to make contributions for the full amount of your coverage. You cannot use this option if you have legally assigned your benefit.

Child Life Insurance

You may also elect life insurance coverage for your eligible children.

You are the beneficiary of any child life insurance you elect. Coverage is available for your children only if you have enrolled in life insurance for yourself.

Eligible Dependents

Your eligible dependents include:

- Your biological children, legally adopted children or children for whom adoption papers were filed
- Stepchildren who live with you and are supported by you
- A child for whom you are legal guardian or managing conservator
- Dependents of your same-gender domestic partner
- Your grandchild who lives with you and is claimed by you as a dependent on IRS tax filings

Children must meet all of the following conditions:

- Unmarried
- Not work on a regular full-time basis
- 14 days of age or older

Coverage ends on your child's 19th birthday unless your child meets the following additional conditions. To be covered beyond age 19, your child must be:

- A full-time student (at an accredited college or university or at a vocational, technical or other recognized post secondary education institution) younger than 25
- Dependent upon you for more than 50 percent of his or her support

If your child meets both of these additional conditions, you must contact the TI Benefits Center before your child's 19th birthday to continue coverage. You are also required on an annual basis to certify (through the TI Benefits Center or the Fidelity NetBenefits® Web site) that your child continues to meet these requirements. Coverage will end when the child fails to meet one of the conditions or on his or her 25th birthday, if earlier. To determine the guidelines for dependents in your location, contact the TI Benefits Center.

If Your Dependent Child is Disabled

Dependent children 19 years of age or older who are physically or mentally disabled may continue to be covered after the child otherwise ceases to meet the definition of an eligible dependent child, provided they were covered as dependents on the day before their 19th birthday (or such later date as is applicable for *covered* full-time students under the age of 25) and if the disability occurred before the time that their status as a dependent child would otherwise end. Coverage is subject to approval. Contact the TI Benefits Center to find out how to apply for coverage.

Your Choices

Coverage for your children includes options of $5,000 or $10,000. Each of your eligible children will have the same amount of coverage elected — whether you have one child or several. An EOI form is not required.

When You May Enroll

New hires have 30 days from their date of employment to choose child life insurance coverage. All other TIers may choose child life insurance, or change existing child life insurance coverage, during annual enrollment, or within 30 days of an appropriate qualified status change.

Two TIers Who Are Married

If you are married to another TIer, only one TIer may enroll the eligible dependents.

Your Cost

You pay the costs for child life insurance on an after-tax basis.

Suicide Exclusion

Employee Additional (not basic life), Spouse and Child Life Insurance

Benefits will not be paid if suicide is committed (whether sane or insane) within two years of the first day of coverage. Instead, an amount equal to the contributions paid for the current coverage level (without interest) will be paid.

If suicide is committed (while sane or insane) more than two years from the first date of coverage, but within two years from the effective date of any increase in the amount of coverage, such increased amount will not be paid. Instead, an amount equal to the amount of coverage that was in effect on the day before the effective date of such increase, plus an amount equal to all contributions paid for the increased amount (without interest) will be paid.

Living Needs Benefits

If terminal illness or injuries are the result of an attempted suicide or injuring oneself on purpose (whether sane or insane), benefits will not be paid.

Claiming Benefits

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

A Certified Death Certificate with the cause and manner of death, should be filed with MetLife.

The beneficiary should file a claim, along with the Certified Death Certificate, with MetLife. When MetLife agrees that the death claim is appropriate for payment, a check will be sent to the named beneficiary. Payment checks are normally mailed within 30 days from receipt of the claim.

You can obtain the Life Insurance claim form and instructions by contacting MetLife at 800-638-6420. Claim should be sent to:

MetLife
Group Life Claims
PO Box 3016
Utica, NY 13504

Payment Methods

Payment to your beneficiary is normally made in a lump-sum settlement (by check); however, a beneficiary can elect to receive payment into a Total Control Account (TCA) or other designated account by notifying MetLife.

Claim Denial and Appeal Information

If a Claim is Denied

A claim for life insurance death benefits must be submitted to the Claims Administrator at the time and in the manner prescribed by the Claims Administrator.

If the Claims Administrator determines that you are not entitled to receive all or part of the benefits you claim, a notice will be provided to you within a reasonable period of time, but no later than 90 days from the day your claim was received by the Claims Administrator. This notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will describe (i) the Claims Administrator's determination, (ii) the basis for the determination (along with appropriate references to pertinent benefit provisions on which the denial is based), and (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, the Claims Administrator may not be able to make a determination within 90 days from the day your claim for benefits was submitted. In such situations, the Claims Administrator, in its sole and absolute discretion, may extend the 90-day period for up to 180 days, as long as the Claims Administrator provides you with a written notice within the initial 90-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

Life Insurance Claim Appeals

If your claim that you are entitled to life insurance is denied, you must appeal the Claims Administrator's denial by requesting a review of your claim by the Claims Administrator. Your written request for an appeal must be received by the Claims Administrator within 60 days of the date you received your notification of the Claims Administrator's denial. Your request for an appeal should be mailed to:

MetLife
Group Life Claims
PO Box 3016
Utica, NY 13502

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits. You may also request reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You will not be charged for this information. The review will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in the Claims Administrator's initial determination of your claim.

