Texas Instruments

2021 Health and Insurance Benefits Summary Plan Description

Issued: October 2020

Update to the
2021 Summary Plan Description
2021 Summary of Material Modifications

Texas Instruments Incorporated (TI) is required to notify participants of important changes to the TI Welfare Benefits Plan and/or the TI Retiree Health Benefit Plan (collectively the "Plan"). This notification, called a Summary of Material Modifications (SMM), reflects the provisions that are effective March 1, 2020. And, it is intended to update the Plan's 2021 Summary Plan Description (SPD), and is incorporated as such. The complete 2021 SPD can be found under the Health & Insurance Reference Library on the Fidelity NetBenefits® website at netbenefits.com/ti.

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

- The 30-calendar-day period (or 60-calendar-day period, if applicable) to request HIPAA special enrollment (for medical coverage only) as a result of:
    - Loss of eligibility for group health coverage or individual health insurance coverage
    - Acquisition of a new spouse or dependent by marriage, birth, adoption, or placement for adoption
    - Loss of Medicaid/CHIP eligibility
    - Becoming eligible for a state premium assistance subsidy under Medicaid/CHIP
- The 60-calendar-day election period for COBRA continuation coverage
- The 45-calendar-day deadline for making an initial COBRA premium payment and the 30-calendar-day grace period for making subsequent COBRA premium payments
- The 60-calendar-day deadline to notify the Plan of a COBRA qualifying event such as divorce/legal separation or a dependent child losing eligibility under the Plan or a disability determination
- The date by which you may file a benefit claim under the Plan's claims procedures
- The date by which you may file an appeal of an adverse benefit determination under the Plan's appeals procedures
- The four-month deadline by which you may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination
- The deadline by which you may provide information to perfect a request for external review upon a finding that the request was not complete

You can find additional details regarding these extensions at:

dol.gov/newsroom/releases/ebsa/ebsa20200428

For specifics regarding these changes and how they may impact you, or if you would like a printed copy of the SPD, please contact the TI Benefits Center at Fidelity through TI HR Connect at 888-660-1411, option 1. Representatives are available from 8:30 a.m. to 8:30 p.m. Eastern time Monday through Friday, excluding all New York Stock Exchange holidays except Good Friday.

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Important Contact Information

TI HR Connect - One number to access benefit providers and obtain guidance from the TI Benefits Center at Fidelity
• Blue Cross Blue Shield (BCBS) HDHP/PPO — bcbstx.com
• Pharmacy Network (CVS Caremark) (BCBS HDHP and PPO participants) — caremark.com
• Work-Life Resources (formerly the Employee Assistance Program or EAP) (Magellan Healthcare) — MagellanAscend.com
• Delta Dental Basic/Dental Plus — deltadentalins.com/TI
• Flexible Spending Accounts (FSA) — healthequity.com
• TI Benefits Center at Fidelity — netbenefits.com/ti
  ○ Health and Insurance
  ○ Fidelity HSA Services
  ○ TI Extended Health Benefits (retiree health)
• Sedgwick, administrator of TI's absence and disability leave program — claimlookup.com/TI
	888-660-1411

• UnitedHealthcare Global — members.uhcglobal.com
  ○ Worldwide Business Travel Medical
  ○ Worldwide provider referral service to obtain medical assistance and evacuation
	866-870-3475 or
	763-274-7364

• Life Insurance (MetLife)	800-638-6420
• VSP® — vsp.com	800-877-7195
• Accidental Death & Dismemberment (MetLife)	800-638-6420
• Business Travel Accident (Zurich American Insurance Company)	800-834-1959

Regional Health Maintenance Organization (HMO)

HMO	(Area Served)	Main Number
• Kaiser HMO — kp.org	(Northern California)	800-278-3296

Dental Health Maintenance Organization

• Aetna DMO — aetna.com	877-238-6200

Introduction

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

The SPD 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 SPD and the plan documents, the plan documents will govern. Plan documents include any documents describing the self-insured benefits as well as any insurance policy or contract detailing the fully-insured benefits. The 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 should not be interpreted as an employment guarantee or as creating an employment contract.

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 as determined by TI, in its sole and absolute discretion, regardless of how you are treated for wage withholding purposes or otherwise if:

- You are providing services on behalf of a third party pursuant to an agreement where you are designated by TI as an independent contractor or otherwise ineligible for benefits
- You have agreed in writing that you are not an employee or are not otherwise eligible to participate
- You are 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 U.S. federal tax law
- You are an intern employee
- Your compensation is reported to the IRS on a form other than a Form W-2

Eligible Dependents – You can enroll your eligible dependents in medical, dental, vision, accidental death and dismemberment (AD&D) and/or life insurance benefits. However, you must be enrolled in medical, dental and/or vision benefits to enroll your eligible dependents in the same benefit option. If you enroll in AD&D, you may enroll your spouse or domestic partner. If you enroll in AD&D, dependent children are automatically covered for 10 percent of your coverage (rounded to the nearest $500), up to $50,000. You are automatically enrolled in basic life insurance coverage so you may enroll your spouse, domestic partner and/or child.

For each eligible dependent, you must provide dependent's name, date of birth and U.S. Social Security number (SSN) or an Internal Revenue Service Individual Taxpayer Identification Number (ITIN) to receive benefits. You may initially enroll an eligible dependent without a SSN or ITIN, however you should provide this number as soon as it is received. You may be required on an annual basis to provide a certification or other proof that your eligible dependents qualify as such under TI's health and welfare benefit plans and programs. The Plan Administrator reserves the right to determine the documentation that is necessary to support or prove eligibility.

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

- **Spouse:** Your "spouse" as recognized under U.S. federal tax law, or

- **Domestic Partner:** Your domestic partner of the same or opposite gender who meets the following criteria:
    - At least 18 years or older,
    - Unmarried,
    - Not be related by blood,
    - Financially interdependent or your domestic partner is primarily dependent on you for care and financial support,
    - Share a common residence for at least one year and intend to do so indefinitely,
    - Affirm you are in a committed relationship and intend to remain so, and
    - Not in a relationship to solely attain benefits.
- **Children:** Your children who meet one of the following requirements:
    - Your biological children including those who do not live with you, but for whom you have parental rights,
    - Legally adopted children or children for whom adoption papers were filed,
    - Stepchildren who live with you in a parent-child relationship at least 50% of the time and for whom you have financial responsibility as determined by U.S. federal tax law,
    - Children of your domestic partner living with you in a parent-child relationship and for whom you have assumed financial responsibility,
    - A child for whom you are legal guardian or managing conservator,
    - A foster child, placed in your care by a court,
    - A child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice, or
    - Your grandchildren who live with you and are claimed by you as dependents on IRS tax filings.

Two TIers Who are Married (or in a Domestic Partnership)

Under medical, dental and/or vision benefits, if you are married to (or in a domestic partnership with) another TIer, only one TIer may enroll the eligible spouse (or domestic partner) or child dependents. TIers cannot be covered both as an employee and as a dependent.

Under life insurance benefits, if you are married to (or in a domestic partnership with) another TIer, only one TIer may enroll the eligible child dependents. Both TIers may enroll their eligible spouse (or domestic partner) in spouse life insurance.

Under AD&D benefits, if you are married to (or in a domestic partnership with) another TIer, you may not enroll your eligible spouse (or domestic partner) in AD&D coverage if they are covering themselves under AD&D.

Under AD&D benefits, if both parents are TIers and both are covered by AD&D, coverage for the dependent children will be 10 percent of the parent with the highest benefit amount (rounded to the nearest $500), up to $50,000. This coverage is provided whether or not you insure your spouse or domestic partner.

Children - Eligibility for Medical, Dental, Vision, AD&D and/or Child Life Insurance

Your eligible dependent children for purposes of participation in medical, dental, vision, AD&D and/or child life insurance benefits include your son or daughter (including your biological child, stepchild, adopted or foster child, child of your domestic partner, or other child as defined above) who is under age 26.

If Your Dependent Child is Disabled

Dependent children 26 years of age or older who are physically or mentally disabled and such disability lends them incapable of self-support, may continue to be covered after the child otherwise ceases to meet the definition of an eligible dependent child, provided they were covered as dependents on the calendar day before their 26th birthday and if the disability occurred before the time that their status as a dependent child would otherwise end. Coverage is subject to approval. To continue coverage, you must contact the TI Benefits Center at Fidelity prior to the dependent child's 26th birthday, to notify them of the dependent child's disabled status otherwise eligibility will be forfeited.

Qualified Status Change Events

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 calendar days of your first calendar day as a TI employee
- Within 30 calendar days of a qualified status change, which includes:
    - Changes in legal marital status (marriage, judgment, decree or order resulting from a divorce, legal separation or annulment)
    - Changes in number of dependents (excluding birth or adoption)
    - Changes in employment status (yours, spouse's or domestic partner's)
    - Changes in dependent eligibility (meets or fails to meet eligibility requirements)
    - Significant changes in cost of health coverage
    - Loss of other health plan coverage, including reaching a plan's lifetime limit on all benefits (yours, spouse's, domestic partner's or dependents)
    - Changes in residence of the employee, spouse or domestic partner, or dependent (move out of an HMO's coverage area)
    - Changes in FMLA/CFRA leave status
    - Significant changes in cost of dependent daycare
    - Entitlement to Medicare or Medicaid by the employee, spouse or domestic partner, or dependent
    - Significant curtailment of TI health coverage
    - Loss of coverage under a governmental plan or educational institution plan, excluding the State child health insurance program (CHIP) or Medicaid program
    - Changes in legal custody that require health coverage for a child (including a Qualified Medical Child Support Order or a National Medical Support Notice)
    - Death of a spouse or domestic partner/dependent
    - Spouse or domestic partner, or dependent goes on or returns from a strike or lockout
    - Exhaustion of all available COBRA coverage for a spouse or domestic partner/dependent
    - Change made by spouse or domestic partner/dependent during annual enrollment for plan of the spouse or domestic partner/dependent
- Within 60 calendar days of a qualified status change, which includes:
    - Loss of coverage or become eligible to participate in a premium assistance program under Medicaid or a State child health insurance program
    - Adding a newborn or adopted child (qualified status change begins on the date of birth, date of adoption or date adoption papers were filed)

Note: Changes in coverage must be consistent with the change in status and may only be effective consistent with the requirements imposed by the IRS. If you fail to drop your spouse,

domestic partner or dependent child within 30 calendar days of the qualified status change causing the loss of eligibility for coverage, the individual who ceases to qualify as your dependent will be dropped from coverage when the TI Benefits Center at Fidelity discovers the ineligibility, however, the amount you pay for the coverage will not change for the current calendar year. If your spouse, domestic partner or dependent child ceases to qualify as an eligible dependent, they will only be eligible to elect COBRA continuation coverage if you notify the TI Benefits Center at Fidelity within 60 calendar days of the date your dependent ceases to qualify under the plan.

- Each year during annual enrollment

You may make appropriate changes to coverage, which are effective retroactive to the date of the qualified status change, by processing the Life Event change on the Fidelity NetBenefits® website at netbenefits.com/ti or by contacting the TI Benefits Center at Fidelity. After you have made the appropriate changes, you should print your "Confirmation of Benefit Election" page for your records, as this will serve as your confirmation.

If you move, you will need to update your home address with TI. To update your home address go to myinfolink.ti.com (select myHR tools). If you were hired prior to January 1, 2012, and are covered by an HMO and move out of the covered service area, you may enroll in the Blue Cross Blue Shield (BCBS) HDHP or BCBS PPO. In such cases, you must process your request on the Fidelity NetBenefits® website at netbenefits.com/ti or contact the TI Benefits Center at Fidelity within 30 calendar days of your move. Your coverage change will be effective retroactive to the date of your move, provided you notify the TI Benefits Center at Fidelity within 30 calendar days of the change.

What to Consider Before Declining Medical or Dental Coverage

Initially, COBRA coverage will only be available for those benefits you were covered under immediately 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. However, during annual enrollment following your initial COBRA election, you may elect COBRA coverage for TI health and welfare benefits previously unavailable due to your failure to participate in such benefits at the time you became eligible for COBRA provided you did not decline any available COBRA coverage during your initial election period. (COBRA stands for the Consolidated Omnibus Budget Reconciliation Act.)

Eligibility Claim Appeal Information

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

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

Claims for Eligibility

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

How to Appeal an Eligibility Claim Denial

First Level of Appeal of Eligibility Claim Denial

If you believe you or your dependent was incorrectly denied eligibility for a benefit plan or program sponsored by TI (including a rescission of coverage), you may request your claim be reviewed. To appeal, you will need to provide in writing the reasons why you do not agree with the determination within 180 calendar days after you receive notice of the denial based on eligibility. Send your appeal to:

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

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

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

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

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

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

Second Level of Appeal of Eligibility Claim Denial

If you believe the Plan Administrator incorrectly made an Adverse Benefit Determination on your, or your dependent's, eligibility, you may request your claim be reviewed for a second time. To appeal, you will need to provide in writing within 90 calendar days after you receive notice of the Adverse Benefit

Determination on eligibility the reasons why you do not agree with the determination and any issues, comments and additional information related to your appeal.

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

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

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

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

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

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

External review is not available for eligibility claims.

If You Need Assistance

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

Legal Action under U.S. Federal Laws

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

Any civil action must be brought within one (1) year of the date such claim was denied in the final level of the appeal process outlined above. You may not file a civil action after the expiration of this deadline.

Other Important Information

ERISA Information

In addition to your rights and obligations under 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.

Plan Interpretation

TI reserves the right and sole and complete discretion to interpret the Plan and its benefit options (excepting fully-insured benefits), as well as the right to delegate these duties to a Claims Administrator. Such discretionary interpretations of the Plan (including any policies or procedures under which it is operated) will be final and binding.

In no event may any representations by an agent of TI or the Claims Administrator change the terms of the benefit plans or programs. If you are in doubt about benefit provisions, contact the designated Claims Administrator.

Before-Tax Health & Insurance Benefits

(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.

Premiums you pay will be automatically paid on a before-tax basis if you are enrolled in:

- Blue Cross Blue Shield HDHP or PPO, or regional Health Maintenance Organization (HMO)
- Delta Dental (Basic or Plus) or Aetna Dental Health Maintenance Organization (DHMO)
- VSP®
- Disability Pay Continuance (DPC) Plus benefits
- Accidental Death and Dismemberment Insurance

Your Benefits

Your share of costs for medical, dental, vision, disability pay continuance plus and/or accidental death and dismemberment coverage for you and your tax qualified dependents 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 U.S. federal income or Social Security (FICA) taxes.

Limitations – Taxable Benefits

Life Insurance Coverage

There are no tax consequences for the first $50,000 of group basic life insurance. The Internal Revenue Service (IRS) sets the value of group term basic 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. The taxable amount is shown on your paycheck in the Earnings section.

Domestic Partner Coverage

If you choose to cover a domestic partner, under any benefits, who is not your dependent for tax purposes and/or their dependents, the value of the company's cost in providing such coverage will be imputed to you as income (and reported to the IRS) and shown on your paycheck in the Earnings section. Taxes related to such imputed income will be deducted from your paycheck on an after-tax basis.

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

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 premiums on a before-tax basis stops, and you will be billed for the plan premiums on an after-tax basis. If you do not pay your bill, your coverage will be dropped effective as of your last paid through date unless otherwise required by law. When you return to work, payment for coverage will resume automatically on a before-tax basis through TI payroll deductions.

If coverage was dropped due to non-payment, certain coverage in place prior to the loss in coverage will resume upon your return to work; however, you may experience a gap in coverage. Supplemental life and spouse/domestic partner life insurance coverage does not resume upon your return to work; rather, you are required to re-enroll and evidence of insurability may be required.

Flexible Spending Accounts

(Note: Only the Health Care Flexible Spending Account and the Dental/Vision Flexible Spending Account (HSA-Compatible) applies to COBRA participants)

ERISA PLAN, offered through the Texas Instruments Incorporated Flexible Benefits Plan

A Quick Look

TI offers three separate Flexible Spending Accounts (FSAs) to eligible employees through the Flexible Benefits Plan:

- Health Care FSA: An account for reimbursement of eligible out-of-pocket health care expenses for you and your eligible family members. May not be used if you are enrolled in the BCBS HDHP option with an HSA.
- Dental/Vision FSA (HSA-Compatible): An account for reimbursement of out-of-pocket dental and vision expenses for you and your eligible family members. May be used if you are enrolled in the BCBS HDHP option with an HSA.
- Dependent Daycare FSA: An account for reimbursement of dependent daycare expenses. If you are married, both you and your spouse must be employed.

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

- You have the opportunity to save money on your taxes by paying for eligible reimbursable expenses with money deducted from your pay before taxes are withheld.
- **You must enroll each year for the full year.** Your enrollment does not carry over to the next calendar year. You may only change your elections if you have an appropriate qualified status change and you notify the Plan Administrator within the 30 or 60 calendar day limit applicable to your qualified status change.
- Your participation is voluntary. You may contribute separately to one or more of the FSAs for which you are eligible or may decide not to contribute at all.
- There is no interest paid to you and no administrative fees (except if you are on COBRA for the Health Care FSA and/or the Dental/Vision FSA (HSA-Compatible)) are charged to you.
- Your contributions are made through payroll deductions.
- Eligible expenses must be submitted for reimbursement. (See section on Filing Claims for information on automatic submission of health care claims). Eligible expenses under the Dental/Vision FSA (HSA-Compatible) differ from those under the other FSAs.
- The money in one FSA cannot be transferred to another FSA.
- Any money left in an FSA which is not used by the end of the calendar year and for which a request for reimbursement was not postmarked by March 31 of the following calendar year will be forfeited. No refunds or carryovers are allowed.
- IRS regulations prohibit reimbursement from an FSA for expenses of domestic partners and/or their dependents, except for those who meet the applicable tax law definition of "dependent."
- If you and your domestic partner get married, you must notify the TI Benefits Center at Fidelity within 30 calendar days of the date of your marriage so your domestic partner will be recognized as your spouse and any medical expenses they incur after your marriage will be eligible to be reimbursed under the Health Care FSA or Dental/Vision FSA.

Impact on Social Security Benefits

Under current law, no FICA tax withholding is required on FSA 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

The plan is subject to nondiscrimination rules which require that TI ensure that contributions do not favor highly compensated employees. If it is determined, before or during any calendar year, that the plan may fail to satisfy for such calendar year any nondiscrimination rules 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 Flexible Spending Account (FSA)

How the Health Care FSA Works

During the calendar year, you can contribute up to $2,750, in whole dollar amounts to the Health Care FSA to be used for reimbursement of eligible health care expenses incurred during the calendar year. If you choose to participate, the minimum annual contribution is $100.

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

Depending on the medical and dental plan in which you enroll, you may need to submit a receipt for the expense to the Health Care FSA Claims Administrator. For the vision plan, you will need to submit a receipt for the expense to the Health Care FSA Claims Administrator. You will be reimbursed from your account for eligible expenses submitted by the required deadline only up to the amount for which you enrolled. Any reimbursement for eligible expenses is not taxable.

You must stay enrolled for the full calendar year, unless you have an appropriate qualified status change as described in the Introduction section.

How to Put Money in the Health Care FSA — Enrollment

You will make contributions to your account over the course of the calendar year through payroll deductions. **According to IRS regulations, any contributions placed in the Health Care FSA that are not used by the end of the calendar 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 calendar year and for which you will submit receipts and related documentation (or auto-submitted, if applicable) by the March 31 immediately following the calendar year.

If you go on a paid leave of absence, your contributions to your Health Care FSA 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, you will receive a bill for your Health Care FSA contributions. If you do not pay your bill, you will no longer be able to contribute to your account effective as of your last paid through date unless otherwise required by law.

Contribution amounts must be set within 30 calendar days of your date of hire or within 30 or 60 calendar days depending on the type of qualified status change or during annual enrollment. Please see the Introduction section for information about whether your specific qualified status change is subject to either

the 30 or 60 calendar day requirement. You cannot stop, reduce or increase your contributions during the calendar year unless an appropriate qualified status change occurs. **Generally, the IRS does not make an exception to this rule even if you make a mistake**.

If you experience a qualified status change, you may choose to change your contributions to your Health Care FSA, provided your change is consistent with the qualified status change (for example, you increase your contribution upon the birth of your child).

If you choose to increase your Health Care FSA election, the increased amount will be effective as of the date of the qualified status change. Expenses incurred prior to the date of the qualified status change may not be paid from the new election amount made to your account as a result of the qualified status change; however, they may be paid from any amount remaining of the amount you contributed before you changed your contributions. Expenses incurred on or after the date of the qualified status change may be paid from your newly elected amount or from any amount remaining of the amount you contributed before you changed your contributions.

While you may reduce your Health Care FSA election on a going forward basis, you may not reverse the contributions made prior to the date of the qualified status change. Expenses incurred prior to the date of the qualified status change may not be paid from the new election amount made to your account as a result of the qualified status change; however, they may be paid from any amount remaining of the amount you contributed before you changed your contributions. Expenses incurred on or after the date of the qualified status change may be paid from your newly elected amount or from any amount remaining of the amount you contributed before you changed your contributions.

It is important to consider the amount of money you elect to contribute to your Health Care FSA carefully. Money cannot be transferred between the Health Care FSA, Dependent Daycare FSA, and Dental/Vision FSA.

Filing Health Care Flexible Spending Account (FSA) Claims

If you are enrolled in the Blue Cross Blue Shield (BCBS) PPO (for both medical expenses and CVS Caremark prescription drug expenses) or Delta Dental (Basic or Plus), your claims will be automatically submitted for reimbursement to HealthEquity (formerly known as WageWorks). If you don't want reimbursement claims automatically sent to HealthEquity, you must log on to your HealthEquity account and select "No" for auto claims submission. 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 HealthEquity after the claim has been submitted and processed by BCBS PPO for medical expenses, CVS Caremark for prescription drug expenses or Delta Dental. As you may be aware, some providers may delay submitting claims for 30 calendar days or more.

If you are enrolled in the BCBS PPO, should you choose to file claims manually, and you have several pharmacy claims to submit, an alternative to submitting individual receipts for each prescription drug is to print and submit your history information from the caremark.com website. A claim form must accompany the CVS Caremark history information.

You must submit a claim reimbursement form if you participate in a regional HMO option. You can obtain a claim form on the Fidelity NetBenefits® website at netbenefits.com/ti. You can also obtain a claim form by contacting the HealthEquity Customer Service Center directly at 855-774-7441 or through their website at healthequity.com.

Claims may be mailed, faxed, or submitted online as follows:

by mail to:
HealthEquity Claims Administrator
P.O. Box 14053
Lexington, KY 40512

by fax to: 877-353-9236
Please do not use a fax cover sheet when submitting claims by fax, as this can cause delays.

or online: by accessing your account via healthequity.com and click on the “Submit Receipt or Claims” link. There is also an option to upload your receipt once you have submitted your claim online.

You’ll need to include itemized receipts or other supporting documentation, such as an Explanation of Benefits (EOB). Please refer to the HealthEquity 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 website to request an EOB.

Once your claim has been processed, you’ll receive notification from HealthEquity 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. To update your designated bank account, go to healthequity.com.

Deadline for Submitting Claims

All claims must be mailed and postmarked, faxed, submitted online or auto-submitted to HealthEquity **no later than three months after the end of the calendar year** in which the expenses were incurred **(that is by March 31 of the year following the calendar year in which you incurred the expense)**; claims submitted after this deadline will be denied as untimely.

Receiving Reimbursement

Expenses incurred prior to the participant’s effective date of enrollment in the Health Care FSA are not eligible for reimbursement. Expenses may 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. Similarly, any expenses incurred prior to the effective date of any increase to your elected contribution under the Health Care FSA are not eligible for reimbursement using amounts contributed as a result of the increase.

Health Care FSA claims will be reimbursed as received up to the amount of your total annual contribution election in effect at the time the claim was incurred.

Health Care FSA Claim and Appeal Information if a Claim is Denied

A Health Care FSA claim for benefits under the Flexible Benefits Plan must be submitted to HealthEquity, the Claims Administrator, by the claim deadline and in the manner prescribed by the Claims Administrator.

If HealthEquity 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 30 calendar days from the calendar day your claim was received by HealthEquity. This notice (which will be provided by 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), (iii) your right to receive, upon request and free of charge, all documents, relevant to your claim, (iv) the

appeal procedures you must follow to obtain a review of the determination, including the applicable time limits on such a review, and (v) 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, why the submission of additional information may be necessary and that you are afforded up to 45 calendar days from the calendar day you receive the notice to provide the additional information.

In certain instances, HealthEquity may not be able to make a determination within 30 calendar days from the calendar day your claim for benefits was received. In such situations, HealthEquity, in its sole and absolute discretion, may extend the 30-calendar-day period for up to 15 calendar 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-calendar-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

Health Care FSA First and Second Level Claim Appeals
If your claim for reimbursement from your Health Care FSA is denied, you may appeal HealthEquity's denial by requesting a first level review of your claim by the Claims Administrator. If you believe the Claims Administrator incorrectly denied your first level appeal, you may request your claim be reviewed for a second time. Your written request for a first or second level appeal must be received by the Claims Administrator within 180 calendar days of the date you received your notification of HealthEquity's denial. Your request should be sent to:

HealthEquity Appeal Board
P.O. Box 991
Mequon, WI 53092-0991

or by fax: 877-220-3248

As part of any 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 appeal will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in HealthEquity's prior determination of your claim. The Claims Administrator's review will not afford any deference to the prior determination and will be conducted by someone who is neither the individual who made the prior determination, nor the subordinate of the individual.

If, after reviewing your appeal, the Claims Administrator denies your claim, a notice will be provided to you within a reasonable period of time, but not later than 30 calendar days from the calendar day your request for a first or second appeal was received by the Claims Administrator.

This notice (which will be provided by 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), (iii) your right to receive, upon request and free of charge, all documents, relevant to your claim, (iv) the appeal procedures you must follow to obtain a review of the determination, including the applicable time limits on such a review, and (v) your right to bring a cause of action for benefits under Section 502(a) of ERISA.

The Claims 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.

The Claims 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 appeal. You

must exhaust the appeal process described above prior to bringing a cause of action for benefits under Section 502(a) of ERISA.

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under Section 502(a) of ERISA if you file such complaint in a federal court within one (1) year of the date such claim was denied in the final level of the appeal process outlined above.

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

If You Terminate Employment with TI

Only the expenses you incurred while working as a TIer (or the last date through which benefits are extended) are eligible for reimbursement, unless COBRA is elected following termination of employment.

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

Eligible Health Care FSA Expenses

Generally, the 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 U.S. federal income tax return. Some eligible itemized expenses under the Internal Revenue 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 HealthEquity Customer Service Center by calling 855-774-7441 or accessing the HealthEquity website at healthequity.com.

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

Examples of Health Care FSA Eligible Expenses

- Acupuncture
- Ambulance services
- Amounts that exceed the Allowable Amount under the plan
- Artificial insemination and in vitro fertilization
- Chemical dependency treatment
- Contact lenses
- Deductibles, copays and coinsurance you pay under the health care plan options
- 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 to the extent not covered by your medical plan
- Medical care provided in a nursing or retirement home
- Nicotine patches (physician's prescription required)

- Over-the-counter drugs and medicines 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 calendar year in which the services were received, unless pre-payment is required before birth. Maternity services are considered received when the baby is born, and birth occurs in the following year. If your delivery will not be payable under a global maternity benefit, the initial prenatal visit is separate from the charges for the delivery, and charges for this visit are payable as of the date of the visit. Please plan your reimbursement deposits to coincide with the year of expected delivery, unless pre-payment is required before birth and birth is to occur in the following calendar year.

Examples of Ineligible Health Care FSA Expenses

You cannot be reimbursed for eligible expenses under the plan if you have deducted or will deduct the same expense on your U.S. 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, nursing or retirement home
- Electrolysis
- Expenses covered by the Dependent Daycare FSA
- Hair growth treatments
- Over-the-counter drugs and medicines 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 plan and deduct the same expense on your U.S. federal income tax return.
2. You cannot be reimbursed for any medical or dental expenses from your Health Care FSA if the expense has been or will be paid by your, or your dependent's, insurance plan(s).

For Additional Information on Health Care FSAs

For additional information, refer to the instructions for filing U.S. 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 irs.gov.

You can visit the HealthEquity website at healthequity.com. A link to the site is also available from the Fidelity NetBenefits® website at netbenefits.com/ti or type FSA/ in your Infolink browser.

Additionally, you can contact HealthEquity Customer Service Center, the Health Care FSA Claims Administrator, at 855-774-7441.

Dental/Vision Flexible Spending Account (FSA) (HSA-Compatible)

How the Dental/Vision FSA Works

You must be enrolled in the HDHP with an HSA to participate in the Dental/Vision FSA. **This is the only health FSA option available to you if you participate in the BCBS HDHP option and receive HSA contributions.**

By establishing an FSA you can save money on taxes by using FSA dollars for dental and vision expenses while preserving your HSA funds for other purposes, including simply saving those funds for your future.

During the calendar year, you can contribute up to $2,750, in whole dollar amounts, to the Dental/Vision FSA to be used for reimbursement of eligible dental and vision expenses incurred during the calendar year. If you choose to participate, the minimum annual contribution is $100.

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

Depending on the dental plan in which you enroll, you may need to submit a receipt for the expense to the Dental/Vision FSA Claims Administrator. For the vision plan, you will need to submit a receipt for the expense to the Dental/Vision FSA Claims Administrator. You will be reimbursed from your account for eligible expenses submitted by the required deadline only up to the amount for which you enrolled. Any reimbursement for eligible expenses is not taxable.

You must stay enrolled for the full calendar year, unless you have an appropriate qualified status change as described in the Introduction section.

How to Put Money in the Dental/Vision FSA — Enrollment

You will make contributions to your account over the course of the calendar year through payroll deductions. **According to IRS regulations, any contributions placed in the Dental/Vision FSA that are not used by the end of the calendar 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 calendar year and for which you will submit receipts and related documentation (or auto-submitted, if applicable) by the March 31 immediately following the calendar year.

If you go on a paid leave of absence, your contributions to your Dental/Vision FSA 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, you will receive a bill for your Dental/Vision FSA contributions. If you do not pay your bill, you will no longer be able to contribute to your account effective as of your last paid through date unless otherwise required by law.

Contribution amounts must be set within 30 calendar days of your date of hire or within 30 or 60 calendar days depending on the type of qualified status change or during annual enrollment. Please see the Introduction section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement. You cannot stop, reduce or increase your contributions during the calendar year unless an appropriate qualified status change occurs. **Generally, the IRS does not make an exception to this rule even if you make a mistake**.

If you experience a qualified status change, you may choose to change your contributions to your Dental/Vision FSA, provided your change is consistent with the qualified status change (for example, you increase your contribution upon the birth of your child).

If you choose to increase your Dental/Vision FSA election, the increased amount will be effective as of the date of the qualified status change. Expenses incurred prior to the date of the qualified status change may not be paid from the new election amount made to your account as a result of the qualified status change; however, they may be paid from any amount remaining of the amount you contributed before you changed your contributions. Expenses incurred on or after the date of the qualified status change may be paid from your newly elected amount or from any amount remaining of the amount you contributed before you changed your contributions.

While you may reduce your Dental/Vision FSA election on a going forward basis, you may not reverse the contributions made prior to the date of the qualified status change. Expenses incurred prior to the date of the qualified status change may not be paid from the new election amount made to your account as a result of the qualified status change; however, they may be paid from any amount remaining of the amount you contributed before you changed your contributions. Expenses incurred on or after the date of the qualified status change may be paid from your newly elected amount or from any amount remaining of the amount you contributed before you changed your contributions.

It is important to consider the amount of money you elect to contribute to your Dental/Vision FSA carefully. Money cannot be transferred between the Health Care FSA, Dependent Daycare FSA, and Dental/Vision FSA.

Filing Dental/Vision Flexible Spending Account (FSA) (HSA-Compatible) Claims

If you are enrolled in Delta Dental (Basic or Plus), your claims will be automatically submitted for reimbursement to HealthEquity (formerly known as WageWorks). If you don't want reimbursement claims automatically sent to HealthEquity, you must log on to your HealthEquity account and select "No" for auto claims submission. 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 HealthEquity after the claim has been submitted and processed by Delta Dental. As you may be aware, some providers may delay submitting claims for 30 calendar days or more.

To submit a claim manually, you must complete and submit a claim reimbursement form. You can obtain a claim form on the Fidelity NetBenefits® website at netbenefits.com/ti. You can also obtain a claim form by contacting the HealthEquity Customer Service Center directly at 855-774-7441 or through their website at healthequity.com.

Claims may be mailed, faxed, or submitted online as follows:

by mail to:
HealthEquity Claims Administrator
P.O. Box 14053
Lexington, KY 40512

by fax to: 877-353-9236
Please do not use a fax cover sheet when submitting claims by fax, as this can cause delays.

or online: by accessing your account via healthequity.com and click on the "Submit Receipt or Claims" link. There is also an option to upload your receipt once you have submitted your claim online.

You'll need to include itemized receipts or other supporting documentation, such as an Explanation of Benefits (EOB). Please refer to the HealthEquity 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 dental or vision plan or visit their website to request an EOB.

Once your claim has been processed, you'll receive notification from HealthEquity 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. To update your designated bank account, go to healthequity.com.

Deadline for Submitting Claims

All claims must be mailed and postmarked, faxed, submitted online or auto-submitted to HealthEquity **no later than three months after the end of the calendar year** in which the expenses were incurred **(that is by March 31 of the year following the calendar year in which you incurred the expense)**; claims submitted after this deadline will be denied as untimely.

Receiving Reimbursement

Expenses incurred prior to the participant's effective date of enrollment in the Dental/Vision FSA are not eligible for reimbursement. Expenses may be reimbursed for the calendar year the participant receives the dental and/or vision care, not in the calendar year when the participant is billed, charged for or pays for the dental and/or vision care expense. Similarly, any expenses incurred prior to the effective date of any increase to your elected contribution under the Dental/Vision FSA are not eligible for reimbursement using amounts contributed as a result of the increase.

Dental/Vision FSA claims will be reimbursed as received up to the amount of your total annual contribution election in effect at the time the claim was incurred.

Dental/Vision FSA Claim and Appeal Information if a Claim is Denied

A Dental/Vision FSA claim for benefits under the Flexible Benefits Plan must be submitted to HealthEquity, the Claims Administrator, by the claim deadline and in the manner prescribed by the Claims Administrator.

If HealthEquity 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 30 calendar days from the calendar day your claim was received by HealthEquity. This notice (which will be provided by 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), (iii) your right to receive, upon request and free of charge, all documents, relevant to your claim, (iv) the appeal procedures you must follow to obtain a review of the determination, including the applicable time limits on such a review, and (v) 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, why the submission of additional information may be necessary and that you are afforded up to 45 calendar days from the calendar day you receive the notice to provide the additional information.

In certain instances, HealthEquity may not be able to make a determination within 30 calendar days from the calendar day your claim for benefits was received. In such situations, HealthEquity, in its sole and absolute discretion, may extend the 30-calendar-day period for up to 15 calendar 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-calendar-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

Dental/Vision FSA First and Second Level Claim Appeals

If your claim for reimbursement from your Dental/Vision FSA is denied, you may appeal HealthEquity's denial by requesting a first level review of your claim by the Claims Administrator. If you believe the Claims Administrator incorrectly denied your first level appeal, you may request your claim be reviewed for a second time. Your written request for a first or second level appeal must be received by the Claims Administrator within 180 calendar days of the date you received your notification of HealthEquity's denial. Your request should be sent to:

HealthEquity Appeal Board
P.O. Box 991
Mequon, WI 53092-0991

or by fax: 877-220-3248

As part of any 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 appeal will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in HealthEquity's prior determination of your claim. The Claims Administrator's review will not afford any deference to the prior determination and will be conducted by someone who is neither the individual who made the prior determination, nor the subordinate of the individual.

If, after reviewing your appeal, the Claims Administrator denies your claim, a notice will be provided to you within a reasonable period of time, but not later than 30 calendar days from the calendar day your request for a first or second appeal was received by the Claims Administrator.

This notice (which will be provided by 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), (iii) your right to receive, upon request and free of charge, all documents, relevant to your claim, (iv) the appeal procedures you must follow to obtain a review of the determination, including the applicable time limits on such a review, and (v) your right to bring a cause of action for benefits under Section 502(a) of ERISA.

The Claims 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.

The Claims 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 appeal. You must exhaust the appeal process described above prior to bringing a cause of action for benefits under Section 502(a) of ERISA.

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under Section 502(a) of ERISA if you file such complaint in a federal court within one (1) year of the date such claim was denied in the final level of the appeal process outlined above.

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

If You Terminate Employment with TI

Only the expenses you incurred while working as a TIer (or the last date through which benefits are extended) are eligible for reimbursement, unless COBRA is elected following termination of employment.

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

Eligible Dental/Vision Flexible Spending Account (FSA) (HSA-Compatible) Expenses

Generally, the IRS rules allow reimbursement for any dental and vision care expense that would be considered deductible if you were to itemize your medical and dental deductions on Schedule A, Form 1040, of your U.S. federal income tax return. Some eligible itemized expenses under the Internal Revenue 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 HealthEquity Customer Service Center by calling 855-774-7441 or accessing the HealthEquity website at healthequity.com.

Following are some examples of expenses recognized as reimbursable from your Dental/Vision FSA.

Examples of Dental/Vision FSA Eligible Expenses

- Amounts that exceed the amount covered under the dental and vision plans
- Deductibles, copays and coinsurance you pay under the dental and/or vision plan
- Contact lenses
- 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
- Orthodontia or dental care in excess of dental plan limits

Examples of Ineligible Dental/Vision FSA Expenses

You cannot be reimbursed for eligible expenses under the plan if you have deducted or will deduct the same expense on your U.S. 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

Two Important Notes

1. You cannot be reimbursed for an eligible expense under this plan and deduct the same expense on your U.S. federal income tax return.
2. You cannot be reimbursed for any dental or vision expenses from your Dental/Vision FSA if the expense has been or will be paid by your, or your dependent's, insurance plan(s).

For Additional Information on Dental/Vision FSAs

For additional information regarding dental and certain vision expenses, refer to the instructions for filing U.S. 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 irs.gov.

You can visit the HealthEquity website at healthequity.com. A link to the site is also available from the Fidelity NetBenefits® website at netbenefits.com/ti or type FSA/ in your Infolink browser.

Additionally, you can contact HealthEquity Customer Service Center, the Dental/Vision FSA Claims Administrator, at 855-774-7441.

Dependent Daycare Flexible Spending Account (FSA)

How the Dependent Daycare FSA Works

During the calendar year, you can contribute up to $5,000, in whole dollar amounts, or what you or your spouse earns during the calendar year, if less, to the Dependent Daycare FSA to be used for reimbursement of eligible dependent daycare expenses incurred during the calendar year. If you choose to participate, the minimum annual contribution is $100. If you are married but file a separate U.S. federal income tax return, then you can only contribute up to $2,500. Contributions to your account are deducted from your pay before U.S. 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).

When you incur an eligible expense for dependent daycare, you must submit a receipt for the expense to the Dependent Daycare FSA Claims Administrator. You will be reimbursed from your account for eligible expenses submitted by the required deadline only up to the amount already deducted. Any reimbursement for eligible expenses is not taxable.

You must stay enrolled for the full calendar year, unless you have an appropriate qualified status change as described in the Introduction section.

How to Put Money in the Dependent Daycare FSA — Enrollment

You will make contributions to your account over the course of the calendar year through payroll deductions. **According to IRS regulations, any contributions placed in the Dependent Daycare FSA that are not used by the end of the calendar year will be forfeited. No refunds or carryovers are allowed.** This means that you should put aside money only for expenses you are confident you will incur during the calendar year and for which you will submit receipts and related documentation by the March 31 immediately following the calendar year. Also, contributions to a Dependent Daycare FSA cannot be more than $5,000 or what you or your spouse earns during the calendar year, if less.

If you go on a paid leave of absence, your contributions to your Dependent Daycare FSA 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 FSA coverage.

Contribution amounts must be set within 30 calendar days of your date of hire or within 30 or 60 calendar days depending on the type of qualified status change or during annual enrollment. Please see the Introduction section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement. You cannot stop, reduce or increase your contributions during the calendar year unless an appropriate qualified status change occurs. **Generally, the IRS does not make an exception to this rule even if you make a mistake**.

If you experience a qualified status change, you may choose to change your contributions to your Dependent Daycare FSA, provided your change is consistent with the qualified status change (for example, you increase your contribution upon the birth of your child).

If you choose to increase your Dependent Daycare FSA election, the increased amount will be effective as of the date of the qualified status change. Expenses incurred prior to the date of the qualified status change may not be paid from contributions made to your account as a result of the qualified status change. Expenses incurred on or after the date of the qualified status change may be paid from your newly elected amount or from the amount contributed before you increased your contributions.

While you may reduce your Dependent Daycare FSA election on a going forward basis, you may not reverse the contributions made prior to the date of the qualified status change. Expenses incurred prior to

the date of the qualified status change may not be paid from contributions made to your account as a result of the qualified status change. Expenses incurred on or after the date of the qualified status change may be paid from your newly elected amount or from the amount contributed before you decreased your contributions.

It is important to consider the amount of money you elect to contribute to your Dependent Daycare FSA carefully. Money cannot be transferred between the Health Care FSA, Dependent Daycare FSA, and Dental/Vision FSA.

Restrictions on Contribution Amounts

The amount you can contribute is limited to $5,000 or to the amount of your earned income, if less. Or if married, the amount you can contribute is further limited by 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 FSA.

If your spouse is a full-time student or is mentally or physically disabled, IRS rules treat them 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 calendar year.

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

If you are married and want to participate in the Dependent Daycare FSA, 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 Dependent Daycare Flexible Spending Account (FSA) Claims

To submit a Dependent Daycare FSA claim, you must complete and submit a claim reimbursement form. You can obtain a claim form on the Fidelity NetBenefits® website at netbenefits.com/ti. You can also obtain a claim form by contacting the HealthEquity (formerly known as WageWorks) Customer Service Center directly at 855-774-7441 or through their website at healthequity.com.

Claims may be mailed, faxed, or submitted online as follows:

by mail to:
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by fax to: 877-353-9236
Please do not use a fax cover sheet when submitting claims by fax, as this can cause delays.

or online: by accessing your account via healthequity.com and click on the “Submit Receipt or Claims” link. There is also an option to upload your receipt once you have submitted your claim online.

You’ll need to include itemized receipts or other supporting documentation. Please refer to the HealthEquity 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 HealthEquity 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. To update your designated bank account, go to healthequity.com.

Deadline for Submitting Claims

All claims must be mailed and postmarked, faxed or submitted online to HealthEquity **no later than three months after the end of the calendar year** in which the expenses were incurred **(that is by March 31 of the year following the calendar year in which you incurred the expense)**; claims submitted after this deadline will be denied as untimely.

Receiving Reimbursement

Expenses incurred prior to the participant's effective date of enrollment in the Dependent Daycare FSA are not eligible for reimbursement. Expenses may be reimbursed for the calendar year the participant receives the dependent daycare, not in the calendar year when the participant is billed, charged for or pays for the dependent daycare expense. Similarly, any expenses incurred prior to the effective date of any increase to your elected contribution under the Dependent Daycare FSA are not eligible for reimbursement using amounts contributed as a result of the increase.

If you submit a dependent daycare 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 FSA Claim and Appeal Information if a Claim is Denied

A Dependent Daycare FSA claim for benefits under the Flexible Benefits Plan must be submitted to HealthEquity, the Claims Administrator, by the claim deadline and in the manner prescribed by the Claims Administrator.

If HealthEquity 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 30 calendar days from the calendar day your claim was received by HealthEquity. This notice (which will be provided by 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), (iii) your right to receive, upon request and free of charge, all documents, relevant to your claim, (iv) the appeal procedures you must follow to obtain a review of the determination, including the applicable time limits on such a review, and (v) 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, why the submission of additional information may be necessary and that you are afforded up to 45 calendar days from the calendar day you receive the notice to provide the additional information.