If, after reviewing your appeal and any further information that you have submitted, the Claims Administrator denies your claim, either in whole or in part, a notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 60 days from the day your request for a review was received by the Claims Administrator. In the event that an extension of time for processing is required, you will be provided a written notice of the extension not later than 60 days from the day your request for a review was received by the Claims Administrator. In such situations, the Claims Administrator, in its sole and absolute discretion, may extend the 60-day period for up to 120 days, as long as the Claims Administrator provides you with a written notice within the initial 60-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

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 Claims Administrator based its determination, (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.

Termination of Coverage

Your TI Group Term Life Insurance coverage will terminate on the earliest of the following:

- When your employment ends
- When you retire
- When you are no longer in an eligible class of covered TIers
- When you fail to pay your required cost
- The date the group insurance contract is canceled
- When you are no longer in active status except:
    - If you are on military leave, your insurance may be continued while on military leave
    - If you are on a leave of absence, you must pay your required costs. Otherwise, your insurance will be canceled

Your dependent life benefits will terminate on the earliest of the following:

- The date your dependent spouse attains age 70
- The date the dependent ceases to be your eligible dependent
- The date you retire, as determined by the employer
- When your employment ends
- The date of your death

Conversion of Coverage

On termination of coverage, you and your dependents may convert your insurance to a personal policy without any further evidence of insurability. Conversion is subject to your completion of a Conversion Privilege Notice and MetLife's approval of the notice following your submission. MetLife will mail this notice to you. If you have any questions or don't receive a notice shortly after termination of your coverage, you should call MetLife at 877-275-6387. The application period is 31 days after your insurance has been terminated. You must have a permanent U.S. address for conversion coverage.

You can convert up to the amount of coverage you and/or your dependents had when you stopped work. However, if the MetLife contract is canceled, and you were insured for at least five years, the maximum amount of insurance available for you and/or your covered dependents to convert is the lesser of: (1) the amount of life insurance coverage you and/or your covered dependents had on the date life insurance coverage ends, less any amount of life insurance that you are eligible for under any Group Policy that takes effect within 31 days after your life insurance coverage ends; or (2) $2,000.

The type of individual policy to which you may convert is determined by MetLife. The converted policy will not be a term policy or a policy with disability or other supplementary benefits.

The rate you pay will be set by MetLife based on:

- Your age on the effective date of the policy
- The risk class to which you belong
- The form and amount of the policy

All costs must be paid by you for the new, converted policy.

The coverage will be effective on the 32nd day after the date your TI group term life insurance ends.

Death Within 31 Days of Termination

If you or your dependents should die during the 31-day period after your insurance stops, MetLife will pay the amount in force at the time the coverage was terminated. Such death benefits are payable to you or your beneficiary whether or not you or your dependents actually made an application to convert.

Portability

If your insurance ends because your employment ends, or you cease to be in a class eligible for such insurance, you must request to continue your additional life insurance coverage and/or your dependent life insurance coverage through portability if you want to continue the coverage.

If you die, or your marriage ends in divorce or annulment, your spouse must request to continue dependent life insurance coverage on their life through portability if your spouse desires continuation.

A request for portability may be made, if on the date of the request, the group policy is in effect, no notice has been received to cancel the group policy, no application has been made to convert the current coverage, and the person making the request resides in a jurisdiction that permits portability. You must have a permanent U.S. address for portability of coverage.

If a request is made to continue life insurance coverage through portability, MetLife will issue a new certificate of insurance which will explain the new insurance benefits. The insurance benefits under the new certificate may not be the same as those that ended under the group policy.

In order to request to continue coverage through portability, call MetLife at 866-492-6983. You must apply for portability within 31 days after your life insurance has been terminated; the 31-day period is also known as the request period.

The maximum amount of additional life insurance which may be continued is the lesser of (1) the total amount of all such insurance for you in effect immediately prior to the date it ends; or (2) for residents of all states other than Michigan $1,000,000; or (3) for residents of Michigan, the maximum amount is limited by law and is $190,900. The minimum amount of additional life insurance benefits which may be continued is $20,000.

If you are making the request to continue dependent life insurance, the maximum amount which may be continued is the lesser of (1) the amount of such insurance in effect immediately prior to the date it ends; or (2) the amount which you have elected to be continued.

If your dependent is making the request to continue dependent life insurance, the maximum amount which may be continued is the amount of such insurance in effect immediately prior to the date it ends.

When a request to continue insurance coverage for you or your dependents is made, the first premium must be paid during the request period. All premium payments must be made directly to MetLife. When a new certificate is issued, MetLife will also provide a schedule of premiums and payment information.

If You Die Within 31 Days of the Date Your Life Insurance Ends

If you die within 31 days of the date your life insurance ends and MetLife has not received an application for portability, MetLife will pay the amount in force at the time the coverage was terminated. If you die within 31 days of the date your life insurance ends and MetLife has received an application for portability, MetLife will only pay benefits for the amount of insurance you requested to be continued.

If Your Dependent Dies During the Request Period

If your dependent dies during the request period and MetLife has not received an application for portability during the request period, MetLife will pay the amount in force at the time the coverage was terminated. If your dependent dies during the request period and MetLife has received an application for portability during the request period, MetLife will only pay benefits for the amount of insurance that was requested to be continued.

Accidental Death and Dismemberment (AD&D)

(Note: This benefit does not apply to COBRA participants)
THIS BENEFIT IS PART OF AN ERISA PLAN

A Quick Look at Benefits

Key features of the TI Accidental Death and Dismemberment (AD&D) Insurance benefits are highlighted below.

- If you are a full-time TIer or a part-time TIer on an alternative work schedule (minimum 20-hours-a-week schedule), you may participate in the AD&D Plan immediately on your date of hire
- You are eligible for coverage of two, four, six, eight or 10 times your annual base earnings. Coverage amounts range from a minimum of $10,000 to a maximum of $500,000, rounded to the nearest $1,000
- You may elect a flat coverage of $200,000
- You may elect coverage for your spouse or same-gender domestic partner at 60 percent of your coverage
- Dependent children are automatically covered for one-tenth of the TIer's coverage, up to $50,000
- Worldwide health assistance is available through International SOS for TIers and their dependents while on personal travel if they have AD&D coverage

When You May Enroll

New hires have 30 days from their date of employment to choose AD&D coverage. All other TIers may choose AD&D coverage, or change existing AD&D coverage, during annual enrollment. You can also make changes to your coverage if an appropriate qualified status change occurs. Please see the Introduction section for information about qualified status changes.

Your Benefits

Accident Protection

The AD&D Insurance benefit provides protection if death or dismemberment is caused by a covered accident. Benefits are payable if the loss is a *result of an accident*, whether you are at work, at home or traveling for business or pleasure.

Your Coverage

You may enroll for coverage (called the principal sum) equal to two, four, six, eight or 10 times your annual base earnings, rounded to the nearest $1,000. Minimum coverage is $10,000; maximum is $500,000. You may also elect a flat $200,000 principal sum amount.

TI Sales Representatives — If you are covered by a sales bonus plan, your annual base salary may include your sales bonus agreement amount, used in the EMISET (estimated monthly income for sales bonus eligible TIers) calculations for income/insurance protection.

When your salary changes, your AD&D coverage changes at the same time.

Coverage for Spouse or Same-Gender Domestic Partner

If your spouse or same-gender domestic partner is not eligible for coverage as a TI employee, you may choose to insure him or her for 60 percent of your coverage (rounded to the nearest $1,000). You may enroll your spouse or same-gender domestic partner within 30 days from the date of your employment or during any enrollment period.

Coverage for Children

When you sign up for AD&D coverage, your eligible children are automatically insured for 10 percent of your amount of coverage (rounded to the nearest $500). The children's coverage is limited to $50,000 per child. If both parents are TIers and both are covered by AD&D, coverage will be 10 percent of the parent with the highest benefit amount. This coverage is provided whether or not you insure your spouse or same-gender domestic partner.

Benefit Schedule

If injuries result in death or dismemberment to you, your covered spouse or same-gender domestic partner or your eligible children within 365 days after the accident, the following benefits are provided by the plan:

What is Covered — What is Paid

Loss of	Benefit Payable
Life	Principal sum
Both hands or both feet or sight of both eyes	Principal sum
One hand and one foot	Principal sum
One hand or foot and sight of one eye	Principal sum
Speech and hearing in both ears	Principal sum
Use of all four limbs	Principal sum
Speech or hearing in both ears	50% of principal sum
Either hand or foot	50% of principal sum
Sight of one eye	50% of principal sum
Use of any three limbs	75% of principal sum
Use of any two limbs	66% of principal sum
Use of one limb	50% of principal sum
Thumb and index finger of the same hand	25% of principal sum
Hearing of one ear	10% of principal sum

Exclusions and Limitations

If you should suffer more than one of the covered losses from any one accident, you will receive only the benefit for the largest covered loss.

Losses

Losses are defined as follows:

- Hands and feet — Actual severance through or above wrist or ankle joint
- Eyes — Total and permanent loss of sight
- Thumb and index finger — Actual severance through or above the metacarpophalangeal joints

"Loss of use" is defined as total paralysis of a limb or limbs which is determined by competent medical authority to be permanent, complete and irreversible.

Loss of speech and hearing means total and permanent loss.

Common Disaster

If you and your covered spouse or same-gender domestic partner die as the result of the same covered accident, your spouse's or same-gender domestic partner's benefit is automatically raised to your benefit amount. The deaths must occur within 180 days of the accident. However, if both husband and wife are TIers, benefits for each one will be equal to the principal sum amount, and no increase will apply. The most paid in any event is the Principal Sum.

Death Benefit

As noted in the preceding table, your beneficiary will receive the full principal sum under AD&D insurance if you die as the result of a covered accident. It is important to note that this death benefit is in addition to your TI Group Life Insurance coverage. If the accident occurred while you were traveling on TI business, this benefit is in addition to your TI Business Travel Accident coverage.