In certain instances, HealthEquity may not be able to make a determination within 30 calendar days from the calendar day your claim for benefits was received. In such situations, HealthEquity, in its sole and absolute discretion, may extend the 30-calendar-day period for up to 15 calendar 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-calendar-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

Dependent Daycare FSA First and Second Level Claim Appeals

If your claim for reimbursement from your Dependent Daycare FSA is denied, you may appeal HealthEquity's denial by requesting a first level review of your claim by the Claims Administrator. If you believe the Claims Administrator incorrectly denied your first level appeal, you may request your claim be reviewed for a second time. Your written request for a first or second level appeal must be received by the Claims Administrator within 180 calendar days of the date you received your notification of HealthEquity's denial. Your request should be sent to:

HealthEquity Appeal Board
P.O. Box 991
Mequon, WI 53092-0991

or by fax: 877-220-3248

As part of any 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 appeal will take into account all comments, documents, records and other information you submitted, without regard to whether such information was submitted and considered in HealthEquity's prior determination of your claim. The Claims Administrator's review will not afford any deference to the prior determination and will be conducted by someone who is neither the individual who made the prior determination, nor the subordinate of the individual.

If, after reviewing your appeal, the Claims Administrator denies your claim, a notice will be provided to you within a reasonable period of time, but not later than 30 calendar days from the calendar day your request for a first or second appeal was received by the Claims Administrator.

This notice (which will be provided by 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), (iii) your right to receive, upon request and free of charge, all documents, relevant to your claim, (iv) the appeal procedures you must follow to obtain a review of the determination, including the applicable time limits on such a review, and (v) your right to bring a cause of action for benefits under Section 502(a) of ERISA.

The Claims 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.

The Claims 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 appeal. You must exhaust the appeal process described above prior to bringing a cause of action for benefits under Section 502(a) of ERISA.

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under Section 502(a) of ERISA if you file such complaint in a federal court within one (1) year of the date such claim was denied in the final level of the appeal process outlined above.

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

If You Terminate Employment with TI

Only the expenses you incurred while working as a TIer (or the last date through which benefits are extended) are eligible for reimbursement.

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

Eligible Dependent Daycare Flexible Spending Account (FSA) Expenses

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

- Daycare for eligible dependent children 12 and under (in your home or elsewhere)
- Household services to care for a qualified dependent
- Nursery school daycare tuition (non-educational)
- Day Camp (if for childcare purposes)

Examples of Ineligible Dependent Daycare FSA Expenses

Generally, ineligible expenses for reimbursement are those that don't qualify for the U.S. 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 FSA or Dental/Vision FSA
- Expenses for overnight camp
- Kindergarten (which is primarily educational in nature or purpose)
- Nursing home care for dependents who don't spend at least eight hours a calendar 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 U.S. 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 calendar day in your home.

Qualifying individuals include:

- A child 12 and under who lives at your home and is claimed as a dependent on your U.S. federal income tax return
- A dependent who is mentally or physically disabled and incapable of self-care and lived with you more than half the year and was your dependent or would have been your dependent except for certain situations recognized under IRS Publication 503. They can be your spouse, parent,

brother, sister, or any other family member, as long as you provide at least half of their financial support and claim them as a dependent on your U.S. federal income tax return

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

The dependent daycare 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 not working, looking for work or a full-time student, they must look for work, be disabled and unable to provide for their 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 FSA should include receipts when filing for reimbursement and keep a copy for their personal records.

Tax Treatment

Under current U.S. federal tax law, 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 U.S. federal income tax return and (ii) participation in a company-sponsored Dependent Daycare FSA. You may only use one type of dependent care tax advantage for an individual expense. The Flexible Benefits Plan offers a Dependent Daycare FSA that permits you to withhold up to $5,000 of earnings from your pay during the calendar year, which may be returned to you as a tax-free reimbursement of your dependent daycare costs.

For Additional Information on Dependent Daycare FSAs

For additional information, refer to the instructions for filing U.S. 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 irs.gov.

You can visit the HealthEquity website at healthequity.com. A link to the site is also available from the Fidelity NetBenefits® website at netbenefits.com/ti or type FSA/ in your Infolink browser.

Additionally, you can contact HealthEquity Customer Service Center, the Dependent Daycare FSA Claims Administrator, at 855-774-7441.

Health Savings Account

Individual Accounts, not an ERISA PLAN

A Quick Look

A Health Savings Account (HSA) is an account that you can put money into to save for future medical expenses as well as for retirement savings. There are certain advantages to putting money into an HSA, including favorable tax treatment.

You can elect to set up your HSA with any provider; however, to receive an employer contribution from TI, you must set up an account with Fidelity HSA Services.

How the HSA Works – You can use the funds in your account to pay tax-free for current medical expenses, including expenses that your insurance may not cover, or save the funds in your account for future needs, such as:

- Health insurance premiums or medical expenses if unemployed
- Medical expenses after retirement (before Medicare enrollment)
- Out-of-pocket expenses and premiums when enrolled in Medicare
- Long-term care expenses and insurance

Savings – You can save the funds in your account for future medical expenses and may grow your account through investment earnings.

Control – You decide:

- How much money to put into the account
- Whether to save the funds for future expenses or pay current medical expenses
- Which medical expenses to pay from funds in the account
- Whether to invest any of the funds in the account and which investments to make if this route is selected

Portability – Accounts are completely portable, meaning you can keep your HSA even if you:

- Change jobs
- Change your medical coverage
- Become unemployed
- Move to another state
- Change your marital status

Ownership – Funds remain in the account from year to year, just like an IRA. There are no “use it or lose it” rules for HSAs.

Tax Savings – An HSA may provide you triple tax savings:

1) Your deposits are before-tax or tax-deductible
2) Earnings, if any, grow tax-free, and
3) Tax-free withdrawals for qualified medical expenses

Employer Contributions - You will receive TI contributions to your HSA if you set up an HSA with Fidelity HSA Services.

Who is Eligible for an HSA under the Plan?

- You can contribute to an HSA if you have coverage under an HSA-qualified “high deductible health plan” (HDHP).

Who is Not Eligible for an HSA (to make a contribution or receive the TI contribution)?

- Anyone covered under a spouse's or dependent's employer traditional medical coverage (PPO, HMO, EPO, POS, etc.)
- Anyone whose spouse elects to participate in their employer's Health Care Flexible Spending Account (FSA) or Health Reimbursement Account (HRA)
- Anyone with other comprehensive medical insurance (Medicare, Medicaid, TRICARE). For those eligible for Medicare, you must decline Part A, Part B (or Part C) and Part D to be eligible for an HSA.
- Individuals with a flexible spending account unless the design limits reimbursement to expenses not covered by an HDHP (e.g., dental or vision expenses)
- Anyone who can be claimed as a dependent on someone else's U.S. federal income tax return
- Anyone who is not eligible to establish a U.S. brokerage or bank account at a custodian who is eligible to maintain HSAs

Enrolling in Your HSA

Enrollment is a three-step process:

1. Enroll in the BCBS High Deductible Health Plan (HDHP) – you are not eligible for an HSA unless you are only enrolled in a qualified high deductible health plan and not covered by any other health plan
2. Enroll in the Health Savings Account - whether or not you want to make contributions, you must enroll in the Health Savings Account benefit on the Fidelity NetBenefits® website at netbenefits.com/ti to receive the employer contribution from TI
3. Establish, or open a Health Savings Account with Fidelity HSA Services to receive the TI contribution

IMPORTANT NOTES:

If, after enrolling in the Health Savings Account benefit, you do not have a Health Savings Account with Fidelity already in place or you fail to establish such account by November 30, 2021, you will forfeit TI's contribution for 2021. After you establish your account, TI's contributions are deposited in your Health Savings Account as soon as administratively possible. TI prorates its contribution toward your Health Savings Account if you enroll in the BCBS HDHP mid-year. If you establish a Health Savings Account promptly upon enrollment when you are hired mid-year, you will receive a prorated TI Health Savings Account contribution for each month or partial month in which you are enrolled and have an established Health Savings Account.

If you are hired during the month of December, TI's contribution may not be made until the following calendar year. If TI's contribution is made in the following calendar year, it will accumulate towards that calendar year's maximum IRS contribution and will affect the maximum amount you can contribute.

High Deductible Health Plans (HDHPs)

You must only have coverage under the HSA-qualified "high deductible health plan (HDHP) to open and contribute to an HSA.

In general, the deductible must apply to all medical expenses (including prescriptions) covered by the plan. Except for preventive care and COVID-19 testing and treatment, an HDHP may not cover the costs of medical benefits (including prescriptions) for any year until the deductible for that year is met. There is no deductible for preventive care and COVID-19 testing and treatment. Preventive care includes:

- Periodic health evaluations (e.g., annual physicals)
- Screenings (e.g., mammograms)
- Routine pre-natal and well-child care
- Routine child and adult immunizations
- Tobacco cessation programs
- Obesity/weight-loss programs

HSA Contributions

Contributions to your HSA can be made by you, TI, or both. However, the total contributions are subject to an annual limit established by the IRS.

- You can elect to make your contributions through payroll deduction. Before-tax payroll contributions will generally be deposited in your HSA on Friday in the week in which your payday falls.
- You can change the amount of your contribution at any time. TI will apply these changes to your account as soon as administratively possible.
- You can also make additional after-tax contributions for the calendar year by forwarding payment directly to the HSA Administrator. These additional contributions can be made as late as April 15 of the year following the calendar year. You can deduct before-tax contributions (even if you do not itemize deductions) when completing your U.S. federal income tax return.
- If you make contributions via payroll and direct contributions to your HSA Administrator, it is your responsibility to make sure your total contributions from all sources do not exceed the IRS maximum annual contribution.
- Contributions may also be made by TI. TI's contributions also apply to the total IRS maximum annual contribution.

Below is the amount TI will contribute to your HSA in 2021 and the maximum amount that may be contributed to your HSA in 2021 (as determined by the IRS). The maximum amount applies to your contribution as well as those of TI. Amounts may be adjusted annually.

	TI Contribution	**2021 IRS Maximum Contribution (You + TI) (under age 55)**	**2021 IRS Maximum Contribution (You + TI) (age 55 and older)**
Employee-only coverage	$750	$3,600	$4,600
Family coverage	$1,250	$7,200	$8,200

If you do not remain eligible for a full year, the annual contribution limit will be prorated for the months you maintain HDHP coverage as measured on the first calendar day of the month. If you contribute more than the amount based on the months you were an eligible individual, a portion of the HSA contribution is includable in gross income and subject to an additional 10% tax if not withdrawn by the required deadline. However, income inclusion and the additional tax do not apply if you fail to remain eligible due to death or disability. Additionally, if you are enrolled in the HDHP on the first calendar day of the last month of the calendar year, you may contribute the maximum HSA amount despite part-year coverage.

If you are an active employee or are on leave (paid leave, bridge to retirement, military leave, FMLA/CFRA leave or medical leave) and are enrolled in TI's HDHP on January 1, 2021, TI will contribute $750 to your HSA if you have You Only coverage or $1,250 if you have You + Spouse, You + Child(ren) or You + Family coverage. The TI contribution will not be deposited until you have established a HSA with Fidelity which includes review and acceptance of Fidelity's Banking HSA Terms & Conditions Agreement.

The maximum you can contribute is the difference between the 2021 Contribution Maximum and the TI Contribution. There is a $1,000 annual "catch-up" contribution allowed for individuals age 55 and older.

Contribution Rules

Your eligibility to contribute to an HSA for each month is generally determined by whether you have only HDHP coverage on the first calendar day of the month. Your maximum contribution for the calendar year is the greater of: (1) the full contribution, or (2) the prorated amount. The full contribution is the maximum annual contribution for the type of coverage you have on December 1. The prorated amount is 1/12 of the maximum annual contribution for the type of HDHP coverage you have times the number of months you

have only that type of coverage. For purposes of proration, a partial month is counted as a full month. If you make a full contribution despite part-year HDHP coverage and you fail to remain covered by an HDHP for the entire following year, the extra contribution above the prorated amount is included in income and may be subject to an additional 10% tax if not withdrawn by the required deadline.

Examples:

1) If you first have family HDHP coverage on July 1, 2021, and keep HDHP coverage through December 31, 2021, you are allowed the full $7,200 family contribution to an HSA for 2021, as you maintained HDHP coverage on December 1. If $7,200 was deposited in your HSA for 2021 and you fail to remain covered by an HDHP for all of 2021, a prorated amount for the months you fail to remain covered by an HDHP would be included in income and subject to an additional 10% tax if not withdrawn by the deadline.
2) If you have family HDHP coverage from January 1, 2021, until June 30, 2021, then cease having HDHP coverage, you are allowed an HSA contribution of 6/12 of $7,200, or $3,600 for 2021.
3) If you have family HDHP coverage from January 1, 2021 until June 30, 2021, and have employee-only HDHP coverage from July 1, 2021 to December 31, 2021, you are allowed an HSA contribution of 6/12 of $7,200 plus 6/12 of $3,600, or $5,400.

Contributions in excess of the maximum and associated earnings must be withdrawn by you or be subject to excise tax. These amounts must be withdrawn by the deadline, including extensions, for filing your U.S. federal income tax return for the year of the excess contributions. You pay income tax on the amount withdrawn, but are not responsible for the 10% penalty.

How to Use Your HSA

You can use the funds in your account to pay for any “qualified medical expense” permitted under U.S. federal tax law. This includes most medical care and services, and dental and vision care.

Generally, you cannot use the money to pay for medical insurance premiums except under specific circumstances, including:

- Any health plan coverage while receiving U.S. federal or state unemployment benefits
- COBRA continuation coverage
- Qualified long-term care insurance
- Medicare premiums and out-of-pocket expenses, including deductible, copays and coinsurance for:
    - Part A (hospital and inpatient services)
    - Part B (physician and outpatient services)
    - Part C (Medicare HMO and PPO plans)
    - Part D (prescription drugs)

You can use the money in the account to pay for medical expenses for yourself, your spouse, or your dependent children. You can pay for expenses of your spouse and dependent children even if they are not covered under your HDHP. You cannot use the money in the account to pay for the expenses of domestic partners. Remember, you are responsible for determining whether an expense is a qualified medical expense. A listing of qualified expenses for medical care, as defined in Internal Revenue Code Section 213(e), may be found in IRS Publication 502, which is available at irs.gov/publications/p502.

It is important that you save your receipts! You must keep records to prove that expenses incurred were not paid for or reimbursed by another source (such as other coverage or a Flexible Spending Account) or taken as an itemized deduction on your U.S. federal income tax return.

Any amount used for purposes other than to pay for “qualified medical expenses” are taxable as income and subject to an additional 20% tax penalty. Examples include:

- Medical expenses that are not considered “qualified medical expenses” under U.S. federal tax law (e.g., cosmetic surgery)
- Other types of health insurance unless specifically described above
- Medicare supplement insurance premiums
- Expenses that are not medical or health-related

After you turn age 65, become disabled and/or enroll in Medicare, the 20% additional tax penalty no longer applies.

Setting up Your Health Savings Account

TI has arranged with Fidelity HSA Services for you to set up an HSA with Fidelity online. You may also request a paper application. After you enroll in the BCBS HDHP and enroll in the HSA on the Fidelity NetBenefits® website at netbenefits.com/ti, you will be notified of the requirement to set up your HSA. Once you review and accept the account terms and conditions agreement, Fidelity will notify TI Payroll that your account is open and available for funding. TI will deposit the Employer Contribution to your Fidelity HSA as soon as administratively possible. If you chose to establish your HSA anywhere other than Fidelity, you will not receive an Employer Contribution.

Investment of HSA Funds

The Fidelity HSA consists of a core position and any investments options you elect. Money in your core position is FDIC protected and used mostly for processing investment transactions and holding any undirected investments. Additionally, contributions are deposited and disbursements are withdrawn from the core position.

While your funds will initially be invested in an FDIC insured position, you can choose to invest in a variety of investment options, including the Fidelity HSA Funds to Consider. These are professionally selected funds with no minimums or transaction fees. Other HSA investing options include, but are not limited to, target date funds, as well as mutual funds, stocks, bonds and U.S. Treasuries. Before investing, consider the fund’s investment objectives, risks, charges and expenses. Contact Fidelity for a prospectus or summary prospectus, if available, containing the information. Read it carefully.

Distributions from your Fidelity HSA will be made from your core position. If the funds in your core position are less than your distribution request, your distribution will not be processed. However, if money is available in other investments in your Fidelity HSA, you may move money from your investments into your core position and then resubmit your distribution request.

For more information on HSA investments, fees or costs, please speak with a Fidelity representative through TI HR Connect at 888-660-1411. Representatives are available from 8:30 a.m. to 8:30 p.m. Eastern time Monday through Friday, excluding all New York Stock Exchange holidays except Good Friday. HSA commission fee information can be found on the Fidelity website at fidelity.com/trading/commissions-margin-rates.

What Happens to My HSA When I Die?

If your spouse is the named beneficiary of your account, the HSA becomes the HSA of your surviving spouse. If the HSA passes to a person other than your spouse, your beneficiary is required to include in gross income the fair market value of the HSA assets as of the date of your death. This includible amount is reduced by any payments from the HSA made for your qualified medical expenses, if paid one year after your death.

A Quick Look

Pre-January 1, 2012 Hires

If you were hired prior to January 1, 2012, you may make an election to enroll in the Blue Cross Blue Shield (BCBS) High Deductible Health Plan, the BCBS PPO or a regional HMO.

Post-December 31, 2011 Hires

If you are hired on or after January 1, 2012, you may only make an election to enroll in the Blue Cross Blue Shield High Deductible Health Plan.

HDHP

Key features of the Blue Cross Blue Shield (BCBS) High Deductible Health Plan (HDHP) are highlighted below. You will find more detailed information on the following pages.

- Services for COVID-19 testing (performed according to CDC criteria as determined by your health care provider) and treatment are covered at 100% (no copay, coinsurance, or deductible applies). *Please remember that services by non-network providers are covered at 100% of the Allowable Amount*.
- The HDHP is the only enrollment option for TIers hired on or after January 1, 2012.
- TIers must have coverage under an HSA-qualified "high deductible health plan" to open and contribute to an HSA. See page 38 for information on contribution limits.
- TI may also make a contribution to the TIer's HSA. See page 38 for more information.
- Family deductible applies to you + spouse, you + child and you + family coverage and is met when all medical and pharmacy claims add up to the family deductible amount.
- No first-dollar coverage - the deductible must apply to all medical expenses (including prescription drugs) covered under the plan. Preventive care is the only exception.
- See pages 36-40 for information on Health Savings Accounts.
- Only one out-of-pocket maximum applies to medical and pharmacy expenses

PPO

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

- Services for COVID-19 testing (performed according to CDC criteria as determined by your health care provider) and treatment are covered at 100% (no copay, coinsurance, or deductible applies). *Please remember that services by non-network providers are covered at 100% of the Allowable Amount*.
- 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.
- Network services are reimbursed at a higher rate
- Separate out-of-pocket maximum for prescription drugs

Regional HMO

- Services for COVID-19 testing are covered at 100% (no copay or coinsurance applies). Services for COVID-19 treatment are covered in accordance with the terms of the regional HMO.
- Key features of the regional HMO (if available in your area) can be viewed during enrollment on the Fidelity NetBenefits® website at netbenefits.com/ti. You can also call the regional HMO directly.
- The regional HMO can be found in the Important Contact Information chart, at the beginning of this document.

Pre-Existing Conditions

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

If You Do Not Enroll

If you do not make an election during your first 30 calendar days of employment, you will automatically be enrolled in the BCBS HDHP option with **employee only coverage** and you will only be able to change that coverage to add family members if you have an appropriate qualified status change (see page 10) or during the next annual enrollment. The design is shown in detail on page 51 for medical and page 72 for prescription drugs.

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

If your medical plan is no longer available for the new calendar year and you do not make an election, you will automatically be enrolled in the BCBS HDHP option at the level of coverage (for example, you + family) you had the previous calendar year. The design is shown in detail on page 51 for medical and page 72 for prescription drugs.

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

Enrolling Yourself and Your Eligible Dependents for Medical Coverage

You and your eligible dependents can be covered by the BCBS HDHP on your first calendar day of work by making an election on the Fidelity NetBenefits® website at netbenefits.com/ti or by contacting the TI Benefits Center at Fidelity during your first 30 calendar days of employment. You must make an election on the Fidelity NetBenefits® website or contact the TI Benefits Center at Fidelity before coverage can begin.

When You Can Change to a Different Coverage

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

When You Can Make Changes

During the annual enrollment period or within 30 or 60 calendar days depending on the type of qualified status change, you may make changes in medical coverage. Please see the Introduction section for

information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement.

Effective Date of Coverage

TIer

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

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

Dependents

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

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

If terminating coverage due to an appropriate qualified status change, coverage is terminated retroactive to the date of the qualified status change, provided you notify the TI Benefits Center at Fidelity within 30 or 60 calendar days depending on the type of qualified status change. Please see the Introduction section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement.

Newborn or Adopted Children

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

Two TIers Who are Married (or in a Domestic Partnership)

If you are married to (or in a domestic partnership with) another TIer, only one TIer may enroll the eligible spouse (or domestic partner) or child dependents. TIers cannot be covered both as an employee and as a dependent.

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 and any expenses above the Allowable Amount for a Non-Network provider.

TIers, covered spouses or domestic partners who use tobacco products pay an additional health care cost. There will be an additional charge of $30 per month for each covered adult tobacco user, with a maximum of $60 per month. You are considered a user of tobacco products if you use cigarettes, e-cigarettes, cigars, pipes or smokeless tobacco (snuff). Tobacco use is defined as any legal use of any tobacco product on average four or more times per week within the last six months (this does not include religious or ceremonial use). You must be tobacco-free for six months before you are considered a non-user. If it is unreasonably difficult due to a health factor for you, your covered spouse or domestic partner to meet the requirement to be tobacco-free for six months (or if it is medically inadvisable for you to attempt to stop using tobacco products), you must complete a formal tobacco cessation program (or request an alternative standard from the Plan Administrator) to avoid this additional cost. You can avoid paying the tobacco surcharge if you can attest that you have completed a formal tobacco cessation program (type stopforgood/ in your Infolink browser for a list of program resources), regardless of whether you actually stop using tobacco products. To change your tobacco user status, contact the TI Benefits Center at Fidelity.

Continuation of Benefits (COBRA)

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

Women's Health and Cancer Rights Act (WHCRA)

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

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

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

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

Medical - Blue Cross Blue Shield HDHP and PPO

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

Deductibles and Coinsurance

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

The out-of-pocket maximum is the annual limit you will pay for most eligible expenses after the deductible is met. Some additional expenses are not applied toward the deductible or out-of-pocket maximum. For additional information, please see the footnotes included on pages 51-52 in the chart "Deductibles, Copays and Coinsurances in the BCBS HDHP and PPO".

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

Networks

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

Network Provider Verification

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

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

Network providers/locations are subject to change without notice.

Network/Non-Network

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

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

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

Notes:

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

Your Benefits

What is Covered under the BCBS HDHP and PPO Options

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

- The service rendered is medically necessary for the treatment of your injury, disease or pregnancy

- The service rendered is delivered by an eligible provider
- The service rendered is covered under the plan

Medically necessary expenses are those services, supplies and procedures which are necessary for the diagnosis, care or treatment of an illness and which are determined to be widely accepted professionally in the U.S. as effective, appropriate, and essential, based on recognized standards of the health care specialty involved. You or your provider can contact BCBS to confirm whether an expense is eligible for coverage. Expenses covered as part of a "clinical trial" are not required to meet the above standards for medically necessary.

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

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

- Eligible medical/behavioral health care practitioners:
    - Covered services must be provided by a legally qualified medical/behavioral health care practitioner. Such practitioner must be licensed in the state in which they are practicing and practicing within the scope of their license (not a resident physician or intern).
    - Examples of legally qualified medical practitioners include Medical Doctor (M.D.), Osteopath (D.O.), Podiatrist (D.P.M.), Chiropractor (D.C.), Dentist (D.D.S. or D.M.D.), Optometrist (O.D.), Ophthalmologist (M.D. or D.O) and Certified Nurse-Midwife (C.N.M.).
    - Examples of legally qualified behavioral health care practitioners include M.D., Ph.D. psychologist, licensed professional counselor, licensed marriage and family therapist, ABA therapist and masters of social work.
- Eligible hospitals include the following institutions when they are rendering covered services:
    - an institution which is primarily engaged in providing, for compensation and on an inpatient basis, surgical and medical care, diagnosis, and treatment through medical, diagnostic, and major surgical facilities. These facilities must be provided on the institution's premises, under the supervision of a staff of physicians, and offer 24-hours-a-day registered graduate (R.N.) nursing services. The institution must be operated consistently with all laws;
    - an institution which is accredited as a hospital by The Joint Commission; or
    - any institution that the Plan Administrator so designates in their sole discretion.

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

Billed Amounts – Network Doctor

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

Case Management

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

transplants). You can contact BCBS's Case Management Department by calling BCBS through TI HR Connect at 888-660-1411.

Preauthorization Requirements

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

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

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

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

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

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

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

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

Allowable Amount

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

When you choose to receive medically necessary services, supplies, and/or procedures from a provider that does not contract with the Claims Administrator, a non-network provider, the Allowable Amount may not equal the provider's billed charges, and you will be responsible for any difference between the Allowable Amount and the billed charges by the non-network provider. This difference may be

considerable. Additionally, you will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable deductibles and coinsurance amounts. If the non-network provider waives your obligation to pay the amounts you are responsible for paying under the Plan, the Plan may not pay any amount on the claim by the non-network provider.

ParPlan

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

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

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

- Any deductibles,
- Coinsurance amounts, and
- Services that are not covered under the benefit option or that are in excess of the benefit option limits.

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

If you seek treatment from an out-of-network provider located outside of Texas, you will be responsible for paying the amounts that exceed the Allowable Amount which is determined using the regional out-of-network reimbursement limit. The regional out-of-network reimbursement limit is approximately 150% of the Medicare rate in a geographic area (1.5 x Medicare). For example, this means that if the Medicare rate for a particular procedure in an area outside of Texas is equal to or less than $900, then $1,350 (150% of $900) would be the most that would be reimbursed for that procedure, or the allowable amount. Here, you would be responsible for charges over $1,350, in addition to your deductible and coinsurance.

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

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

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

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

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

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

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

1) Call your doctor's office and ask for
    - The CPT Code of each procedure (including the office visit)
    - Your doctor's fee for each procedure
    - The ZIP code of your doctor's office

2) Call BCBS
    - Give the doctor's ZIP code and each CPT Code and fee to the BCBS Benefits Representative
    - You will be told if the fees are within the reimbursement limits. If they are more than the Allowable Amount, you will be given an estimate of the additional amount you would pay.

What You Will Pay

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

Expenses that are Not Covered

Expenses for treatment provided which are not covered:

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

Deductibles, Copays and Coinsurances in the BCBS HDHP and PPO

TIers share in the cost of coverage through the deductibles, copays and coinsurances, as shown in the chart below. The deductible, copay and coinsurance rates below represent the amounts paid by the participant.

	HDHP		PPO	
Your Cost	**Network**	**Non-Network**	**Network**	**Non-Network**
	Deductibles and Copays			
Annual Deductible – Medical/ Behavioral Health Care (and Pharmacy for HDHP only) [7]	$1,500 individual $3,000 family [1]	$1,500 individual $3,000 family [1]	$400 individual $800 family	$400 individual $800 family
Annual Deductible – Pharmacy	Included in above		No deductible	
Annual Out-of-Pocket Maximum for Medical/ Behavioral Health Care (and Pharmacy for HDHP only) [7]	$3,000 individual $6,000 family [1]	$6,000 individual $12,000 family [1]	$3,000 individual $6,000 family	$6,000 individual $12,000 family
Annual Out-of-Pocket Maximum for Pharmacy [8]	Included in above		$4,000 individual $8,000 family	$4,000 individual $8,000 family
Annual Hospital Copay	$0		$0	$300
Benefit	**Coinsurance Paid by Participant**			
Doctor [2]	10%	50%	10%	50%
MDLIVE Virtual Visit	10%	Not covered	10%	Not covered
Professional Services [3]	10%	50%	10%	50%
Hospitals/Facilities [4] (inpatient & outpatient)	20%	50%	20%	50%
Medical Nutrition Therapy	10%	Not covered	10%	Not covered
Behavioral Health Care (doctor)	10% [6]	50% [5, 6]	10% [6]	50% [5, 6]
Behavioral Health Care [4] (facility/outpatient)	20% [6]	50% [5, 6]	20% [6]	50% [5, 6]
Behavioral Health Care [4] (hospital/inpatient)	20% [6]	50% [5, 6]	20% [6]	50% [5, 6]

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

[2] This includes e-visits, virtual visits and telemedicine visits. If a lead network surgeon is used and services are performed at a network facility and the assistant surgeon is non-network, the claims for the assistant surgeon's services would be reimbursed at the in-network level. If the lead surgeon and the assistant surgeon are both non-network providers, claims for their services would be reimbursed at the non-network level. Preauthorization may be required, see page 48 for more information.

[3] Professional services include(s), but are not limited to, surgeons, radiologists, anesthesiologists, physical therapists and home health care providers. Preauthorization may be required, see page 48 for more information.

[4] Hospitals/Facilities include, but are not limited to, emergency rooms, skilled nursing facilities and hospice facilities. Preauthorization may be required, see page 48 for more information.

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

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

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

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

Lifetime Dollar Limits

The plan does not impose any lifetime dollar limits on essential health benefits.

Adult and Baby/Child Preventive Health Care – BCBS HDHP and PPO Participants

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

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

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

Women's Health Preventive Services

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

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

Flu Vaccinations

Flu vaccinations for you, your eligible spouse (or domestic partner) and dependent children are covered at 100%. Most TI sites provide free access to flu vaccinations for you, your eligible spouse (or domestic partner) and dependent children age 18 and older. Or, you, your spouse (or domestic partner) and dependent children can receive your annual flu vaccination at your doctor's office, a TI-preferred health clinic or at CVS Caremark's in-network pharmacies. Flu vaccinations at CVS Caremark's in-network pharmacies are subject to availability by location and for dependent children, the age protocols established by the states. If a non-network BCBS provider provides the vaccination, services are covered at the Allowable Amount.

Inpatient Maternity Admissions

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

Emergency Care

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

Emergency illness or injury requiring immediate care should be treated at the nearest provider (facility or doctor) that is able to provide the necessary care, regardless of whether that provider is in the network. Emergency care received outside of the network will be reimbursed at the Allowable Amount for in-network as required under Section 2719A(b) of the Public Health Service Act and the regulations and guidance issued thereunder. You may be held responsible for charges in excess of the BCBS Allowable Amount for emergency services. If you are billed for such charges, you may wish to contact a BCBS representative at 866-866-2300 to review the bill and determine your share of the responsibility, if any. You may not assign the right to request a review to any other person or entity.

If hospitalization is required — once stable, transfer to a network hospital (if available) to receive the highest benefit coverage levels may be necessary. (See earlier section on Allowable Amount for Out-of-Network HDHP and PPO Emergency Services for additional information on the eligible expenses of out-of-network providers in an emergency situation.)

Behavioral Health Care

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

- Psychological problems
- 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
- Eating disorders

In order to receive appropriate referral and treatment, TIers covered under the BCBS HDHP and PPO are encouraged to call Work-Life Resources (formerly the Employee Assistance Program or 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 Work-Life Resources (formerly the Employee Assistance Program or EAP)?

You will set up an appointment with a Work-Life Resource counselor. In most cases, the Work-Life Resource counselor will be able to provide short-term counseling (up to 8 in-person sessions per issue each calendar year) at no cost. *If more care is needed and is medically necessary*, the Work-Life Resource 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 Work-Life Resources at 800-888-CARE (2273) or access an in-network provider on your own. If you contact Work-Life Resources, they will provide free short-term counseling (up to 8 in-person sessions per issue each calendar year) designed to assist you with your issue(s) and recommend a treatment plan at no charge to you. Work-Life Resources will refer you to a Behavioral Health Care Network provider when additional *medically necessary* care is needed or you may select your own health care provider. Coinsurance for doctor services is 10% and for hospital care is 20% of covered expenses, after the medical deductible (up to plan limits). Preauthorization may be required, see page 48 for more information.	Select your own behavioral health care provider — licensed M.D., Ph.D. psychologist, licensed professional counselor, licensed marriage and family therapist, ABA therapist or masters of social work. Coinsurance is 50% of average network negotiated rates for inpatient care and 50% of the Allowable Amount for outpatient care. Coinsurance is applied to covered expenses, after the medical deductible (up to plan limits).

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

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

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

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

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

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 Allowable Amount for the examination and second opinion. Charges by a non-network doctor are subject to the Allowable Amount that may not equal the provider's billed charges. This benefit is not subject to coinsurance.

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

A surgical opinion covers:

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

The surgical opinion must:

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

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

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

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

Other Covered Expenses — BCBS HDHP and PPO

Other covered expenses under the BCBS HDHP and PPO include:

- Room and board at the semiprivate room rate and other medically necessary services and supplies the hospital furnishes to the patient
- Room and board at the private room rate is only covered if isolation is medically required, the illness is imminently terminal or if no semiprivate rooms are available
- Outpatient charges
- Surgical extraction of full bony impacted wisdom teeth
- Charges made by an RN or a nursing agency for skilled nursing care if approved in advance
- Drugs and medicines that by law require a physician's prescription

- Diagnostic laboratory and X-ray examinations, radium and radioactive isotope therapy
- Anesthesia and oxygen
- Rental or purchase of durable medical or surgical equipment necessary for the medical or surgical treatment of a covered disease or injury
- Medically necessary local ambulance or air ambulance service to the nearest facility offering medically required services
- Artificial limbs and artificial eyes when part of an approved treatment plan
- Tubal ligation covered at 100%, deductible does not apply
- Up to 48 hours of hospitalization following a vaginal delivery and 96 hours following a Cesarean-section delivery
- Blood transfusions
- Birth control pills, injections or devices that are medically prescribed and not considered experimental or investigational unless they are part of a clinical trial (See Exclusions and Limitations)
- Medically necessary abortion
- Elective abortion if legal where performed
- Physical therapy that is prescribed as to type, frequency and duration by the attending medical doctor and from which there is the reasonable expectation of functional improvement.
- Reconstructive breast surgery following mastectomy, including reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications of all stages of mastectomy, including swelling associated with the removal of lymph nodes
- Medically necessary transsexual surgery (gender reassignment surgery)
- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided:
    - the deformity or disfigurement is accompanied by a documented clinically significant functional impairment, and there is a reasonable expectation that the procedure will result in meaningful functional improvement; or
    - the orthognathic surgery is medically necessary as a result of tumor, trauma, disease; or
    - the orthognathic surgery is required as a result of severe congenital facial deformity or congenital condition.

    Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements, and there is a high probability of significant additional improvement as determined by the utilization review physician.
- Developmental delay therapies related to a medical condition, including, but not limited to:
    - Psychosocial speech delay
    - Behavioral problems
    - Attention disorders
    - Conceptual handicap
    - Reduced cognitive function
- Cognitive rehabilitation provided to treat an acquired brain injury, which is brain damage caused by events after birth, rather than as part of a genetic or congenital disorder such as birth defects, fetal alcohol syndrome, perinatal illness or perinatal hypoxia, provided:
    - the cognitive therapy is used to restore mental skills or functions to at or near the pre-accident/disease state;

- the cognitive therapy is prescribed by a licensed Physician and is rendered by a qualified licensed professional acting within the scope of their license (an individual with a professional license who is qualified by training to treat acquired brain injury);
- medical records indicate that you or your covered dependent has sufficient cognitive function to understand and participate in the rehabilitative cognitive therapy program, adequate language expression and comprehension (i.e., no severe aphasia) and a likely expectation of achieving measurable improvement in a predictable period of time; and
- you or your covered dependent receiving the rehabilitative cognitive therapy must demonstrate continued objective improvement in function as a result of cognitive therapy measured by objective rehabilitative cognitive therapy effectiveness tests, including but not limited to: Functional Cortical Mappings, Electroencephalography (EEGs), Electromyography (EMGs), biofeedback and psychological evaluations.

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

- Applied behavior analysis prescribed for treatment of autism spectrum disorder. Preauthorization required, see page 48 for more information. Applied behavior analysis encompasses behavior modification training techniques, therapies and programs, including, but not limited to:
  - Early Intensive Behavioral Intervention (EIBI)
  - Lovaas Therapy
  - Discrete Trial Training
  - Learning Experiences and Alternative Programs (LEAP)
  - Treatment and Education of Autistic and Related Communication of Handicapped Children (TEACCH)
  - Denver Program
  - Rutgers Program
  - Psycho Educational Profile
  - Any similar program or therapy related to behavior modification training

Allergy Testing and Treatment

Benefits coverage for allergy testing and treatment:

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

Bariatric Surgery

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

- Diagnosis of morbid obesity, defined as a:
  - Body mass index (BMI) equal to or greater than 40kg/meter; or
  - BMI equal to or greater than 35kg/meters with at least one (1) of the following clinically significant obesity-related diseases or complications that are not controlled by best practice medical management:
    - Hypertension,
    - Dyslipidemia,
    - Diabetes mellitus,
    - Coronary heart disease,
    - Sleep apnea, or
    - Osteoarthritis in weight bearing joints
- Documentation the patient has satisfied the following requirements:
  - Growth is completed (generally by age 18)

    - Patient has completed evaluation by a licensed professional counselor, psychologist or psychiatrist within the 12 months preceding the request for surgery

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

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

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

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

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

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

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

Lap band adjustments (if needed) are covered in an office setting if the patient's surgery was at a Blue Distinction Center for Bariatric Surgery or if the initial lap band was placed prior to 2015.

Chiropractic Services

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

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

Benefits coverage for chiropractic services:

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

Durable Medical Equipment

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

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

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

Hearing Therapy and Treatment for Hearing Loss

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

The following benefits coverage applies:

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

Home Health Care

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

Benefits coverage for Home Health Care:

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

Preauthorization required, see page 48 for more information.

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

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

Home Health Care covered services include:

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

Care must require skilled nursing interventions.

Home Health Care services not covered include:

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

Hospice Care Program

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

Benefits coverage for Hospice Care:

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

Preauthorization required, see page 48 for more information.

Hospice Care covered services include:

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

Hospice Care services not covered include:

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

Note: Some of these excluded counseling services are available through Work-Life Resources (formerly the Employee Assistance Program or EAP).

Infertility

Medical benefits coverage for infertility:

- Network coinsurance for doctor and professional services is 10%, after the deductible is met
- Network coinsurance for hospitals/facilities is 20%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met
- Lifetime maximum is $25,000 for medical benefits (combined network and non-network)

Pharmacy benefits coverage for infertility:

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

Infertility covered services include:

- Artificial insemination (AI) or intrauterine insemination (IUI)
- Reproductive procedures, which include:

    - in vitro fertilization (IVF)
    - uterine embryo lavage
    - gamete intrafallopian tube transfer (GIFT)
    - intracytoplasmic injection (for male factor infertility)
    - low tubal ovum transfer
    - embryo transfer (ET) or blastocyst transfer
    - zygote intrafallopian tube transfer (ZIFT)
- Charges for fertility and/or infertility medications

Services/expenses not covered under infertility include:

- Assisted hatching, co-culture of embryos
- Cryopreservation of ovarian tissue or oocytes
- Cryopreservation, storage, thawing and re-transplantation of testicular tissue
- Intracytoplasmic sperm injections (ICSI) in the absence of male factor infertility
- Tests of sperm DNA integrity, including but not limited to, sperm chromatin assays and sperm DNA fragmentation assays
- Acupuncture
- Direct intraperitoneal insemination, intrafollicular insemination and fallopian tube sperm transfusion
- Early Embryo Viability Assessment (EEVA®) test
- EmbryoGlue®
- Hyperbaric oxygen treatment
- Immune treatments (e.g., leukocyte immunization and intravenous immunoglobulins)
- Intravaginal culture of oocytes (e.g., INVOcell®)
- Uterine transplant
- Reversal of voluntary sterilization
- Expenses for medical services or supplies rendered to a surrogate for purposes of child birth
- Expenses associated with cryopreservation and storage of sperm, eggs and embryos
- Expenses associated with the procurement of sperm, or harvesting of eggs and embryos from a donor
- Living and/or travel expenses

Injuries to Teeth

Services available to you and your covered dependents include the correction of damage caused solely by external violent accidental injury to healthy natural teeth and supporting tissues. The services must be performed within 24 months of the accidental injury. Implants are not covered. An injury sustained as a result of biting or chewing is not considered to be an accidental injury.

Medical Nutrition Therapy

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

Benefits coverage for Medical Nutrition Therapy:

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

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

- Cancer (e.g., breast, colon, lung or stomach)
- Cardiovascular Disease
    - Congestive heart failure, chronic
    - Coronary artery disease
    - Hypercholesterolemia (high cholesterol)
    - Hyperlipidemia (abnormal blood fats)
    - Hypertension (chronic high blood pressure)
    - Hypertension in pregnancy
- Diabetes/endocrine disorders
    - Diabetes, insulin-dependent
    - Diabetes, noninsulin-dependent
    - Diabetes, gestational (during pregnancy)
    - Hypoglycemia, reactive (low blood sugar)
- Gastrointestinal disorders
- HIV infection with HIV-related complications
- Food allergy that causes abnormal weight loss or acute asthma
- Failure to thrive/malnutrition/eating disorders
- Obesity
- Renal/kidney disease

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

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

Outpatient Physical Therapy Benefits

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

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

Skilled Nursing Facility

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

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

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

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

Preauthorization required, see page 48 for more information. Skilled nursing facility means a facility primarily engaged in providing skilled nursing services and other therapeutic services, and which is 1) licensed in accordance with state law (where the state law provides for licensing of such facility); or 2) Medicare or Medicaid eligible as a supplier of skilled nursing care.

Human Organ or Tissue Transplants

Certain organ and tissue transplants are covered including heart, heart/lung, bone marrow (autologous/allogeneic), liver and simultaneous pancreas kidney. Not all organ or tissue transplants are covered and certain limitations apply. Call BCBS for additional information. Preauthorization may be required, see page 48 for more information.

Transplant Network

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

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

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

Benefits coverage for human organ or tissue transplants:

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

[1] If a lead network surgeon is used and services are performed at a network facility and the assistant surgeon is non-network, the claims for the assistant surgeon's services would be reimbursed at the in-network level. If the lead surgeon and the assistant surgeon are both non-network providers, claims for their services would be reimbursed at the non-network level. Preauthorization may be required, see page 48 for more information.

[2] Professional services include(s), but are not limited to, surgeons, radiologists, anesthesiologists, physical therapists and home health care providers. Preauthorization may be required, see page 48 for more information.

[3] Hospitals/Facilities include, but are not limited to, emergency rooms, skilled nursing facilities and hospice facilities. Preauthorization may be required, see page 48 for more information.

Treatment for Loss or Impairment of Speech

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

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

Benefits coverage for outpatient treatment for loss or impairment of speech:

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

MDLIVE Virtual Visit

Benefits coverage for MDLIVE virtual visit:

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

When to use MDLIVE virtual visit:

Non-emergency medical conditions, such as:

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

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

- Cold and flu
- Earache
- Nausea

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

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

Telephone and video availability varies by state.

Right to Rescind Coverage – BCBS HDHP and PPO

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

Exclusions and Limitations

Services that are Not Covered under the Plan

The plan does not cover:

- Treatment not prescribed by a licensed physician or dentist
- Experimental or investigational treatment under the HDHP or PPO options, except that certain clinical trial coverage is available under the HDHP or PPO options (see the section titled "Clinical Trials" on page 79). Experimental or investigational treatment includes procedures, treatments,

care, services and supplies which do not represent a commonly accepted form of treatment; are not generally accepted by the medical community in the United States as effective, appropriate and essential for the treatment of a diagnosed condition; or are not proven effective in the treatment of an illness. BCBS determines experimental and investigational treatment, according to its medical policies and procedures on such matters. For a copy of such policies and procedures, please refer to bcbstx.com/important-info/policies.