Higher Education Benefit

The plan also includes a higher education benefit that will pay a benefit equal to five percent of your principal sum to a maximum of $5,000. This amount will be paid for each year the dependent child(ren) continues his/her education, not to exceed four consecutive years. This benefit is for dependent children:

- Who are attending an institution of higher learning on a full-time basis on the date of loss, or
- Who are high school seniors and attend an institution of higher learning within 12 months of the date of loss

If you have no qualified dependents, an additional lump sum payment of $1,000 will be made to your beneficiary.

Coverage During a Leave of Absence

Your AD&D insurance will continue during any approved leave of absence up to 12 months, except military leave. AD&D coverage for TIers on military leave of absence is discontinued, based on the exclusion of benefits during military service. TIers on military leave of absence may continue AD&D

coverage on spouses or same-gender domestic partners and children at group rates following the military leave of absence start date. You must make arrangements to pay the required costs during the time you are on leave of absence. You will be billed for coverage. If you do not pay your bill, your coverage will be dropped. Payroll deductions will resume once you return to work.

Coverage During Total Disability

If you become totally disabled as a result of an accidental injury, you will be eligible for waiver of your AD&D cost if:

- You have AD&D coverage when you become disabled as defined as "the inability of the insured to perform the substantial and material duties of his or her regular occupation and as attended to on a regular basis by a duly licensed physician other than the insured or a member of his or her immediate family"
- You remain totally disabled longer than six consecutive months.

Your coverage will end when you are no longer totally disabled because of the injury; or you reach age 70; or the policy terminates.

Exclusions and Limitations

The AD&D insurance does not cover any loss that is caused by, contributed to or results from purposely self-inflicted injuries; suicide or attempted suicide; illness or disease; pregnancy, including childbirth, but not including complications thereof; infection, except pus forming infections from an accidental wound; flying in any aircraft being used for aerial photography, test or experimental purposes or any aircraft that requires a special permit or waiver from the agency that has jurisdiction over civil aviation, even if granted; or any type of active, full-time, military service.

In addition, this policy does not cover any loss caused by or resulting from declared or undeclared war or any act thereof occurring within any of the states in the United States of America, the District of Columbia, the covered person's country of residence, and the following countries: Afghanistan, Algeria, Bahrain, Chechnya, China, Cyprus, Egypt, India, Indonesia, Iran, Iraq, Israel, Jordan, Kashmir, Kazakhstan, Kuwait, Lebanon, Libya, Macedonia, Nigeria, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sri Lanka, Sudan, Syria, Tajikistan, Turkey, Turkmenistan, United Arab Emirates, Uzbekistan, Yemen.

Beneficiary Information

Designation of Beneficiaries

On your date of hire, you should make a beneficiary election on the "Your Profile" tab on the Home Page of the Fidelity NetBenefits® Web site. This allows you to name the beneficiaries you wish to receive benefit payment. Please be ready to provide your beneficiary(ies) complete name, Social Security number and date of birth. Later, if you wish to change your beneficiaries, you can change your election(s) on the "Your Profile" tab on the Fidelity NetBenefits® Web site or contact the TI Benefits Center. You can make changes to your beneficiaries at any time.

You may name specific individuals, a trust, a charitable organization, or your estate as beneficiaries. Zurich American Insurance Company (the Claims Administrator) will make prompt payment directly to the named beneficiary unless a written notice of an adverse claim is received before making a payment. If no AD&D beneficiary has been designated, Zurich American will pay benefits according to the life insurance beneficiary designees. If no beneficiary designee on life insurance, Zurich American will use the succession rules to determine beneficiary (spouse or same-gender domestic partner, child or children, mother or father, sisters or brothers, estate).

If Your Beneficiary is a Minor

If your named beneficiary is a minor at the time of your death, Zurich American has the right to require the court to appoint a legal guardian before benefit payments are made on the minor's behalf. Zurich American also can pay benefits to persons or institutions caring for the minor.

To eliminate duplicate payments, Zurich American may require legal proceedings to take place before benefits are paid.

Spouse or same-gender domestic partner and dependent child benefits are automatically paid to the TIer, unless another beneficiary is on file.

Claiming Benefits

NOTE: All Claims are administered by the Claims Administrator, Zurich American. TI has not reserved the right to interpret the terms of the plan or policy with respect to fully insured benefits. All AD&D insurance benefits are provided solely through the insurance policy issued by Zurich American. No benefits other than the benefits available under the policy from the insurance company are available. No benefits are provided by TI outside of the insurance policy.

If you should have a loss that is covered, you or your beneficiary (claimant) must notify the TI Benefits Center, who will notify Zurich American of the coverage and provide claimant contact information. Zurich American will contact the claimant and mail the claim forms. The claimant must complete the forms and return them to Zurich American. Claim should be sent to:

Zurich American Insurance Company
PO Box 9102
Plainview, NY 11803-9002
or
58 South Service Road
Melville, NY 11747-2342

Showing Proof of Loss

Full information about the nature and extent of your accident must be included when you or your beneficiary return the claim forms. Copies of doctor's statements, hospital records and other written proof will be treated as physical evidence of the claim. In case of death, an autopsy may be requested at the expense of Zurich American.

Your request for benefits must be made within 90 days of the date of loss, claims submitted after this deadline will be denied as untimely. You may be requested to furnish proof of your continuing disability from time to time. Any and all requests will come directly from Zurich American.