- Cosmetic surgery or treatment, except for:
    - correcting damage caused by accidental injury
    - reconstructive breast surgery following mastectomy as described in the Other Covered Expenses section
- Occupational illness or injuries
- Exercise programs or vitamins
- Routine health checkups and tests not specified in preventive care (See the Adult and Baby/Child Preventive Health Care section for information about preventive health care.)
- Fitting or cost of eyeglasses, except when needed because of an injury to the eye
- Hearing aids and exams to the extent not covered
- Eye exams made for or in connection with treating or diagnosing astigmatism, myopia or hyperopia
- Dental work and dental X-rays, except for accidental injury. The services must be performed within 24 months of the accidental injury. Implants are not covered. An injury sustained as a result of biting or chewing is not considered to be an accidental injury.
- Charges for services of a resident physician or intern
- Charges for services for which a covered individual is not legally obligated to pay, for which a covered individual is not billed or for which a covered individual would not have been billed except that they were covered under this plan
- Charges for education, special education or job training
- Non-network doctor fees above the Allowable Amount
- Sonograms during pregnancy, unless medically necessary
- Birth control devices which are experimental/investigational or which are purchased without a prescription
- Providers not covered include, but are not limited to, massage therapists, exercise physiotherapists and acupuncturists. Acupuncture is only covered when used in lieu of anesthesia for surgery.
- Speech therapy is not covered for any of the following reasons:
    - Speech dysfunctions that are self-correcting
    - Services which maintain function that are neither diagnostic or therapeutic
    - Any procedure which may be carried out by someone other than a licensed/certified speech therapist
    - Psychoneurotic or psychotic conditions
    - Stammering or stuttering that is not related to an underlying medical condition
- Foot orthotics are not covered, unless medically necessary and prescribed by a physician, chiropractor and/or other qualified provider. Orthotic devices used for sports-related activities; and/or are upgraded splints (e.g., decorative items, or functionality or features beyond what is

required for management of the patient's current medical condition) are not considered medically necessary.

- Select Specialty Medications (including self-administered and physician administered injectables, along with certain oral medications) are covered exclusively under the Pharmacy Network administered by CVS Caremark. These select Specialty Medications are not eligible for coverage by BCBS. For more information, refer to the Specialty Medications part of the Pharmacy Network section.
- Rehabilitative cognitive therapy services involving non-medically necessary care including, but not limited to, services and treatments of dementia, Alzheimer's disease, Huntington's Chorea, and AIDS are not covered by the Plan.
- Custodial care

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

Know Your Benefits

To get the most from your benefits:

- Call BCBS before care is received or to verify medical necessity
- Use a network provider
- Call Work-Life Resources (formerly the EAP) first for short-term behavioral health care counseling and provider referral

Claiming Medical/Behavioral Health Care Benefits

When You Must File Your Claims

All medical/behavioral health care expense claims must be submitted according to administrative claim procedures and postmarked to BCBS **no later than 365 calendar days from the date of service**; claims submitted after this deadline will be denied as untimely. It is your responsibility to ensure that your claims are filed before the deadline. **Reminder** – any claims under your Health Care Flexible Spending Account (FSA) or Dental/Vision FSA must be submitted (or auto-submitted, if applicable) by March 31 of the year following the calendar year in which you incurred the expense.

Administrative Claim Procedures

Payment of Hospital Expenses

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

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

Payment of Doctor Expenses

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

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

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

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

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

Flexible Spending Account (FSA) and Automatic Claim Submissions

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

If You Need Help Filing a Claim

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

Claims should be sent to:

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

You also may write to BCBS at the following address:

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

Additional Information

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

Other Important Information

Right to Recovery

By accepting the payment and/or reimbursement of benefits made by the plan, the 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, subject to reduction for the plan's pro rata share of legal expenses the TIer or other covered person incurred to obtain such recovery.

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

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

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

If You Have Other Medical Insurance

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

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

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

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

If You Have Other Private Medical Insurance

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

Birthday Rule

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

Coverage During a Leave of Absence

If you are on a paid leave of absence, contributions for your medical 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 provided you pay for such coverage. You will be billed for these benefits. If you do not pay your bill, your coverage will be dropped effective as of your last paid through date unless otherwise required by law.

If you are on an unpaid leave, when you return to work, payment for coverage will resume automatically on a before-tax basis for coverage offered on a before-tax basis and on an after-tax basis for coverage so offered. Such payments will resume automatically through TI payroll deductions (note: if coverage was dropped due to non-payment, your coverage in place prior to the loss in coverage will resume upon your return to work; however, you may experience a gap in coverage).

In the case of military leave, your medical coverage and that of your covered dependents may continue while on military leave provided you pay for such coverage. You will be billed for these benefits. If you do not pay your bill, your coverage will be dropped effective as of your last paid through date unless otherwise required by law.

Termination of Coverage

If You Terminate Employment with TI or Change Your Employment Status

Your medical coverage will terminate on the earliest of the following dates:

- Date employment ends (including death)
- Date TI discontinues the plan
- Last date through which benefits are extended
    - For more information on available retiree medical benefits, see the TI Extended Health Benefits section beginning on page 100
    - For more information on continuing medical benefits, see the COBRA section beginning on page 125
- Last date for which payment was made for your coverage

It is your responsibility to inform the TI Benefits Center at Fidelity that a dependent’s coverage should end. Your dependent coverage will terminate on the earliest of the following dates in most cases:

- Date a dependent becomes covered as a TIer
- Date the dependent does not meet the definition of an eligible dependent
- Date of their death

- Date your TI coverage ends for reasons other than death
- Date dependent coverage is no longer offered under the plan
- Last date for which payment was made for dependent coverage
- Date of expiration of the period to which a Qualified Medical Child Support Order or a National Medical Support Notice applies

Death

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

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

Pharmacy Network

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

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

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

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

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

Routine immunizations can also be obtained at no cost through CVS Caremark's in-network pharmacies (subject to availability). Certain immunizations, through any pharmacy may require a physician's prescription. Certain immunizations are covered, check the caremark.com website for coverage or contact CVS Caremark through TI HR Connect at 888-660-1411.

BCBS Prescription Drug Benefits – HDHP

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

HDHP			
Type	**In-Network** **Coinsurance/Maximum**	**Out-of-Network** **Coinsurance**	**Mail-Order Program*** **Coinsurance/Maximum**
Generic Drugs	20% / $25 (whichever is less) of the total drug cost, for up to a 30-calendar-day supply	45% of the total drug cost, for up to a 30-calendar-day supply	20% / $75 (whichever is less) of the total drug cost, for up to a 90-calendar-day supply
Preferred Brand-name Drugs**	30% / $75 (whichever is less) of the total drug cost, for up to a 30-calendar-day supply	60% of the total drug cost, for up to a 30-calendar-day supply	30% / $225 (whichever is less) of the total drug cost, for up to a 90-calendar-day supply
Non-preferred Brand-name Drugs**	50% / $100 (whichever is less) of the total drug cost, for up to a 30-calendar-day supply	60% of the total drug cost, for up to a 30-calendar-day supply	50% / $300 (whichever is less) of the total drug cost, for up to a 90-calendar-day supply
Specialty Drugs**	10% of the total drug cost, for up to a 30-calendar-day supply Required to be filled through the CVS Caremark SpecialtyRx Pharmacy****	Not covered	Not covered
Prescription Contraceptives for Women	Total drug cost covered, you pay $0 – applies to generic drugs and brand-name drugs (when no generic available), for women only		
Annual pharmacy deductible	No separate pharmacy deductible; pharmacy claims are applied to the BCBS HDHP medical deductible		
Annual pharmacy out-of-pocket maximum***	No separate pharmacy out-of-pocket maximum; pharmacy claims are applied to the BCBS HDHP medical out-of-pocket maximum		

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

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

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

**** For more information, see the Specialty Medications section on page 77. For Specialty Medications, only the amounts actually paid by the participant will apply to the annual medical deductible and the annual medical out-of-pocket maximum.

BCBS Prescription Drug Benefits – PPO

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

PPO			
Type	**In-Network Coinsurance**	**Out-of-Network Coinsurance**	**Mail-Order Program* Coinsurance**
Generic Drugs	20% of the total drug cost, for up to a 30-calendar-day supply	45% of the total drug cost, for up to a 30-calendar-day supply	20% of the total drug cost, for up to a 90-calendar-day supply
Preferred Brand-name Drugs**	30% of the total drug cost, for up to a 30-calendar-day supply	60% of the total drug cost, for up to a 30-calendar-day supply	30% of the total drug cost, for up to a 90-calendar-day supply
Non-preferred Brand-name Drugs**	50% of the total drug cost, for up to a 30-calendar-day supply	60% of the total drug cost, for up to a 30-calendar-day supply	50% of the total drug cost, for up to a 90-calendar-day supply
Specialty Drugs**	10% of the total drug cost, for up to a 30-calendar-day supply Required to be filled through the CVS Caremark SpecialtyRx Pharmacy****	Not covered	Not covered
Prescription Contraceptives for Women	Total drug cost covered, you pay $0 – applies to generic drugs and brand-name drugs (when no generic available), for women only		
Annual pharmacy deductible	No deductible		
	In-Network	**Out-of-Network**	
Annual pharmacy out-of-pocket maximum***	$4,000 individual $8,000 family	$4,000 individual $8,000 family	

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

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

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

**** For more information, see the Specialty Medications section on page 77. For Specialty Medications, only the amounts actually paid by the participant will apply to the annual pharmacy out-of-pocket maximum.

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

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

Quality Care

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

Lost or Stolen Medication

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

Drugs Subject to Standard Formulary and Compound Exclusions

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

Covered Drugs Subject to Prior Authorization

Prior Authorization determines benefit coverage or the appropriateness of drug therapy for drugs that would otherwise not be covered by the Plan based on certain evidence-based medical or other criteria, including, but not limited to, strict FDA approval criteria, and the inclusion of the drug in one or more national compendia (which are summaries of drug information compiled by experts who have reviewed clinical data on drugs). Your pharmacist will inform you at the point-of-sale if your drug requires Prior Authorization and instruct you to have your physician contact the CVS Caremark Prior Authorization Unit. You may contact CVS Caremark Customer Care through TI HR Connect at 888-660-1411 if you have questions regarding whether your drug requires prior authorization. If your Prior Authorization is not approved by CVS Caremark, you will be responsible for the entire cost of the drug.

Covered Drugs Subject to Dispensing Limitations

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

Specialty Medications

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

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

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

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

Claiming Pharmacy Benefits

When You Must File Your Pharmacy Claims

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

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

All pharmacy expense claims must be postmarked to CVS Caremark **no later than 365 calendar days from the date of service**; claims submitted after this deadline will be denied as untimely. It is your responsibility to ensure that your claims are filed before the deadline. **Reminder** – any claims under your Health Care Flexible Spending Account (FSA) or Dental/Vision FSA must be submitted (or auto-submitted, if applicable) by March 31 of the year following the calendar year in which you incurred the expense.

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

Flexible Spending Account (FSA) and Automatic Claim Submissions

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

If You Need Help Filing a Claim

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

Claims should be sent to:

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

Plan Provisions that apply to BCBS (including CVS Caremark)

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

Clinical Trials

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

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

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

The plan will not discriminate against the individual on the basis of the individual's participation in a clinical trial. BCBS determines coverage for clinical trials, according to its medical policies and procedures on such matters. For a copy of such policies and procedures, please refer to bcbstx.com/important-info/policies.

If You are Entitled to Medicare (does not apply to CVS Caremark)

Certain active employees and/or their dependents may be entitled to and receiving Medicare benefits. In such situations, U.S. federal rules determine when the plan pays for health care claims first. For active employees, these rules provide:

- If you and/or your covered spouse turn age 65, the plan continues to be the primary payer for the Medicare eligible individual. Medicare benefits are calculated for the person age 65 or older based on any unpaid portion of the claim. If your covered domestic partner is eligible for Medicare due to reaching age (65 or older), Medicare pays primary and the plan pays secondary.
- If you and/or your covered dependents (e.g., children, domestic partner) qualify for Medicare by reason of disability (under age 65 and have received Social Security disability benefits for 24 months), the plan pays primary and Medicare pays secondary. Additionally, you should be automatically enrolled in Medicare Part B if you qualify for Medicare by reason of disability.
- If you and/or your covered dependents are entitled to Medicare benefits due to being diagnosed with end stage renal disease, the plan pays primary for the first 30 months after you and/or your covered dependents become eligible to enroll in Medicare and Medicare pays secondary.

When You Have A Complaint

The Claims Administrator wants you to be satisfied with the care you receive. That is why they have established a process for addressing your concerns and solving your problems. If you have a complaint regarding a person, a service, the quality of care, or plan benefits not related to Medical Necessity or plan coverage or a rescission of plan coverage you can call or write to the Claims Administrator and explain

your concern. A complaint does not include: a misunderstanding or problem of misinformation that can be promptly resolved by the Claims Administrator by clearing up the misunderstanding or supplying the correct information to your satisfaction; or you or your provider's dissatisfaction or disagreement with an adverse determination. Please call us at the Customer Service toll-free number that appears on your Benefit Identification card, explanation of benefits or claim form, or write to us at the following address:

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

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

Claim Filing and Appeals Procedures

Interpretation of Employer's Plan Provisions

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

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

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

Claim Dispute Resolution

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

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

Claim and Appeal Procedures

Claim Determinations

For the HDHP and PPO options, BCBS is the Claims Administrator for medical (including behavioral health care) claims and CVS Caremark is the Claims Administrator for pharmacy claims. When the Claims Administrator receives a properly submitted claim, it has final authority and discretion to interpret and determine benefits in accordance with the plan's provisions.

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

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

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

Adverse Determination Appeals Procedure

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

BCBS HDHP or PPO	
For Medical Claims:	**For Pharmacy Claims:**
Claim Review Section Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	CVS Caremark Prescription Claim Appeals P.O. Box 52084 Phoenix, AZ 85072-2084 Or faxed to 866-443-1172

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

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

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

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

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

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

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

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

If you are not satisfied with the Adverse Determination, you may appeal the Adverse Determination in writing. Any such appeal must be submitted within 180 calendar days after you receive notice of the Adverse Determination. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. The Claims Administrator will acknowledge the appeal in writing within five business days after they receive the Adverse Determination Appeal request.

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

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

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

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

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

External Independent Review Procedure

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

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

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

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

BCBS HDHP or PPO	
For Medical Claims:	**For Pharmacy Claims:**
Claim Review Section Blue Cross and Blue Shield of Texas P.O. Box 660044 Dallas, TX 75266-0044	CVS Caremark Prescription Claim Appeals P.O. Box 52084 Phoenix, AZ 85072-2084 Or faxed to 866-443-1172

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

The IRO will provide you with timely notice that states you may submit in writing within ten calendar days following receipt of the notice additional information that the IRO must consider when conducting the external Independent Review. You will receive written notice of the IRO decision within 45 calendar days after the IRO receives your request for external Independent Review. The notice of Independent Review decision will contain: (a) a general description of the reason for the request for external Independent Review; (b) the date the assignment to conduct the external Independent Review was received and the date of the IRO decision; (c) reference to the evidence or documentation considered; (d) a discussion of the principal reason(s) for the decision; (e) a statement that the determination is binding; (f) a statement that judicial review may be available to you; and (g) information about any office of health insurance consumer assistance or ombudsman available to assist you.

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

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

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

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

Notice of Benefit Determination on Appeal

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

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

Relevant Information

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

Legal Action Under U.S. Federal Laws

If your Plan is governed by ERISA, you have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the outcome of the Appeals Procedure. In most instances, you may not initiate a legal action against the Claims Administrator until you have completed the Claim and Adverse Determination Appeal process. Generally, if the Plan did not provide access to reasonable claims

procedures consistent with the regulations, there is no need to complete the Claim and Appeal process prior to bringing legal action.

Deadline for Bringing a Legal Action

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under Section 502(a) of ERISA if you file such complaint in a federal court within one (1) year of the date such claim was denied in the final level of the appeal process outlined above.

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

Medical - Regional Health Maintenance Organization (HMO)

Some TI employees can choose a regional Health Maintenance Organization (HMO) as an alternative to the BCBS HDHP or PPO. This section offers an overview of the services that HMOs generally provide. Details about the regional HMO can be obtained on the Fidelity NetBenefits® website at netbenefits.com/ti or directly from the HMO. Before choosing a medical option, you should carefully weigh the benefits under the health care options available to you, the accessibility of that care and the cost.

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

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

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

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

Enrolling in an HMO may not be advisable if:

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

You cannot change your enrollment from a BCBS HDHP or PPO, or a regional HMO except during annual enrollment, or when you move away from the geographic area served by the regional HMO.

Newborn or Adopted Children

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

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

Continuation of Benefits (COBRA)

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

Dental — Delta Dental (Basic and Plus) Preferred Provider Organization (PPO) and Aetna Dental Health Maintenance Organization (DHMO)

ERISA PLAN, offered through the TI Employees Health Benefit Plan

A Quick Look

Delta Dental Insurance Company (Delta Dental)

TIers may choose from two Delta Dental PPO plan options with different costs and coverage:

- Dental Basic
- Dental Plus

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

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

If You Do Not Enroll

If you do not make an election during your first 30 calendar days of employment, you will automatically be enrolled in Delta Dental Basic with **employee only coverage** and you will only be able to change that coverage to add family members if you have an appropriate qualified status change (see page 10) or during the next annual enrollment.

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

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

Enrolling Yourself and Your Eligible Dependents for Dental Coverage

You and your eligible dependents can be covered by the Delta Dental (Basic or Plus) or the TI-sponsored Aetna DHMO (if available in your area) on your first calendar day of work by making an election on the Fidelity NetBenefits® website at netbenefits.com/ti or by contacting the TI Benefits Center at Fidelity during your first 30 calendar days of employment. You must make an election on the Fidelity NetBenefits® website or contact the TI Benefits Center at Fidelity before coverage can begin. Eligible dependents must be enrolled for the same dental coverage that the TIer is enrolled in — family members cannot have dental coverage under different options.

When You Can Change to a Different Coverage

You may change from Dental Basic / Dental Plus to a DHMO (or vice versa) only during annual enrollment or when you move away from the geographic area served by the DHMO.

When You Can Make Changes

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

Effective Date of Coverage

TIer

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

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

Dependents

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

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

If terminating coverage due to an appropriate qualified status change, coverage is terminated retroactive to the date of the qualified status change, provided you notify the TI Benefits Center at Fidelity within 30 or 60 calendar days depending on the type of qualified status change. Please see the Introduction section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement.

Newborn or Adopted Children

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

Two TIers Who are Married (or in a Domestic Partnership)

If you are married to (or in a domestic partnership with) another TIer, only one TIer may enroll the eligible spouse (or domestic partner) or child dependents. TIers cannot be covered both as an employee and as a dependent.

Cost — Who Pays

TIers

TI and the TIer share in the cost for dental 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.

Dependents

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

Your Benefits (Delta Dental Basic and Dental Plus)

Pre-Existing Condition Limitations

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

What is Covered

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

Preventive and Diagnostic	Basic Services	Major Services	Orthodontics (only covered under Dental Plus)
Periodic oral exams Cleanings Preventive x-rays	Fillings, Routine extractions, Non-surgical periodontal services	Crowns, Dentures, Oral surgery, Root canals, Surgical periodontics, Implants, Non-Surgical TMJ	Braces Other services to straighten teeth

Network Providers You can choose any dentist to obtain dental services. Visit a dentist in the PPO network to maximize your savings. These dentists have agreed to reduced fees, and you won't get charged more than your expected share of the bill. If you cannot find a PPO dentist, Delta Dental Premier dentists offer the next best opportunity to save. Unlike non-Delta Dental dentists, they have agreed to set fees, and you won't get charged more than your expected share of the bill. By having network prices, you and TI pay less for dental care. There is not a penalty if you do not use a Delta Dental network dentist, but maximum plan allowance reimbursement limits apply. Maximum plan allowance reimbursement limits do not apply if you use network providers.

The listing of network dentists can be found on the Fidelity NetBenefits® website at netbenefits.com/ti. You can search for a provider based on defined criteria or by the provider name.

Deductible and Coinsurances in Delta Dental Basic and Dental Plus

TIers share in the cost of coverage through the deductible and coinsurances, as shown in the chart below. The deductible and coinsurance rates below represent the amounts paid by the participant.

Your Cost	Dental Basic	Dental Plus
Annual deductible*	$50	$50
Benefits	**Coinsurance Paid by Participant****	
Preventive care	**Dental Basic**	**Dental Plus**
- Oral exam, preventive x-rays, cleanings	0%	0%
Basic services	**Dental Basic**	**Dental Plus**
- Fillings	30%	10%
- Routine extractions	30%	10%
- Non-surgical periodontal services	30%	10%

Major services	Dental Basic	Dental Plus
- Crowns	60%	40%
- Dentures	60%	40%
- Endodontics (root canal therapy)	60%	40%
- Oral surgery	60%	40%
- Surgical Periodontics	60%	40%
- Implants (requires review by dental consultant)	60%	40%
Orthodontia services	**Dental Basic**	**Dental Plus**
- Orthodontia services (adult and children)	Not covered	50%

* Annual deductible applies to Basic and Major services only, not preventive and diagnostic or orthodontia services. A deductible is the amount you must pay for eligible expenses each calendar year before most benefits begin.

** Coinsurance is the percentage that you must pay for your eligible dental expenses after you meet your deductible (unless otherwise noted).

Annual and Lifetime Maximums

	Dental Basic	Dental Plus
Annual maximum*	$1,000	$2,000
Orthodontic lifetime maximum*	N/A	$1,500
TMJ lifetime maximum*	$750	$750

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

Benefits for orthodontia treatment (for you or your covered dependents), are paid as follows: if less than $500, Delta Dental will pay in one lump sum at date of banding. If greater than $500, Delta Dental will pay 50% at date of banding and 50% 12 months later pending eligibility. The payment(s) is subject to the applicable coinsurance level and lifetime maximum amount, shown in the charts above, and member eligibility.

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

Maximum Plan Allowances (applies to non-network providers only)

A maximum plan allowance is the usual cost for comparable treatment in a local geographic area. Maximum plan allowance limits will apply to all non-network dental services.

How Maximum Plan Allowance is Determined

The maximum plan allowance 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 dentist office and asking them to submit a pretreatment estimate to Delta Dental before receiving dental care.

Limitations and Exclusions (Dental Basic/Dental Plus)

The following are limitations:

- Preventive/diagnostic exams – two per calendar year
- Cleanings – two per calendar year
- Enhanced coverage for pregnant women includes an additional exam, cleaning or periodontal procedure as needed, once pregnancy is confirmed
- Periodontal cleanings – combined limit of four per calendar year, including two routine cleanings
- Periodontal scaling and root planing – once per quadrant in 24 consecutive months
- Periodontal surgery – once per quadrant in 36 consecutive months
- Bitewing x-rays one (1) set per calendar year for adults
- Bitewing x-rays two (2) sets per calendar year for children up to age 19
- Topical application of fluoride – for children up to age 19; limited to two per calendar year
- Sealants – for children up to age 19, applies only to permanent premolars/molars, replacement limit of once every 60 consecutive months
- Complete intraoral x-ray series (including bitewings) OR panoramic film (without bitewings) – once during a period of 60 consecutive months
- Denture relining – covered if within a six month period after installation; one per denture during any period of 6 consecutive months
- Denture adjustments – covered if within a six month period after installation
- Temporomandibular joint dysfunction (TMJ) – maximum lifetime 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 seven years ago
- Replacement of an existing crown/inlay/onlay that was installed less than seven years ago

- Dental expenses that are covered under a medical benefit option under the TI Employees Health Benefit Plan
- The initial installation of any prosthesis including a denture, bridge or implant to replace one or more natural teeth lost before coverage began under a TI 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 up to age 19
- Periodontal splinting
- Temporary or provisional restorations
- Temporary or provisional appliances
- Services or supplies furnished by a family member
- Accidents to sound, natural teeth (may be covered under medical)

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

Alternate Benefits (Dental Basic/Dental Plus)

Sometimes there are several ways to treat a particular dental problem. During the dental necessity review of the submitted documentation, Delta Dental may determine that a more cost-effective treatment is available that is adequate and meets generally accepted standards of dental care. If so, Delta Dental will provide benefits based upon that alternate treatment. You and your dentist may choose the more costly treatment, but you will be responsible for the difference in charges. This applies even if you don't get a pretreatment estimate (see below for more information on a pretreatment estimate). It is recommended that a pretreatment estimate of benefits is obtained for all services in excess of $300 so that you are aware of what the dental plan will pay for eligible services.

Pretreatment Estimate (Dental Basic/Dental Plus)

When You Should Ask for an Estimate

If you think your bill will exceed $300, or if you are not sure it is a covered expense (for example, bleaching after an accident), obtaining a pretreatment estimate helps avoid any unpleasant surprises by letting you know ahead of time:

- The cost of the dental service you are considering
- The amount the plan will cover (coordination of benefits and benefit maximums are not considered in this estimate)
- The estimated amount of out-of-pocket expenses you will have to pay
- Whether a professional result can be achieved by another form of treatment. In this case, you have the chance to discuss your options with the dentist before you have the work done.

Most dentists are familiar with this procedure. Here is how it works:

You

1. Fill out the standard dental claim form (available from the Fidelity NetBenefits® website at netbenefits.com/ti or the Delta Dental website at deltadentalins.com/TI) and take it to your dentist.

Your Dentist

2. Fills in the description of the proposed treatment and its cost. (Be sure the dentist does not sign the section that certifies that the treatment has been completed.)
3. Submits the form to Delta Dental for review.

Delta Dental

4. Reviews the proposed treatment and costs.
5. Tells you and your dentist approximately how much the plan will cover.

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

As the dental plan does not require precertification, seeking and obtaining a pretreatment estimate will not be treated as a claim for benefits. As a result, the claims procedures set forth below under "If a Claim is Denied" are not applicable. Only when you submit a post-service claim with a denial of benefits, either in whole or in part, will it result in the application of the claims procedures.

Claiming Dental Benefits

When You Must File Your Claims

All dental expense claims must be submitted according to administrative claim procedures and postmarked to Delta Dental **no later than 365 calendar days from the date of service**; claims submitted after this deadline will be denied as untimely. It is your responsibility to ensure that your claims are filed before the deadline. **Reminder** – any claims under your Health Care Flexible Spending Account (FSA) or Dental/Vision FSA must be submitted (or auto-submitted, if applicable) by March 31 of the year following the calendar year in which you incurred the expense.

Administrative Claim Procedures

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

Delta Dental claim forms can be found on the Fidelity NetBenefits® website at netbenefits.com/ti. You can also obtain a claim form by contacting Delta Dental through TI HR Connect at 888-660-1411 or you can go to the deltadentalins.com/TI website. Fill in the patient information section on the claim form. Be sure to include your Enrollee ID number and sign the form. Your dentist should complete the dentist's section of the form or provide an itemized bill for you to submit.

Claims should be sent to:

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

Any additional itemized bills must include your Enrollee ID number, name of patient, and service provided.

Flexible Spending Account (FSA) and Automatic Claim Submissions

If you have elected to decline automatic claim submissions for your Health Care FSA, or your Dental/Vision FSA you must complete, sign and submit an FSA claim form to receive reimbursement for dental expenses. (See Flexible Spending Accounts 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 Delta Dental, the Claims Administrator, at the time and in the manner prescribed by the Claims Administrator.

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

In certain instances, Delta Dental may not be able to make a determination within 30 calendar days after receiving your claim. In such situations, Delta Dental may extend the 30-calendar-day period for up to an additional 15 calendar days. Delta Dental will provide you with a written notice within the initial 30-calendar-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected. If the reason for the delay is due to your failure to provide information necessary to decide your claim, the notice will describe the information needed and give you up to 45 calendar days to provide the required information.

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

Delta Dental Basic and Dental Plus Plan Claim Appeals

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

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

As part of your appeal, you may submit written comments, documents, records and other information relating to your claim for benefits, without regard to whether such information was submitted and considered in the initial determination of your claim. You will receive written acknowledgment within 5 days upon receipt of your appeal. You may also request reasonable access to, and copies of, all documents, records, and other information relevant to your claim. You will not be charged for this information.

Delta Dental will conduct a full and fair review and may ask for more documents during this review, if needed. Delta Dental's review will (i) take into account the information submitted (comments, documents, records or other information), regardless of whether such information was submitted or considered initially, (ii) not afford deference to the initial adverse determination, and (iii) be conducted by someone who is neither the individual who made the initial determination nor a subordinate of such individual.

If your appeal involves a determination based in whole or part on a dental judgment (including determinations with regard to whether a particular treatment is experimental or not medically necessary or appropriate), Delta Dental will consult with a dentist with the appropriate training and experience. When requested by you, Delta Dental will provide you with the name of the dentist whose advice was sought in connection with your appeal.

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

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

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

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

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

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

This second-level decision shall be the final determination of the claim. If it is not furnished within the appropriate period described above, the claim should be considered denied on review.

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under Section 502(a) of ERISA if you file such complaint in a federal court within one (1) year of the date such claim was denied in the final level of the appeal process outlined above.

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

Coordination of Benefits

If You Have Other Dental Insurance

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

If you have coverage under another group dental plan, your coverage under Delta Dental will be coordinated. This means that one of your plans is considered primary and the other secondary. The primary plan pays your expenses first.

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

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

If You Have Other Private Dental Insurance

Delta Dental will not coordinate with other private dental insurance policies such as those available through individual insurance purchased on your own. If you carry insurance, other than another group plan, Delta Dental will ignore the private policy.

Birthday Rule

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

Coverage During a Leave of Absence

If you are on a paid leave of absence, contributions for your dental 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 provided you pay for such coverage. You will be billed for these benefits. If you do not pay your bill, your coverage will be dropped effective as of your last paid through date unless otherwise required by law.

If you are on an unpaid leave, when you return to work, payment for coverage will resume automatically on a before-tax basis for coverage offered on a before-tax basis and on an after-tax basis for coverage so offered. Such payments will resume automatically through TI payroll deductions (note: if coverage was dropped due to non-payment, your coverage in place prior to the loss in coverage will resume upon your return to work; however, you may experience a gap in coverage).

In the case of military leave, your dental coverage and that of your covered dependents may continue while on military leave provided you pay for such coverage. You will be billed for these benefits. If you do

not pay your bill, your coverage will be dropped effective as of your last paid through date unless otherwise required by law.

Termination of Coverage

If You Terminate Employment with TI or Change Your Employment Status

Your dental coverage will terminate on the earliest of the following dates:

- Date employment ends (including death)
- Date TI discontinues the plan
- Last date through which benefits are extended
    - For more information on available retiree dental benefits, see the TI Extended Health Benefits section beginning on page 100
    - For more information on continuing dental benefits, see the COBRA section beginning on page 125
- Last date for which payment was made for your coverage

It is your responsibility to inform the TI Benefits Center at Fidelity that a dependent's coverage should end. Your dependent coverage will terminate on the earliest of the following dates in most cases:

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

Death

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

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

When Benefits Change

If you terminate employment, dental coverage ends. However, Delta Dental will pay for covered services incurred while you were eligible if the procedures were completed within 30 calendar days of the date your coverage ended. A dental service is incurred:

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

Dental Health Maintenance Organization (DHMO)

Most 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.

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

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

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

Enrolling in a DHMO may not be advisable if:

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

You'll be able to compare the available options, including their costs and benefits, when you enroll or when you're eligible to make mid-year changes to your coverage (appropriate qualified status change).

You cannot change DHMO coverage or enroll in Dental Basic / Dental Plus except during annual enrollment, or when you move away from the geographic area served by the DHMO.

Newborn or Adopted Children

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

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

Continuation of Benefits (COBRA)

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

TI Extended Health Benefits (Retiree Medical and Dental)

ERISA PLAN, offered through the TI Retiree Health Benefit Plan
Via Benefits - Individual Insurance Policies, not an ERISA PLAN

Below is a brief summary - for more information please refer to the Retiree Health Benefits Summary Plan Description in effect for that calendar year. You can locate the current Retiree Health Benefits Summary Plan Description from inside TI's network, at myHR > myCompensation & myBenefits (click on "Legal notices and plan documents"). **Note:** TI group retiree benefits may differ from TI group active benefits.

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

TI Extended Health Benefits under the TI Retiree Health Benefit Plan provides access to TI group retiree medical (includes prescription drug) and/or dental coverage after leaving TI for those under age 65.

Via Benefits, a private exchange, provides access to purchase an individual medical, prescription drug, and/or dental insurance policy after leaving TI for those ages 65 or over. Via Benefits also offers access to vision coverage.

If you have questions about eligibility, enrollment and/or the cost of TI group retiree medical or dental coverage, please contact the TI Benefits Center at Fidelity through TI HR Connect at 888-660-1411. If you have questions about retiree health coverage available through Via Benefits, please contact Via Benefits at 844-638-4642 or through their website at My.ViaBenefits.com/TI.

Eligibility for TI Extended Health Benefits or Via Benefits

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

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

Your service date (sometimes referred to as your Enterprise Seniority Date) is the date used to determine your eligibility for TI Extended Health Benefits. Your service date is your employment date. If you were rehired prior to January 1, 2018, the service date will be your rehire date unless you are entitled to prior service credit under TI policy.

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

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

Your service date (sometimes referred to as your Enterprise Seniority Date) is the date used to determine your eligibility for TI Extended Health Benefits. Your service date is your employment date. If you were rehired on or after January 1, 2018, the service date will be your rehire date.

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

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

IMPORTANT NOTES:

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

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

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

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

For those rehired prior to January 1, 2018: If you are rehired as an employee eligible for active benefits after you terminated employment and elected TI Extended Health Benefits, you will no longer be eligible for TI Extended Health Benefits, effective immediately upon the date of your rehire. You may be eligible for TI Extended Health Benefits or Via Benefits when you terminate employment again. The retirement eligibility status in effect at the date of your original termination of employment will apply to your subsequent termination of employment. You may qualify for additional years of service.

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

Cost — Who Pays

If you were hired/rehired into TI or acquired by TI before January 1, 2001 – You pay part of the cost for your coverage and TI provides a financial contribution. This TI contribution increases with each year of service up to 30 years of service. Covered dependents must pay the entire cost. You will also be

responsible for deductibles, copays and coinsurance payments and any expenses above the Allowable Amount for a Non-Network provider.

If you were hired/rehired into TI or acquired by TI on or after January 1, 2001 – You must pay the entire cost for your coverage and coverage for your covered dependents. TI will not make any financial contribution. You will also be responsible for deductibles, copays and coinsurance payments and any expenses above the Allowable Amount for a Non-Network provider.

For the above to apply, you must be eligible for and elect TI Extended Health Benefits, as discussed in the Eligibility for TI Extended Health Benefits or Via Benefits section above.

This cost-sharing policy may change at any time.

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

Other Important Information

Eligibility and plan rules for TI Extended Health Benefits coverage under the TI Retiree Health Benefit Plan may differ from the eligibility and plan rules for pension benefits under the TI Employees Pension Plan. Therefore, satisfaction of the eligibility requirements under the TI Employees Pension Plan will not automatically provide eligibility for TI Extended Health Benefits coverage offered through the TI Retiree Health Benefit Plan.

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

Work-Life Resources (EAP)

Provided to all employees through the TI Employees Health Benefit Plan
THE EAP IS PART OF AN ERISA PLAN
(Note: This does not apply to retirees)

TI's Work-Life Resources (formerly the Employee Assistance Program or 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 Healthcare, Inc. ("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, your coverage and coverage of your eligible household members is automatic and not subject to pre-conditions. As such, you do not need to take any steps to enroll and enrollment in TI medical coverage is not required to use Work-Life Resources. Additionally, use of Work-Life Resources is not required in order to receive behavioral health care services under a TI medical option.

Eligible household members include your dependents and individuals who live with you.

How to Obtain Work-Life Resource Services

You can obtain Work-Life Resource services by contacting Magellan Healthcare 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 Work-Life Resources, a Magellan representative will:

- Ask you questions to help identify the issue 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 issue.

Spanish-speaking representatives and counselors are available.

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

Telehealth is an option that may be used in lieu of the in-person sessions and provides a convenient, secure option for accessing Work-Life Resources counseling via a HIPAA compliant telephonic and video conferencing solution. Telehealth allows you to receive Work-Life Resources counseling from the privacy of your own home, parked car or office. Telehealth also includes live chat and text messaging options. Expanded evening and weekend appointments are available for members choosing Telehealth. You may select a Telehealth Work-Life Resources counselor (i) by calling Magellan at 800-888-CARE (2273) or (ii) through Magellan's online Work-Life Resources self-referral process. Magellan's clinical team helps match you to a provider that meets your unique needs. Video conferencing availability varies by state.

You can also access information, self-help tools, and other resources through Magellan's website. You can reach this website directly at MagellanAscend.com or type usworklife/ in your Infolink browser

Participation in Work-Life Resources 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 Work-Life Resources is your personal choice. It will not adversely affect your job security or advancement opportunities. However, participation in Work-Life Resources in no way relieves you of the responsibility to meet acceptable work performance and attendance standards.

Covered Services

Work-Life Resources provide confidential assessment and counseling services to help with issues or concerns 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 8 in-person sessions per issue each calendar year. If you obtain in-person counseling for an issue together with an eligible household member, such as your spouse, the total number of in-person sessions for which you and the other person are eligible for that issue is still 8. The number of sessions does not double simply because two persons participate in counseling or triple because three persons participate.

Work-Life Resources will help you develop solutions for issues such as:

- Relationship issues (marital tension, parental concerns, etc.)
- Emotional stress (anxiety, depression, etc.)
- Stress related to financial and legal issues
- Life crises
- Substance abuse (drug, alcohol, prescription drugs, etc.)
- Adjusting to change, self-improvement
- Grief
- Work performance/career issues
- Elder care concerns/issues
- Parenting and childcare issues (schooling and education, teen and young adult issues)

Work-Life Resources also provides:

- Resource library – Magellan offers a comprehensive library of articles, tools, calculators, self-assessments, webinars and podcasts on topics such as childcare and parenting, adult care and aging, travel, pets, education, adoption, daily needs, special needs, safety, pregnancy, mothers at work and more.
- Referrals for personal convenience services (home or auto repair, pet care, relocation assistance)

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

Payment of Counselors

Magellan pays Work-Life Resource counselors directly. You do not have to file claims for Work-Life Resource services.

Work-Life Resources and Your Medical Coverage

If you participate in Work-Life Resources and require assistance beyond what Work-Life Resources can provide, Work-Life Resources will refer you to BCBS or your HMO for assistance with benefit coverage of your needed treatment.

Work-Life Resource Exclusions and Limitations

Work-Life Resources will not pay for the following:

- Services by providers who are not part of Magellan's Work-Life Resources Counselor network
- In-person sessions that were not accessed through Magellan (either through the toll-free telephone access line or the on-line self-referral service) for the particular issue
- Charge for failure to keep a scheduled visit
- Supplies
- Services rendered before TI employment
- Services rendered by a family member
- Medical care, including services for a condition that requires psychiatric treatment (for example, a psychosis)
- Inpatient treatment
- More than 8 in-person Work-Life Resource sessions per issue per calendar year
- Psychological, psychiatric, neurological, educational, or IQ testing
- Remedial and social skills education services, such as evaluation or treatment of learning disabilities, learning disorders, academic skills disorders, language disorders, mental retardation, motor skill disorders, or communications disorders, behavioral training, cognitive rehabilitation
- Medication or medication management
- 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 or recommendations used in legal actions of any kind (for example, child custody proceedings, child abuse proceedings, criminal proceedings, workers' compensation proceedings)
- Testimony, creation of records, or other services in connection with legal proceedings
- Evaluations/counseling mandated by any state or federal judicial officer or other governmental official or agency
- Acupuncture
- Aversion therapy
- Biofeedback and hypnotherapy
- Sleep therapy
- Group counseling
- Guidance on workplace issues when the participant sues or threatens to sue TI

Continuation of Benefits (COBRA)

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

Note: COBRA participants enrolled in the TI Employees Health Benefit Plan are automatically covered under Work-Life Resources.

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 (including death)
- TI discontinues the program
- TI ceases contracting with Magellan for these services

Complaint Review

If you have a counselor you cannot work with, call Work-Life Resources to request a different counselor.

Magellan realizes that employees may encounter situations where the performance of Work-Life Resources does not meet their expectations. Magellan will make every effort to resolve problems or complaints in a timely manner.

In the unlikely event that a claim for Work-Life Resource services is denied by Magellan, please call Magellan at 800-888-CARE (2273) to lodge a formal claim for Work-Life Resource services and/or appeal an adverse Work-Life Resources claim determination.

Vision

THIS BENEFIT IS PART OF AN ERISA PLAN

A Quick Look

The vision benefit, administered by VSP® 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 and you do not need to file a claim with VSP to be reimbursed.
- 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 calendar day of work by making an election on the Fidelity NetBenefits® website at netbenefits.com/ti or by contacting the TI Benefits Center at Fidelity during your first 30 calendar days of employment. You must make an election on the Fidelity NetBenefits® website or contact the TI Benefits Center at Fidelity before coverage can begin.

When You Can Make Changes

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

Effective Date of Coverage

TIer

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

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

Dependents

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

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

If terminating coverage due to an appropriate qualified status change, coverage is terminated retroactive to the date of the qualified status change, provided you notify the TI Benefits Center at Fidelity within 30 or 60 calendar days depending on the type of qualified status change. Please see the Introduction section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement.

Newborn or Adopted Children

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

Two TIers Who are Married (or in a Domestic Partnership)

If you are married to (or in a domestic partnership with) another TIer, only one TIer may enroll the eligible spouse (or domestic partner) or child dependents. TIers cannot be covered both as an employee and as a dependent.

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, lined trifocal, and standard progressive 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 $160 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. Special rebates and other pricing advantages available on popular brands of contacts. Visit vsp.com for the details.
Contacts (medically necessary)	The plan pays 100% after you pay a $25 copay
Laser vision correction surgery	Discounted rates available**. The VSP doctor will coordinate referrals for qualified candidates to participating VSP Laser Surgery Centers.

* 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. Contact lenses are in lieu of lenses and frame.

The listing of VSP network providers can be found on the Fidelity NetBenefits® website at netbenefits.com/ti. You can search for a provider based on defined criteria or by the provider name. You can also obtain provider information by visiting the VSP website at vsp.com or by contacting VSP at 800-877-7195. VSP can also be reached through TI HR Connect at 888-660-1411.

Your benefit includes eyeconic.com® an online eyewear store for VSP Members. Eyeconic connects your eyewear, your insurance coverage, and the VSP® doctor network. You can connect to your VSP benefits, upload your prescription and order your glasses or contacts following your eye exam.

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 premium and custom progressives.
- 30% off additional glasses and sunglasses (after your initial frame purchase), including lens options, from the same VSP doctor on the same calendar 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).
- Special rebates and other pricing advantages available on popular brands of contacts. Visit vsp.com for the details.
- UV (ultraviolet) protective coating covered in full.
- Polycarbonate lenses for dependent children covered in full.
- VSP has an exclusive agreement with Costco Optical locations, Walmart and Visionworks. You'll receive coverage similar to what is available through a VSP doctor; however, there are some coverage differences, including lens options and discounts on overages. You will not need to file a claim form - simply pay your copay(s), costs over your coverage amounts, and costs of any additional non-covered services and selections. Contact VSP for additional information.