Payment of Claim

On receipt of the claim form and any attachments, Zurich American will review the claim. If Zurich American supports the facts of the claim, a check for the amount of benefit will be mailed to you or your beneficiary.

Claim Denial and Appeal Information

If a Claim is Denied

A claim for disability or death benefits under AD&D insurance must be submitted to the Claims Administrator at the time and in the manner prescribed by the Claims Administrator.

If the Claims Administrator determines that you are not entitled to receive all or part of the benefits you claim, a notice will be provided to you within a reasonable period of time, but no later than 90 days from the day your claim was received by the Claims Administrator. This notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will describe (i) the Claims Administrator's determination, (ii) the basis for the determination (along with appropriate references to pertinent benefit provisions on which the denial is based), and (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, the Claims Administrator may not be able to make a determination within 90 days from the day your claim for benefits was submitted. In such situations, the Claims Administrator, in its sole and absolute discretion, may extend the 90-day period for up to 180 days, as long as the Claims Administrator provides you with a written notice within the initial 90-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

AD&D Insurance Claim Appeals

If your claim that you are entitled to AD&D is denied, you must appeal the Claims Administrator's denial by requesting a review of your claim by the Claims Administrator. Your written request for an appeal must be received by the Claims Administrator within 60 days of the date you received your notification of the Claims Administrator's denial. Your request for an appeal should be mailed to:

Zurich American Insurance Company
PO Box 9102
Plainview, NY 11803-9002
or
58 South Service Road
Melville, NY 11747-2342.

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits. You may also request reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You will not be charged for this information. The review will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in the Claims Administrator's initial determination of your claim.

If, after reviewing your appeal and any further information that you have submitted, the Claims Administrator denies your claim, either in whole or in part, a notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 60 days from the day your request for a review was received by the Claims Administrator. In the event that an extension of time for processing is required, you will be provided a written notice of the extension not later than 60 days from the day your request for a review was received by the Claims Administrator. In such situations, the Claims Administrator, in its sole and absolute discretion, may extend the 60-day period for up to 120 days, as long as the Claims Administrator provides you with a written notice within the initial 60-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

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 Claims Administrator based its determination, (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.

Termination of Coverage

Your AD&D benefit coverage will terminate on the earliest of the following:

- The date this plan is canceled
- The covered person ceases to be an eligible person
- The date you end employment with TI (including retirement)
- The end of the period for which costs are paid

When Dependent Coverage Stops

Coverage for your legal spouse or same-gender domestic partner (who is not a TI employee) or your eligible dependent children will terminate automatically on the earliest of the following:

- The date you cease to be an employee of TI
- The date you cease paying AD&D costs for spouse or same-gender domestic partner coverage
- The date spouse or same-gender domestic partner or dependent coverage is canceled
- The date an individual is no longer your legal spouse or unmarried dependent child
- The date your dependent child reaches age 19 or, if attending school on a full-time basis, up to age 25
- The date a child who is dependent by reason of physical or mental disability ceases to be a dependent

Conversion

On termination of coverage, you may purchase AD&D coverage under an individual insurance policy for a coverage amount not to exceed the amount for which you were insured under the group policy, up to a maximum of $100,000. Application for conversion must be made within 31 days after your coverage under the group plan ends. You must have a permanent U.S. address for conversion of coverage. If you cover your spouse or same-gender domestic partner, you may purchase an individual insurance policy with family coverage.

If you die, your spouse or same-gender domestic partner may convert up to 60 percent of your coverage amount, up to a maximum of $100,000. Your dependent child(ren) may convert up to 10 percent of your coverage amount, up to a maximum of $25,000.

If you become dismembered or die during the 31-day period in which you are eligible to convert your insurance, you or your beneficiary will receive AD&D benefits.

To convert to an individual policy, call Zurich American at 800-834-1959.

Eligibility for conversion coverage shall end at age 70.

International SOS

International SOS provides 24-hour, worldwide health assistance for TIers and dependents accompanying a TIer on business travel who are 100 miles or more from their home or in another country. TIers and their dependents who are covered by employee-paid AD&D insurance also have access to 24-hour, worldwide health assistance services through International SOS during personal travel.

More information is available online at benefits.ti.com. Select Live Healthy Web site, then TravelWell.

Business Travel Accident Insurance

(Note: This benefit does not apply to COBRA participants)
THIS BENEFIT IS PART OF AN ERISA PLAN

A Quick Look

Key features of the TI Business Travel Accident Insurance benefit are:

- The plan covers all TIers
- You are covered on your first day of employment
- Claims paid are in addition to other TI Group Life Insurance benefits, AD&D Insurance benefits and your personal life insurance coverage
- Your coverage is in effect while traveling on authorized TI business. The benefit payable is five times your annual base salary, up to a maximum of $500,000
- International SOS provides worldwide health assistance to TIers and their accompanying dependents on business travel if they have AD&D coverage

Eligibility

The plan covers all TIers worldwide. There are no service requirements for eligibility. Your enrollment is automatic, and your coverage begins on the date you become actively employed at TI.

All employees of TI or its affiliates, associated and subsidiary companies are participants in the plan.