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

Here's what the plan pays for covered services/eyewear:

Annual eye exams	The plan pays up to $50 after you pay a $10 copay
Single vision lenses*	The plan pays up to $50 per pair after you pay a $25 copay
Lined bifocal lenses*	The plan pays up to $75 per pair after you pay a $25 copay
Lined trifocal lenses*	The plan pays up to $100 per pair after you pay a $25 copay
Progressive lenses*	The plan pays up to $75 per pair after you pay a $25 copay
Frames*	The plan pays up to $70 after you pay a $25 copay
Contacts (elective)	The plan pays up to $200
Contacts (medically necessary)	The plan pays up to $210 after you pay a $25 copay
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.

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, you will be responsible for the additional costs.

- Blended lenses
- Oversize lenses
- Photochromic lenses; tinted lenses except pink #1 or pink #2
- Premium and custom progressive multifocal lenses
- The coating of a lens or lenses
- The laminating of a lens or lenses
- Cosmetic lenses
- Optional cosmetic processes

The following services/eyewear are not a covered benefit:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (lenses with refractive correction of less than ± .50 diopter)
- Two pairs of glasses instead of bifocals
- Replacement of spectacle lenses, frames and/or contact lenses which are lost or broken, except at the normal intervals when services/eyeware are otherwise eligible
- Medical or surgical treatment of the eyes (may be covered under BCBS HDHP or PPO, or a regional 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
- Contact lens insurance policies or service agreements
- Refitting of contact lenses after the initial (90-calendar-day period) fitting period
- Contact lens modification, polishing or cleaning
- Local, state and/or federal taxes for vision services/eyewear, except where VSP is required by law to pay
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology
- Some brands of spectacle frames may be unavailable for coverage, or may be subject to additional limitations. You may obtain details regarding frame brand coverage from your VSP member doctor or by calling VSP's Customer Care Division at 800-877-7195.

The plan may impose further limitations and exclusions. *These additional limitations and exclusions may not be included in the list*. If you have any questions about coverage, contact VSP.

Coverage During a Leave of Absence

If you are on a paid leave of absence, contributions for your vision 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 provided you pay for such coverage. You will be billed for these

benefits. If you do not pay your bill, your coverage will be dropped effective as of your last paid through date unless otherwise required by law.

If you are on an unpaid leave, when you return to work, payment for coverage will resume automatically on a before-tax basis for coverage offered on a before-tax basis and on an after-tax basis for coverage so offered. Such payments will resume automatically through TI payroll deductions (note: if coverage was dropped due to non-payment, your coverage in place prior to the loss in coverage will resume upon your return to work; however, you may experience a gap in coverage).

In the case of military leave, your vision coverage and that of your covered dependents may continue while on military leave provided you pay for such coverage. You will be billed for these benefits. If you do not pay your bill, your coverage will be dropped effective as of your last paid through date unless otherwise required by law.

Termination of Coverage

If You Terminate Employment with TI or Change Your Employment Status

Your vision coverage will terminate on the earliest of the following dates:

- Date employment ends (including death)
- 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 at Fidelity that a dependent's coverage should end. Your dependent coverage will terminate on the earliest of the following dates in most cases:

- Date a dependent becomes covered as a TIer
- Date the dependent does not meet the definition of an eligible dependent
- Date of their death
- Date your 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 the COBRA section.

Claiming Vision 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.

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 with VSP for reimbursement. Claims must be submitted to VSP and postmarked within 1 year from your date of service, claims submitted after this deadline will be denied as untimely. **Reminder** – any claims under your Health Care Flexible Spending Account (FSA) or Dental/Vision FSA must be submitted (or auto-submitted, if applicable) by March 31 of the year following the calendar year in which you incurred the expense.

You can get a claim form and filing instructions online on the Fidelity NetBenefits® website at netbenefits.com/ti or on the VSP website at vsp.com, or by calling VSP through TI HR Connect at 888-660-1411.

Flexible Spending Account (FSA) and Claim Submission

To receive reimbursement from your Health Care FSA or Dental/Vision FSA for vision care expenses, you must complete, sign and submit an FSA 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 calendar days from the calendar day your claim was received by VSP. This notice (which will be provided to you in writing by mail, or hand delivery, or through email) 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), (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 calendar days from the calendar day your claim for benefits was received. In such situations, VSP, in its sole and absolute discretion, may extend the 30-calendar-day period for up to 15 calendar 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-calendar-day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected. If the reason for the delay is due to your failure to provide information necessary to decide your claim, the above-mentioned notice will describe the information needed and afford you up to 45 calendar days from the calendar day you receive the notice to provide the required information.

If your claim for 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 calendar days of the date you received your notification of VSP's denial. Your request for an appeal should be mailed to:

VSP
Claims Administrator
Member Appeals
3333 Quality Drive
Rancho Cordova, CA 95670

Or sent via email to imember@vsp.com

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. 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 calendar days from the calendar 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.

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under Section 502(a) of ERISA if you file such complaint in a federal court within one (1) year of the date such claim was denied in the final level of the appeal process outlined above.

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

THIS FORM WAS PREPARED FOR COMPLIANCE WITH U.S. FEDERAL HIPAA PRIVACY. YOU SHOULD CONSULT THE APPLICABLE STATE LAWS FOR STATE DIFFERENCES

NOTICE OF PRIVACY RIGHTS – HEALTH CARE RECORDS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 23, 2013, and applies to health information received about you by the Texas Instruments Incorporated Welfare Benefits Plan (the "Plan"). You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). The Privacy Regulations were most recently amended effective January 17, 2013. Additionally, the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA") both amended the privacy requirements under the Privacy Regulations. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan, including genetic information (your "Protected Health Information" or "PHI"). This notice is intended to inform you about how the Plan will use or disclose your Protected Health Information, your privacy rights with respect to the Protected Health Information, the Plan's duties with respect to your Protected Health Information, your right to file a complaint with the Plan or with the U.S. Department of Health and Human Services and the office to contact for further information about the Plan's privacy practices. The following uses and disclosures of your Protected Health Information may be made by the Plan:

For Payment. Your Protected Health Information may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, and disclosures to obtain reimbursement under insurance, reinsurance or stop loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your Protected Health Information may be disclosed to other health plans maintained by Texas Instruments Incorporated for any of the purposes described above. Disclosures for purposes of payment must meet the minimally necessary standard.

For Treatment. Your Protected Health Information may be used or disclosed by the Plan for purposes of treating you. For example, if your doctor requests information on what other drugs you are currently receiving.

For the Plan's Operations. Your Protected Health Information may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances; however, your genetic information, if any, contained in your PHI will not be disclosed for underwriting, premium rating, renewal of coverage, or for securing or placing a contract for reinsurance of risk. Disclosures for purposes of health care operations must meet the minimally necessary standard. The Plan may disclose your Protected Health Information for purposes of referring you to case management or a pharmacy benefit manager.

When Required by Law. The Plan may also be required to disclose or use your Protected Health Information for certain other purposes when the Plan is required by law to disclose or use your Protected Health Information. For example, if certain types of wounds occur that require reporting, or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena.

For Workers' Compensation. The Plan may disclose your Protected Health Information without authorization as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illnesses.

Pursuant to Your Authorization. Any other use or disclosure of your Protected Health Information will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.

For Appointment Reminders and Health Plan Operations. Your Protected Health Information may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders, information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. Information may be provided to the sponsor of the Plan provided that the sponsor has certified that this information will not be used for any other benefits, employee benefit plans or employment related activities.

Other Uses or Disclosures of Protected Health Information

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release:

Disclosure of your Protected Health Information to family members, other relatives and your close personal friends involved in your health care or the payment for your health care is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care;
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected;
- the information is needed for notification purposes; or
- if you are deceased, your Protected Health Information is relevant to such person's involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

Uses and disclosures for which authorization or opportunity to object is not required:

Use and disclosure of your Protected Health Information is allowed without your authorization or any opportunity to agree or object under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Protected Health Information may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.
- When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For

the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.

- When the disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under U.S. federal or state laws when the parents or other representatives may not be given access to a minor's Protected Health Information.
- When the Protected Health Information is immunization records for a student or prospective student that is disclosed to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.
- The Plan may disclose your Protected Health Information to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your Protected Health Information when required for judicial or administrative proceedings. For example, your Protected Health Information may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose Protected Health Information for research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- The Plan may disclose your Protected Health Information to your employer, provided certain requirements are met, and provided that the Protected Health Information is not used for any other employment decision and it is not further disclosed or used; however, no genetic information may be used in underwriting or obtaining bids for coverage.
- The Plan may use your Protected Health Information (excluding any genetic information) for underwriting purposes. The Plan is prohibited from using or disclosing Protected Health Information that is genetic information of an individual for such purposes.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization. State laws may provide you with additional rights or protections.

Uses and Disclosures Requiring an Authorization

The Plan may only use your Protected Health Information if you provide your written authorization to so use your Protected Health Information for the following uses or disclosures:

- Any access to psychotherapy notes from your treatment or counseling sessions (whether individual or group);
- If the Plan wants to use your Protected Health Information for marketing purposes, for example using your phone number to contact you to try to sell you a product unrelated to your health care; or
- If the Plan wants to sell your Protected Health Information. (This notice regarding the selling of your Protected Health Information is required to comply with the Privacy Regulations. The Plan has no intention to sell your Protected Health Information.)

You may revoke any authorization that you have previously provided to the Plan. You should contact the Plan in writing to revoke any prior written authorization.

The Plan's Obligations

The Plan is required by law to maintain the privacy of the Protected Health Information it creates or receives, to provide individuals with notice of its legal duties and privacy practices with respect to Protected Health Information, and to notify affected individuals following a breach of unsecured Protected Health Information. The Plan is required to abide by the terms of the Plan's current privacy notice.

Rights You May Exercise

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your protected health information in writing. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to any restriction you may request.

In certain circumstances, the Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243.

To Access. You have the right to request access to your Protected Health Information and to inspect and copy your Protected Health Information in the designated record set under the policies and procedures established by the Plan. The designated record set is the series of codes that make up each electronic claim. This does not include psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or Protected Health Information that is maintained by a covered entity that is a clinical laboratory. The requested information will be provided within 30 calendar days if the information is maintained on site or within 60 calendar days if the information is maintained offsite. A single 30-calendar-day extension is allowed if the Plan is unable to comply with the deadline. To the extent that the Plan uses or maintains an electronic health record you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person designated by the individual.

You or your personal representative will be required to complete a form to request access to the Protected Health Information in your designated record set. Requests for access to Protected Health Information should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243. If access is denied, you or your personal representative will be provided with a written

denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the U.S. Department of Health and Human Services.

To Amend. You have the right to request an amendment to your Protected Health Information in writing under the policies established by the Plan. The Plan has 60 calendar days after the request is made to act on the request. A single 30-calendar-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your Protected Health Information. Requests for amendment of Protected Health Information in a designated record set should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243. You or your personal representative will be required to complete a written form to request amendment of the Protected Health Information in your designated record set.

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your Protected Health Information, other than those for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your Protected Health Information during the six years prior to the date of your request. However, such accounting need not include Protected Health Information disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own Protected Health Information; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan.

If the accounting cannot be provided within 60 calendar days, an additional 30 calendar days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To Request a Paper Copy of this Notice. An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, contact the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243.

To Request Confidential Communication. You have the right to request to receive confidential communications of your Protected Health Information. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate certain reasonable requests to receive communications of PHI by alternative means or at alternative locations. Such requests should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243.

A Note About Personal Representatives. You may exercise your rights through a personal representative (e.g., having your spouse or domestic partner call for you). Your personal representative will be required to produce evidence of their authority to act on your behalf before that person will be given access to your Protected Health Information or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a signed authorization completed by you;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your Protected Health Information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all Protected Health Information the Plan maintains. Any Protected Health Information that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all Protected Health Information it receives or maintains.

Any revised version of this notice will be distributed within 60 calendar days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing Protected Health Information or when requesting Protected Health Information from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of Protected Health Information necessary to accomplish the intended purpose of the use, disclosure or request.

However, the minimum necessary standard will not apply in the following situations: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual; (3) disclosures made to the U.S. Department of Health and Human Services; (4) uses or disclosures made pursuant to an authorization you signed; (5) uses or disclosures in the designated record set; (6) uses or disclosures that are required by law; (7) uses or disclosures that are required for the Plan's compliance with legal regulations; and (8) uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan may use or disclose a “Limited Data Set” which may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set. Disclosures of a Limited Data Set need not be included in any accounting of disclosures by the Plan. Effective for uses or disclosures on and after February 17, 2010, the minimally necessary shall be defined as the Limited Data Set, or the minimal amount necessary as determined by the recipient, until such time as regulations defining what constitutes the minimally necessary are promulgated and effective.

You have the right to file a complaint with the Plan or the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. You will not be retaliated against for filing a complaint, but such complaint must be filed within 180 calendar days of any alleged violation.

You may file a complaint with the Plan by sending a letter describing when you believe the violation occurred and what you believe the violation was to Texas Instruments Incorporated, Attention: Privacy Complaint Official, 13570 N. Central Expressway, MS 3999, Dallas, Texas 75243, calling 214-479-1242, or sending an email to privacy_complaint_official@list.ti.com.

You may also file a complaint by sending a letter to the U.S. Department of Health and Human Services

Office for Civil Rights, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington, DC 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

If you would like to receive further information, you should contact the Privacy Official or the Privacy Complaint Official for the Plan. This notice will remain in effect until you are notified of any changes, modifications or amendments.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-**866-444-EBSA (3272).

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility –

ALABAMA – Medicaid	**COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)**
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Health First Colorado Website: https://www.healthfirstcolorado.com/ Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711 CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus CHP+ Customer Service: 1-800-359-1991/ State Relay 711 Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program HIBI Customer Service: 1-855-692-6442
ALASKA – Medicaid	**FLORIDA – Medicaid**
The AK Health Insurance Premium Payment Program Website: http://myakhipp.com/ Phone: 1-866-251-4861 Email: CustomerService@MyAKHIPP.com Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html Phone: 1-877-357-3268
ARKANSAS – Medicaid	**GEORGIA – Medicaid**
Website: http://myarhipp.com/ Phone: 1-855-MyARHIPP (855-692-7447)	Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp Phone: 678-564-1162 ext 2131

CALIFORNIA – Medicaid	INDIANA – Medicaid
Website: https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 916-440-5676	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.in.gov/fssa/hip/ Phone: 1-877-438-4479 All other Medicaid Website: https://www.in.gov/medicaid/ Phone 1-800-457-4584
IOWA – Medicaid and CHIP (Hawki)	**MONTANA – Medicaid**
Medicaid Website: https://dhs.iowa.gov/ime/members Medicaid Phone: 1-800-338-8366 Hawki Website: http://dhs.iowa.gov/Hawki Hawki Phone: 1-800-257-8563	Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084
KANSAS – Medicaid	**NEBRASKA – Medicaid**
Website: http://www.kdheks.gov/hcf/default.htm Phone: 1-800-792-4884	Website: http://www.ACCESSNebraska.ne.gov Phone: 1-855-632-7633 Lincoln: 402-473-7000 Omaha: 402-595-1178
KENTUCKY – Medicaid	**NEVADA – Medicaid**
Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website: https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx Phone: 1-855-459-6328 Email: KIHIPP.PROGRAM@ky.gov KCHIP Website: https://kidshealth.ky.gov/Pages/index.aspx Phone: 1-877-524-4718 Kentucky Medicaid Website: https://chfs.ky.gov	Medicaid Website: http://dhcfp.nv.gov Medicaid Phone: 1-800-992-0900
LOUISIANA – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)	Website: https://www.dhhs.nh.gov/oii/hipp.htm Phone: 603-271-5218 Toll free number for the HIPP program: 1-800-852-3345, ext 5218
MAINE – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Enrollment Website: https://www.maine.gov/dhhs/ofi/applications-forms Phone: 1-800-442-6003 TTY: Maine relay 711 Private Health Insurance Premium Webpage: https://www.maine.gov/dhhs/ofi/applications-forms Phone: -800-977-6740. TTY: Maine relay 711	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710

MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/eohhs/gov/departments/masshealth/ Phone: 1-800-862-4840	Website: https://www.health.ny.gov/health_care/medicaid/ Phone: 1-800-541-2831
MINNESOTA – Medicaid	**NORTH CAROLINA – Medicaid**
Website: http://mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp Phone: 1-800-657-3739	Website: https://medicaid.ncdhhs.gov/ Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA – Medicaid**
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
OKLAHOMA – Medicaid and CHIP	**UTAH – Medicaid and CHIP**
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Medicaid Website: https://medicaid.utah.gov/ CHIP Website: http://health.utah.gov/chip Phone: 1-877-543-7669
OREGON – Medicaid	**VERMONT– Medicaid**
Website: http://healthcare.oregon.gov/Pages/index.aspx http://www.oregonhealthcare.gov/index-es.html Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx Phone: 1-800-692-7462	Website: https://www.coverva.org/hipp/ Medicaid Phone: 1-800-432-5924 CHIP Phone: 1-855-242-8282
RHODE ISLAND – Medicaid and CHIP	**WASHINGTON – Medicaid**
Website: http://www.eohhs.ri.gov/ Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)	Website: https://www.hca.wa.gov/ Phone: 1-800-562-3022
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA – Medicaid**
Website: https://www.scdhhs.gov Phone: 1-888-549-0820	Website: http://mywvhipp.com/ Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)
SOUTH DAKOTA - Medicaid	**WISCONSIN – Medicaid and CHIP**
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: 1-800-362-3002

TEXAS – Medicaid	WYOMING – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/ Phone: 1-800-251-1269

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Continuation of Medical, Dental, Vision, Health Care Flexible Spending Account (FSA) and/or Dental/Vision Flexible Spending Account (FSA) (HSA-Compatible) Benefits (COBRA Benefits)

COBRA Continuation Coverage

This notice has important information about your right to continuation health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which provides for a temporary extension of health coverage under the TI Employees Health Benefit Plan ("the Plan"). **This notice explains when COBRA continuation coverage may become available to you and eligible members of your family, and what you need to do to obtain it.** TI, in accordance with COBRA allows "qualified beneficiaries" to elect to continue medical, dental, and/or vision benefits offered under the Plan and/or Health Care FSA and/or Dental/Vision FSA 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." See the section below entitled "Qualifying Events – When COBRA continuation coverage is available" for a description of the qualifying events. You, your spouse or domestic partner, and your dependent children (or children of your domestic partner) could become qualified beneficiaries if coverage is lost because of a qualifying event.

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

Qualified beneficiaries may elect to continue one or more of medical, dental, vision, Health Care FSA and/or Dental/Vision FSA benefits in any combination; however, if medical coverage is elected, Work-Life Resources (EAP) benefit is automatically included at no additional cost. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage during the 60-calendar-day period following a qualifying event. A COBRA enrollment notice will be provided to qualified beneficiaries explaining when and how they can elect COBRA coverage. Additionally, they should contact the Health Insurance Marketplace in their state to determine when they may enroll in the health insurance coverage offered through the Marketplace because its election period may be different than the COBRA continuation coverage election period.

Qualified beneficiaries electing to receive COBRA benefits have all the rights of employees and dependent(s) covered under the medical, dental, vision, Health Care FSA and/or Dental/Vision FSA benefits, including the right to add newborn children, children placed for adoption, and other dependent(s) within 60 calendar days following an appropriate qualified status change, or within 60 calendar days if the qualified status change is gaining eligibility or losing eligibility for CHIP or Medicaid coverage. Dependent(s) not covered when COBRA benefits began may also be added during annual enrollment.

Qualifying Events – When COBRA continuation coverage is available

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

- Your hours of employment are reduced, resulting in a loss of medical, dental, vision, Health Care FSA and/or Dental/Vision FSA benefits; or
- Your employment ends for any reason.

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

- Death of the covered employee;
- Reduction in the hours worked by the covered employee, resulting in the loss of medical, dental, vision, Health Care FSA and/or Dental/Vision FSA benefits;
- Termination of the covered employee's employment for any reason;
- The covered employee becomes entitled to Medicare benefits (under Part A, Part B, or both);
- Divorce or legal separation from the covered employee; or
- The end of your domestic partnership with the covered employee

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

- Loss of dependent child status under the Plan rules

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

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- Your hours of employment are reduced, resulting in a loss of medical, dental, vision, Health Care FSA and/or Dental/Vision FSA benefits;
- Your employment ends for any reason; or
- Your death

For all other qualifying events (such as 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 at Fidelity within 60 calendar days after the qualifying event occurs. You must provide this notice by calling the TI Benefits Center at Fidelity through TI HR Connect at 888-660-1411 or by logging on to the Fidelity NetBenefits® website at netbenefits.com/ti. You must provide the date of your divorce or legal separation or the date your dependent stopped being eligible to be covered under the Plan. You must also provide updated contact information for the spouse or dependent.

Electing COBRA Coverage

Once the TI Benefits Center at Fidelity has been notified of the occurrence of a qualifying event, the qualified beneficiaries will be provided with instructions on how to elect COBRA continuation coverage. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses or domestic partners or dependent children, and parents may elect COBRA continuation coverage on behalf of their children. Your spouse may also elect COBRA continuation coverage on behalf of themself and their dependent children. They must elect COBRA continuation coverage within the 60-calendar-day period as specified in the enrollment notice. If they initially decline COBRA continuation coverage within the specified 60-calendar-day period, they may still elect COBRA continuation coverage provided such election is made within the specified 60-calendar-day period. However, in no event can they elect COBRA continuation coverage after the specified 60-calendar-day period.

In considering whether to elect COBRA continuation coverage, qualified beneficiaries should take into account that they have special enrollment rights under U.S. federal laws. Qualified beneficiaries have the

right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 calendar days after their group health coverage under the Plan ends because of a qualifying event. They will also have the same special enrollment right at the end of continuation coverage if they get continuation coverage for the maximum time available to them.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period. Some of these options may cost less than COBRA continuation coverage. Additionally, in the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be estimated to be by the Marketplace before you make a decision to enroll. Qualified beneficiaries can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Maximum Periods of COBRA 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 FSA and/or Dental/Vision FSA only continues through the end of the calendar year in which your qualifying event occurred.