Cost — Who Pays

TI pays the entire cost of the benefit. There is no cost to you.

Your Benefits

The TI Business Travel Accident Insurance benefit provides insurance coverage for accidental death or dismemberment while traveling on authorized TI business. Authorized TI business means you have approval to travel from your supervisor before departure. Side trips (not exceeding 30 days) attached to a business trip may also be covered.

Coverage begins at the actual start of your TI business trip, whether from your home, another location or the place where you work. A covered trip ends when you return to your home or the place where you work, whichever occurs first.

Business travel includes travel from plant to plant on TI business. *Coverage does not include travel to and from your home and your normal workplace, unless on scheduled business travel*.

While on a common carrier, the plan also includes:

- Travel under TI sponsorship on a bona fide leave of absence, home leave or vacation and
- Travel while in transfer status pending permanent residence but not longer than 120 days.

Amount of Coverage

Your coverage is equal to five times your annual base salary, subject to a minimum of $250,000 and a maximum of $500,000. (This is called the principal sum.)

Benefit Schedule

Accidental death or dismemberment losses caused by or resulting from a covered accident, if such losses occur within one year after the date of the accident, are payable by the plan as follows:

Loss of	Benefit Payable
Life	Principal sum
Both hands or both feet or sight of both eyes	Principal sum
One hand and one foot	Principal sum
One hand or foot and sight of one eye	Principal sum
Speech and hearing in both ears	Principal sum
Use of all four limbs	Principal sum
Speech or hearing in both ears	50% of principal sum
Either hand or foot	50% of principal sum
Sight of one eye	50% of principal sum
Use of any three limbs	75% of principal sum
Use of any two limbs	66% of principal sum
Use of one limb	50% of principal sum
Thumb and index finger of the same hand	25% of principal sum
Hearing of one ear	10% of principal sum

Death Benefit

Your beneficiary will receive the full principal sum under the Business Travel Accident insurance if you die as a result of a covered accident while traveling on TI business.

Losses

Losses are defined as follows:

- Hands and feet — Actual severance through or above wrist or ankle joint
- Eyes — Total and permanent loss of sight

- Thumb and index finger — Actual severance through or above the metacarpophalangeal joints

"Loss of use" is defined as total paralysis of a limb or limbs which is determined by competent medical authority to be permanent, complete and irreversible.

Loss of speech and hearing means total and permanent loss.

Exclusions and Limitations

If you should suffer more than one of the covered losses from any one accident, you will receive only the benefit for the largest covered loss.

You are not covered by the plan during any trips if:

- The travel is not authorized TI business
- You are commuting to or from your usual place of employment

Coverage Not Payable

This insurance does not cover any loss that is caused by, contributed to or results from purposely self-inflicted injuries; suicide or attempted suicide; illness or disease; pregnancy, including childbirth, but not including complications thereof; infection, except pus forming infections from an accidental wound; flying in any aircraft being used for aerial photography, test or experimental purposes or any aircraft that requires a special permit or waiver from the agency that has jurisdiction over civil aviation, even if granted; or any type of active, full-time, military service.

In addition, this policy does not cover any loss caused by or resulting from declared or undeclared war or any act thereof occurring within any of the states in the United States of America, the District of Columbia, the covered person’s country of residence, and the following countries: Afghanistan, Algeria, Bahrain, Chechnya, China, Cyprus, Egypt, India, Indonesia, Iran, Iraq, Israel, Jordan, Kashmir, Kazakhstan, Kuwait, Lebanon, Libya, Macedonia, Nigeria, Oman, Pakistan, Qatar, Saudi Arabia, Somalia, Sri Lanka, Sudan, Syria, Tajikistan, Turkey, Turkmenistan, United Arab Emirates, Uzbekistan, Yemen.

Multiple Accident Limitations

The maximum payable under this plan to all insured TIers for any one aircraft accident is $10 million. The maximum payable to all TIers who suffer covered losses at the annual stockholder's meeting is $20 million. In either event, each TIer will receive a percentage of the applicable coverage amount according to how his or her losses compare with the losses of all other TIers involved.

Beneficiary Information

Designation of Beneficiaries

Zurich American Insurance Company (the Claims Administrator) will make prompt payment directly to the named AD&D beneficiary unless a written notice of an adverse claim is received before making a payment. If no AD&D beneficiary has been designated, Zurich American will pay benefits according to the life insurance beneficiary designees. If no beneficiary designee on life insurance, Zurich American will use the succession rules to determine beneficiary (spouse or same-gender domestic partner, child or children, mother or father, sisters or brothers, estate).

For TIers not on a U.S. benefit plan, Zurich American will pay benefits according to the succession rules (spouse, child or children, mother or father, sisters or brothers, estate).

If Your Beneficiary is a Minor

If your named beneficiary is a minor at the time of your death, Zurich American has the right to require the court to appoint a legal guardian before benefit payments are made on the minor's behalf. Zurich American also can pay benefits to persons or institutions caring for the minor.

To eliminate duplicate payments, Zurich American may require legal proceedings to take place before benefits are paid.

Claiming Benefits

NOTE: All claims are administered by the Claims Administrator, Zurich American. TI has not reserved the right to interpret the terms of the plan or policy with respect to fully insured benefits. All Business Travel Accident Insurance benefits are provided solely through the insurance policy issued by Zurich American. No benefits other than the benefits available under the policy from the insurance company are available. No benefits are provided by TI outside of the insurance policy.

If you suffer a loss that is covered by the plan, you or your beneficiary must notify the TI Benefits Center, who will notify Zurich American of the coverage and contact information. Zurich American will contact the claimant and mail the claim forms. The claimant must complete the forms and return them to Zurich American. Claim should be sent to:

Zurich American Insurance Company
PO Box 9102
Plainview, NY 11803-9002
or
58 South Service Road
Melville, NY 11747-2342.

Showing Proof of Loss

Full information about the nature and extent of your accident must be included when you or your beneficiary return the claim forms. Copies of doctor’s statements, hospital records and other written proof will be treated as physical evidence of the claim. In case of death, an autopsy may be requested at the expense of Zurich American.

Your request must be made within 90 days of the date of loss. You may be requested to furnish proof of your continuing disability from time to time. Any and all requests will come directly from Zurich American.

Payment of Claim

On receipt of the claim form and any attachments, Zurich American will review the claim. If Zurich American supports the facts of the claim, a check for the amount of benefit will be mailed to you or your beneficiary.

Claim Denial and Appeal Information

If a Claim is Denied

A claim for Business Travel Accident Insurance disability or death benefits must be submitted to the Claims Administrator at the time and in the manner prescribed by the Claims Administrator.

If the Claims Administrator determines that you are not entitled to receive all or part of the benefits you claim, a notice will be provided to you within a reasonable period of time, but no later than 90 days from the day your claim was received by the Claims Administrator. This notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will describe (i) the Claims Administrator's determination, (ii) the basis for the determination (along with appropriate references to pertinent benefit provisions on which the denial is based), and (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, the Claims Administrator may not be able to make a determination within 90 days from the day your claim for benefits was submitted. In such situations, the Claims Administrator, in its sole and absolute discretion, may extend the 90-day period for up to 180 days, as long as the Claims Administrator provides you with a written notice within the initial 90-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

Business Travel Accident Insurance Claim Appeals

If your claim that you are entitled to Business Travel Accident Insurance is denied, you must appeal the Claims Administrator's denial by requesting a review of your claim by the Claims Administrator. Your written request for an appeal must be received by the Claims Administrator within 60 days of the date you received your notification of the Claims Administrator's denial. Your request for an appeal should be mailed to:

Zurich American Insurance Company
PO Box 9102
Plainview, NY 11803-9002
or
58 South Service Road
Melville, NY 11747-2342.

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits. You may also request reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You will not be charged for this information. The review will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in the Claims Administrator's initial determination of your claim.

If, after reviewing your appeal and any further information that you have submitted, the Claims Administrator denies your claim, either in whole or in part, a notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will be provided to you within a reasonable period of time, but not later than 60 days from the day your request for a review was received by the Claims Administrator. In the event that an extension of time for processing is required, you will be provided a written notice of the extension not later than 60 days from the day your request for a review was received by the Claims Administrator. In such situations, the Claims Administrator, in its sole and absolute discretion, may extend the 60-day period for up to 120 days, as long as the Claims Administrator provides you with a written notice within the initial 60-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

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 Claims Administrator based its determination, (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.

Termination of Coverage

Your coverage will end on the earliest of:

- The date you cease to be an employee
- The date the policy is canceled by TI or the insurance company

International SOS

International SOS provides 24-hour, worldwide health assistance for TIers and dependents accompanying a TIer on business travel who are 100 miles or more from their home or in another country. TIers and their dependents who are covered by employee-paid AD&D insurance also have access to 24-hour, worldwide health assistance services through International SOS during business travel.

More information is available online at benefits.ti.com. Select the Live Healthy Web site, then TravelWell.

ERISA

ERISA Guidelines

The Employee Retirement Income Security Act of 1974 (ERISA) protects your rights under your benefit plans and ensures you receive appropriate information.

- Texas Instruments Incorporated Welfare Benefits Plan
    - TI Employees Health Benefit Plan (includes medical and dental)
    - Texas Instruments Incorporated Flexible Benefits Plan
    - Disability Benefit Plan of Texas Instruments Incorporated
    - Accidental Death & Dismemberment benefit
    - VSP® benefit
    - Group Term Life Insurance benefit
    - Business Travel Accident benefit

Texas Instruments Benefit Plans Under ERISA

Texas Instruments Incorporated Welfare Benefits Plan

Type of Plan

Hospitalization and Medical-Care Benefit
Dental Benefit
Flexible Spending Benefit
Disability Benefit
Accidental Death or Dismemberment Benefit
Vision Benefit
Business Travel Accidental Death and Dismemberment Insurance Benefit
Group Term Life Insurance Benefit

Employer Identification Number: 75-0289970

Plan Number: 501

Plan Trustee

The Northern Trust Company
Master Trust
Corporate Financial Services
South LaSalle Street
Chicago, Illinois 60675

Plan Year

January 1 through December 31

Sponsoring Employer

Texas Instruments Incorporated
12500 TI Boulevard
Dallas, Texas 75243

Agent for Service of Legal Process

Joseph F. Hubach, Secretary
Texas Instruments Incorporated
12500 TI Boulevard
Dallas, Texas 75243

Plan Administrator:

Texas Instruments Incorporated Welfare Benefits Plan
Attn: Plan Administrator
P.O. Box 650311
Dallas, Texas 75265

Claims Administrators/Insurance Companies:

The Administration Committee is the appointed Plan Administrator for purposes of claim appeals related to the TI Employees Health Benefit Plan, the Texas Instruments Incorporated Flexible Benefits Plan and the Disability Benefit Plan of Texas Instruments Incorporated.

PPO: Blue Cross Blue Shield PPO benefits are administered by Blue Cross Blue Shield. 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

HMOs: HMO benefits are fully insured and claims are administered by the respective HMOs.

CIGNA Arizona
900 Cottage Grove Road
Hartford, CT 06152

CIGNA Houston/Austin
PO Box 28087
Raleigh, NC 27611

CIGNA North Texas
PO Box 28087
Raleigh, NC 27611

CIGNA North Carolina
54 Regional Drive
Concord, NH 03302

HMO Blue New England
Landmark Center, 401 Park Drive
Boston, MA 22153

HMO Illinois
300 E. Randolph Street
Chicago, IL 60601

Kaiser Northern California
1305 Tommydon Street
Stockton, CA 95210

Kaiser Southern California
PO Box 1840
Corona, CA 91718

Optimum Choice (MAMSI)
UnitedHealthcare of the Mid-Atlantic
4 Taft Court
Rockville, MD 20850

PacifiCare California
5701 Katella Avenue
Cypress, CA 90630

Dental: The Dental benefit is self-insured and claims are administered by MetLife Dental.

Dental
MetLife Dental
PO Box 14093
Lexington, KY 40512

DHMO: The DHMO benefit is fully insured and claims are administered by Aetna.

Aetna
2777 Stemmons Freeway, #300
Dallas, TX 75207

AD&D: The Accidental Death & Dismemberment benefit is fully insured and claims are administered by Zurich American Insurance Group.

Accidental Death & Dismemberment Policy
Zurich American Insurance Group
Accident & Health Special Risk
One Liberty Plaza
New York, New York 10006
Policy # GTU-2620650

Disability Plan: The Disability Benefit Plan (which is part of the Texas Instruments Incorporated Welfare Benefit Plan) is self-insured and claims are administered by the TI Disability Benefit Plan Claims Administrator.

TI Disability Benefit Plan
TI Disability Claims Administrator
PO Box 650311, MS 3938
Dallas, TX 75265

TI Flexible Benefits Plan: The TI Flexible Benefits Plan (which is part of the Texas Instruments Incorporated Welfare Benefit Plan) is self-insured and claims are administered by Ceridian.

TI Flexible Benefits Plan
Ceridian FSA Services
P.O. Box 534134
St. Petersburg, FL 33747

VSP: The VSP benefit is a voluntary benefit paid for solely by employees. Claims are administered by VSP.

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

Group Term Life and Business Travel Accident: These benefits are fully insured and claims are administered by the respective insurers.

Group Term Life Insurance
Metropolitan Life Insurance Company
1 Madison Avenue
New York, New York 10010
Policy # 94757

Business Travel Accidental Death and Dismemberment Insurance
Zurich American Insurance Group
Accident & Health Special Risk
One Liberty Plaza
New York, New York 10006
Policy # GTU-2620651

Your Rights Under ERISA

As a participant in any or all of the plans described in the preceding summary plan descriptions, 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(s) and Benefits

You may examine, without charge, at the Plan Administrator's office or at other specified locations, all documents governing the plan(s), including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan(s) 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 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.

There may be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 timeframes.

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 annual report from the plan and do not receive them within 30 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 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.

Addendum

Updates as of Jan. 12, 2010

Hearing Loss Treatment

(Addition to section on Other Covered Expenses — Blue Cross Blue Shield PPO, page 36)

The Blue Cross Blue Shield PPO will reimburse up to $1,000 maximum per person during any three-year period for treatment of hearing loss. This limit is based on the allowed amount. To be covered, treatment must consist of (i) the provision of hearing aids and/or (ii) services related to hearing disabilities if the services are considered medically necessary.

Benefits for treatment of hearing loss:

- Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Special One-Time COBRA Election and Subsidy

(Replaces section on page 102)

If a participant involuntarily terminated on or after September 1, 2008, and before February 17, 2009, and did not elect COBRA or had COBRA continuation coverage in effect on February 17, 2009, he or she had a one-time opportunity to elect COBRA continuation coverage a second time, within 60 days after receiving appropriate notice from TI.

The participant may be entitled to a subsidy if involuntarily terminated between September 1, 2008, and February 28, 2010 (or such later deadline if the duration is extended by legislation). The subsidy of the COBRA continuation coverage, depending on eligibility, will continue for the lesser of: (i) 15 months, (ii) until the date the COBRA continuation coverage would have expired had the participant elected COBRA continuation coverage at the time of the original COBRA election period, or (iii) until the occurrence of an event specified in the Early Termination of COBRA Continuation Coverage section below.