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

18-Month COBRA Continuation Coverage Period

If coverage for you or your covered dependent(s) ends because your employment ends 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 date the qualified beneficiary fails to pay the required monthly premium when due or following the end of any applicable grace period;
- The date of cancellation of the Plan if the Plan is canceled for all 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, 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 beneficiary.

Disability Extension

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled before or within 60 calendar days of the time of your termination of employment or reduction in hours, and you provide the TI Benefits Center at Fidelity 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 at Fidelity must be notified within 30 calendar 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 date the qualified beneficiary fails to pay the required monthly premium when due or following the end of any applicable grace period;
- The date of cancellation of the Plan if the Plan is canceled for all employees;
- The date you or your covered dependent(s) first become covered under another group health plan, or you or your covered dependent(s) become entitled to Medicare; or
- The first calendar day of the month that begins more than 30 calendar 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 at Fidelity. This extension may be available to your spouse and any dependent children receiving COBRA continuation coverage if you die, become entitled to Medicare benefits (under Part A, Part B, or both), or get divorced or legally separated, or if the dependent child

stops being eligible under the Plan as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

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

- 36 months from the date COBRA benefits began;
- The date the qualified beneficiary fails to pay the required monthly premium when due or following the end of any applicable grace period;
- The date of cancellation of the Plan if the Plan is canceled for all employees; or
- The date you or your covered dependent(s) first become covered under another group health plan, 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, your domestic partner and your eligible children (or children of your domestic partner) for up to 36 months:

- 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/domestic partner;
- A dependent child ceasing to be a dependent child under the terms of the Plan; and
- Loss of coverage under the Plan because of your entitlement to Medicare. 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 of employment 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 of employment or reduction in hours within 18 months following your entitlement to Medicare;
- The last calendar day for which the required premium was paid;
- The date of cancellation of the Plan if the Plan is canceled for all employees; or
- The date after you elect COBRA continuation coverage on which your covered dependent(s) first become covered under another group health plan, or you or your dependent(s) become entitled to Medicare (for additional information, see the Important Note in Premiums section).

Medicare Coverage at Age 65

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

Generally, everyone age 65 or older is eligible for Medicare Part A (generally automatic coverage) and Part B (elected enrollment). To enroll and ensure that you receive full medical coverage protection, you or your covered spouse should check with your Social Security office at least three months before you or your covered spouse reach age 65.

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

Early Termination of COBRA Continuation Coverage

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

- Texas Instruments no longer provides group health coverage to any of its employees;
- The premium for COBRA continuation coverage is not paid in a timely manner;
- The qualified beneficiary becomes covered (after electing COBRA continuation coverage) under another group health plan;
- The qualified beneficiary becomes entitled to Medicare (Note: COBRA continuation coverage will be offered for the maximum period to an individual who is eligible for Medicare before experiencing a COBRA qualifying event);
- The qualified beneficiary received extended continuation coverage up to 29 months due to a Social Security disability and a final determination has been made that they are no longer disabled; or
- The qualified beneficiary notifies the TI Benefits Center at Fidelity that they wish to cancel continuation coverage.

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

COBRA Premiums

A qualified beneficiary does not have to show they are insurable in order to choose COBRA continuation coverage. But a qualified beneficiary must have been actually covered under the medical, dental, and/or vision benefits offered under the Plan, and/or Health Care FSA and/or Dental/Vision FSA benefits offered under the Texas Instruments Incorporated Flexible Benefits Plan on the calendar day before the qualifying event occurs in order to qualify for COBRA coverage.

A qualified beneficiary will have to pay all of the applicable premiums, which generally equals 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 will 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 Plan increase.

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

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

IMPORTANT NOTE: Coverage can be terminated before the 18-, 29- or 36-month period if a qualified beneficiary becomes covered under another group health plan. You must notify the Plan Administrator within 30-calendar-days of you or any of your dependents becoming covered under another group health plan 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 or any of your dependents lose eligibility if you fail to notify the Plan Administrator within this 30-calendar-day period. If you or a member of your family were determined to be disabled for Social Security purposes within 60 calendar days of the event triggering your eligibility for COBRA continuation

coverage, your period of COBRA continuation coverage can be extended to up to 29 months. If while you are on the extended period of COBRA continuation coverage, the disabled family member is determined to no longer be disabled for Social Security purposes, you must provide the TI Benefits Center at Fidelity with a copy of the Social Security determination within 30 calendar days of receipt of such determination. If you fail to notify the TI Benefits Center at Fidelity of such determination within 30 calendar days, the coverage will terminate as of the date of such determination and you WILL NOT be entitled to any refund of premium payments made after such determination.

If Qualified Beneficiaries Have Questions

Questions concerning the Plan or their COBRA continuation coverage rights should be addressed to the contact or contacts identified below in the 'Plan Contact Information' section. For more information about their rights under Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, 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 their area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep the TI Benefits Center at Fidelity Informed of Address Changes

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

Plan Contact Information

Qualified beneficiaries may obtain additional information about their rights and responsibilities under the Plan by accessing the Fidelity NetBenefits® website at netbenefits.com/ti or by contacting the TI Benefits Center at Fidelity through TI HR Connect at 888-660-1411. When calling the TI Benefits Center at Fidelity please be prepared to provide your Social Security number and Fidelity password. The TI Benefits Center at Fidelity representatives are available between 8:30 a.m. and 8:30 p.m., Eastern time, Monday through Friday (excluding all New York Stock Exchange holidays except Good Friday). The website is available virtually 7 days per week, 24 hours per day, except for scheduled maintenance windows.

Coverage for Eligible Employees in California Enrolled in an HMO

There is a coverage extension available to persons living in California who are enrolled in a California HMO. It applies to individuals who are otherwise on U.S. federal COBRA continuation coverage after July 1, 2003.

Please examine your options carefully before declining this coverage.

California's COBRA Extension for Persons in an HMO 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 U.S. federal COBRA laws. 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 (or your domestic partner) is also eligible if they also elected COBRA. A former spouse (or domestic partner) 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 U.S. 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 at Fidelity 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 HDHP or PPO benefit option, you will lose all rights to the California COBRA extension and will only be entitled to the U.S. federal COBRA continuation coverage period explained above. You must be covered by a California HMO and be living in California at the time your U.S. 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.

Income Protection
Time Off Benefits
(Note: This does not apply to COBRA participants or retirees)

A Quick Look

Key features of Time Off benefits are:

- Time Bank that provides all TIers with a set number of hours each calendar 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 **not** eligible for Time Off benefits from TI if:

- You are an employee who is a leased employee as defined by U.S. federal tax law
- Your compensation is reported to the IRS on a form other than a Form W-2
- You have agreed in writing that you are not an employee or are not otherwise eligible to participate

Time Bank

To the extent that applicable state or local law provides greater paid leave protection or benefits than this Time Bank policy, TI shall comply with the applicable law. For more information about the interaction between Time Bank and the paid sick leave laws in certain states and municipalities, from inside TI visit myHR > myCompensation & myBenefits > Time > Paid sick time (location specific). For more information about the rights and remedies under the Dallas paid sick ordinance, visit http://library.amlegal.com/nxt/gateway.dll/Texas/dallas/cityofdallastexascodeofordinances/volumei/chapter20earnedpaidsicktime?f=templates$fn=default.htm$3.0$vid=amlegal:dallas_tx$anc=JD_Ch.20.

Eligibility

You are eligible for Time Bank 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 an intern employee (minimum 20-hours-a-week schedule), you are eligible.

Accrual Rate

Your Time Bank accrual rate is based on the number of full years of service that you have completed before the first calendar day of each month. Your Time Bank account will be credited with Time Bank hours for each month on the first calendar day of that month. For your month of hire, your account will be credited with one month’s accrual of Time Bank hours shortly following your date of hire.

Time Bank Accrual During Leave of Absence

If you are on a leave of absence (LOA) due to workers' compensation, disability, paid parental leaves, the Family and Medical Leave Act (FMLA)/California Family Rights Act (CFRA) or pursuant to any other applicable law providing for leave, you will continue to earn monthly Time Bank accruals for up to 6

months, at the same rate you had before going on leave, or at an increased rate if your service anniversary falls during your leave. If you are on a military leave of absence (LOA), you will continue to earn monthly Time Bank accruals for up to 1 year, at the same rate you had before going on leave, or at an increased rate if your service anniversary falls during your leave. If you are on any other type of leave of absence, you will not continue to earn monthly Time Bank accruals during your leave.

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 hired on or after August 1, 2019, you will receive a full month's accrual of Time Bank hours for your first month of employment, no matter what day of the month you begin work.

Time Bank Accrual Chart

Full Years Of Service	Hours Accrued Per Month	Approximate Calendar 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

Hourly 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).

Salaried 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

Waiting period for benefits under the Disability Benefit Plan — 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 scheduled work time missed will be taken as Time Bank or paid sick time (if available) or as unpaid time, due to a non-occupational illness or injury. Maternity leave is not subject to the disability benefits waiting period.

Family and Medical Leave Act (FMLA) Usage

TIers **must** use Time Bank hours for approved Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA) 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/CFRA 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 FMLA/CFRA absences, unless approved to take negative Time Bank.

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. Note that absences for bereavement should not be coded as FMLA/CFRA unless they otherwise qualify (e.g., time taken due to serious health condition, where FMLA/CFRA has been approved).

Time Bank on Holidays

TIers who are scheduled to work on holidays can receive Time Bank hours in addition to holiday pay if the holiday is a regular workday and supervisory approval to take Time Bank on the holiday is received.

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 calendar 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 on December 31, 2021 will be cashed out at 75 percent of your regular rate of pay as of December 31, 2021, except for Time Bank hours attributable to the COVID-19 Hardship Gifted Time Bank (may vary based on applicable law). Payment will be included in your first full pay period's paycheck in January of 2022.

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 of employment from TI, you will receive a 100 percent cash-out of your Time Bank balance (except any unused portion of the COVID-19 Hardship Gifted Time Bank) in your final paycheck based on your base pay on your last calendar day worked.

COVID-19 Gifted Time Bank

TIers in the U.S. whose roles required them to work on site the majority of the time between March 13, 2020 and June 1, 2020 received four weeks of gifted Time Bank in 2020 ("Essential On-site TIer Gifted Time Bank"), which became part of their Time Bank balance and is eligible for use, cash-out and carry over pursuant to the rules of this policy. TIers in the U.S. who did not receive Essential On-Site TIer Gifted Time Bank were eligible to receive up to four weeks of gifted Time Bank for hardships related to COVID-19 ("COVID-19 Hardship Gifted Time Bank"), but this gifted Time Bank is not eligible for cash out at termination or year-end or for use when TI returns to normal business operations as determined by TI, except as required by applicable law. Any unused COVID-19 Hardship Gifted Time Bank will be removed from TIers' Time Bank balance when TI returns to normal business operations as determined by TI, to the extent permitted by applicable law. U.S. TIers were eligible to receive either four weeks of Essential On-Site TIer Gifted Time Bank or up to four weeks of COVID-19 Hardship Gifted Time Bank, but not both.

Absence Notification Periods

Time Bank use is subject to approval from your supervisor. Absence notification periods are business-unit specific, unless a law applies with a different notice requirement. 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 above a zero balance and are encouraged to review this Income Protection section fully for situations that require mandatory Time Bank usage.

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 future 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 employed TIers on active status.

Eligibility

You are eligible for paid holidays if you are a salaried TIer, an hourly full-time TIer or an hourly part-time TIer on an alternative work schedule (minimum 20-hours-a-week schedule). If you are an intern employee (minimum 20-hours-a-week schedule), you are eligible. Salaried TIers who are not assigned to work compressed workweeks shall receive their full salary for days designated as TI holidays irrespective of whether they work, but shall not receive extra pay for such days.

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.

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.

Hourly employees will receive their hourly pay for any of their regularly-scheduled hours that they spend on jury duty or when they are subpoenaed as a witness. Salaried employees shall receive their full salary for any workdays in which they serve on a jury or are subpoenaed as a witness. To qualify for jury duty/legal proceeding pay, employees must present the summons or subpoena to their supervisor prior to reporting for their scheduled duty.

TIers assigned to a night shift schedule are permitted to take off both the shift immediately preceding the start of jury duty (if scheduled to work the day before jury duty starts) and the shift immediately after jury duty ends (if scheduled to work the day after jury duty ends), and will receive their hourly pay for these shifts.

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 jury duty/legal proceeding pay if you are a principal party (a plaintiff or defendant) in a legal proceeding. You must use your Time Bank hours for time away from work spent participating in a legal proceeding in such an instance.

Time Off to Vote for Texas Employees[1]

On Election Day, TIers in Texas who have not already voted may take time off to vote without penalty if the polls are not open for two consecutive hours outside their working hours. If a TIer has two consecutive hours in which to vote outside of working hours, the TIer should vote at that time (before/after work). However, if a TIer does not have two consecutive hours in which to vote outside of working hours, the TIer will be given reasonable time off, allowing travel time to and from the polling place, with no change in pay or attendance consequences. The time spent voting on Election Day will not reduce Time Bank hours. Paid time off to vote primarily should affect compressed workweek employees working the day shift on Election Day. Paid time away from work to vote is not available for early voting. Two hours of paid time to vote will ordinarily be considered reasonable time to vote, allowing travel time, unless a TIer has a very long commute or other unique circumstances.

[1] Paid time off to vote is available to TIers in other locations, in accordance with applicable local law.

U.S. Military Leave

TIers will be provided with military leave if their absence is necessary to satisfy a military obligation in the U.S. uniformed services. Unless military necessity prevents it, or it is otherwise impossible or unreasonable, a TIer should provide their supervisor or Human Resources representative with notice of the need for leave as far in advance as is reasonable under the circumstances. Written notice is preferred, but not required. As explained below, all TIers on military leave may be eligible for special TI pay.

When the TIer's military obligation in the U.S. uniformed services concludes, the TIer must return to work or notify their supervisor or Human Resources representative (verbally or in writing) of their intention to return to work in a timely manner under applicable law. TIers returning to work from military leave will generally be reinstated to the job they would have attained if not absent due to military service or, in some cases, to a comparable job. A TIer absent for military service for 31 calendar days or more must provide their Human Resources representative or supervisor with military discharge documentation to establish the duration of military service, the honorable discharge from service, and the timeliness of seeking return to work.

In order to be eligible to return work, a TIer who has engaged in service in the uniformed services must generally report to work according to the following schedule:

1. If the military service is less than 31 calendar days (or for the purpose of taking an examination to determine fitness for service), the TIer must report for work at the beginning of the first regularly scheduled workday/shift on the first full calendar day following the completion of their service and the expiration of eight hours after a period allowing time for safe transportation home from the place where the military service was performed.
2. If the military service is for 31 calendar days or more but less than 181 calendar days, the TIer must notify their supervisor or Human Resources representative of their intent to return to work no later than 14 calendar days following their completion of service.
3. If the military service is over 180 calendar days, the TIer must notify their supervisor or Human Resources representative of their intent to return to work no later than 90 calendar days following the completion of service.
4. If the TIer is hospitalized or convalescing from a military service-connected injury or illness, the TIer must notify their supervisor or Human Resources representative at the end of the period necessary for recovering from the illness or injury of their intent to return to work (which shall generally be no later than two years following completion of service.)

Short-Term Military Leave

TI considers an absence for a military obligation lasting 16 calendar days or less (such as military exercises or National Guard training) to be a short-term military leave. All TIers absent from work due to a short-term military leave should use the unpaid absence code "MIL" in the Time system for workdays missed. The time missed for short-term military leave will be considered as an excused absence.

Long-Term Military Leave

TI considers an absence for a military obligation lasting 17 continuous calendar days or more to be a long-term military leave. All TIers on long-term military leave will be placed on unpaid leave of absence and do not need to record their absences in the Time system. The time missed for long-term military leave will be considered as an excused absence.

Special TI Pay

TIers on military leave due to service in the U.S. uniformed services are eligible for special TI pay to offset the difference between regular TI base pay and military base pay for up to 16 total calendar days each military calendar year for short-term military leave(s). TIers on long-term military leave are eligible for special TI pay for up to one year per long-term military leave to offset the difference between regular TI base pay and military base pay. The sum of the special TI pay and the military base pay will equal the TIer's base rate of pay. For a salaried TIer, base pay is defined as monthly salary. For an hourly TIer, base pay is defined as hourly rate times scheduled hours per week. The military base pay for the period will be used to calculate the special TI pay. Allowances for room and board and food are excluded.

In order to receive the special TI pay, TIers must provide their current military orders, military pay vouchers and military pay rate chart to TI Payroll. If this documentation is received by TI Payroll prior to the leave, the TIer will receive the special TI pay on their normal pay schedule. If this documentation is not given to TI Payroll prior to the commencement of the leave, then the special TI pay will be paid after the TIer returns to work or, if the documentation is provided sooner, after the relevant documentation is provided and in accordance with their ongoing normal pay schedule.

Time Bank for Military Duty

TIers on military duty may elect to use Time Bank for their absences using the Time Bank code "TBL", if they so choose, but they are not required to do so. For any date on which a TIer elects to use Time Bank during a military leave, special TI pay will not be paid for that date.

Other Time Off or Leaves of Absence (LOA)

Time off or leaves of absence will be granted in all cases where required by applicable law. For example, to the extent provided by local law, TI will grant time off to victims of domestic violence or sexual assault, crime victims, bone marrow or organ donors, military spouses and domestic partners, and volunteer firefighters, peace officers, or emergency rescue personnel and will grant time off for voting, school visitation, and for veterans to attend appointments at Department of Veterans Affairs medical facilities. As another example, to the extent provided by Tennessee law, TI will grant up to four months of leave to Tennessee employees for adoption, pregnancy, childbirth or nursing an infant. Applicable law will govern notice requirements, the amount of time off allowed and whether it is paid or unpaid. A leave of absence may be available as a religious accommodation. A leave of absence may additionally be available as an accommodation pursuant to the Americans with Disabilities Act or pursuant to a state or local disability law, provided that the leave does not impose an undue hardship for TI. Other types of medical accommodations may also be requested. TI is committed to providing reasonable accommodations to help otherwise qualified employees with a disability perform their essential job functions. If you would like to request a medical accommodation, please send an email to accommodation_request@list.ti.com and ask for an accommodation request form. You can also access the accommodation request form online from inside TI's network at myHR > myCompensation & myBenefits > Disability benefits > Request Medical Accommodation.

In addition to those leaves required by law, a leave of absence may also be granted for:

- Essential personal reasons that require absence from work
- 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
- Special conditions such as a "bridge to retirement" or which are of mutual advantage to the TIer and TI

Employees should speak to their Human Resources representative for more information.

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 premiums on an after-tax basis.

In the case of military leave, medical, dental and vision coverage may be continued (as long as you pay the associated premiums) for you and 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) or the California Family Rights Act (CFRA) or another type of paid leave required by applicable law. To apply for leave under the Disability Benefit Plan, Workers' Compensation or FMLA/CFRA, call TI HR Connect at 888-660-1411 and choose the appropriate option.

If you are on an unpaid LOA other than FMLA or another type of unpaid non-military leave required by applicable law, all disability coverages and premium deductions stop. Also, while on an unpaid LOA or while receiving Long-Term Disability benefits from the Disability Benefit Plan, your Dependent Daycare Flexible 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 by its due date or all coverages are subject to cancellation effective as of 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) and California Family Rights Act (CFRA)

(Note: This does not apply to COBRA participants or retirees)

To be eligible for leave under the Family and Medical Leave Act (FMLA) and, for California employees, the California Family Rights Act (CFRA), TIers must have a minimum of one year of service and have worked 1,250 hours for TI in the past 12 months. To be eligible for FMLA leave, TIers must work at a location where at least 50 employees are employed by TI within 75 miles of the location*. Sedgwick must approve all FMLA/CFRA leaves. TIers must consult with Sedgwick, administrator of TI's absence and disability leave program, in order to determine if an absence qualifies under FMLA/CFRA. To apply for FMLA/CFRA leave, call TI HR Connect at 888-660-1411 and choose the appropriate option. There may be other state leaves to which you are entitled; you may contact Sedgwick for information. TIers may contact Sedgwick by phone through TI HR Connect at 888-660-1411 (choose option 5) or by using the online portal at claimlookup.com/TI.

* 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 both FMLA and CFRA leaves of absence unless otherwise noted:

- Eligible TIers are entitled to up to 12 workweeks of unpaid FMLA/CFRA leave during a 12-month period for the following reasons: for a TIer's own serious health condition that makes the TIer unable to perform their job; or to care for the TIer's parent, spouse or child with a serious health condition; or to bond with and/or care for the TIer's child after birth or placement for adoption or foster care; or because of certain "qualifying exigencies" related to the deployment or call to active duty of a member of the Armed Forces of the United States who is the TIer's spouse, domestic partner, child or parent; or under FMLA only, for incapacity due to pregnancy, prenatal medical care or child birth; or, for leaves of absence beginning 1/1/2021 or after and under CFRA only, to care for the TIer's grandparent, grandchild or sibling with a serious health condition. The 12-month period is calculated as a rolling 12-month period measured backward from the date of any FMLA/CFRA leave usage.
- A serious health condition is an illness, injury, impairment or physical or mental condition that involves either inpatient care, or continuing treatment by a health care provider for a condition that either prevents the TIer from performing the TIer's job, or prevents the TIer's qualified family member from participating in work, school or other daily activities. Subject to certain conditions, the continuing treatment requirement may be met, without limitation, by a period of incapacity of more than three consecutive full calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to a chronic condition, or (under the FMLA) incapacity due to pregnancy. Other conditions may meet the definition of continuing treatment.
- An eligible TIer who is the spouse, son, daughter, parent, or next of kin of a covered servicemember is entitled to up to 26 workweeks of unpaid FMLA (but not CFRA) leave in a single 12-month period to care for the covered servicemember if they have a serious injury or illness ("military caregiver leave"). This single 12-month period will commence on the date the TIer first begins leave to care for the covered servicemember.
- For purposes of administering FMLA and CFRA leave, TI considers a "spouse" to be an individual who is married to another individual of the same or opposite sex (including under common law) or who is the domestic partner of someone of the same or opposite sex.
- The maximum amount of leave that may be taken in a single 12-month period for FMLA leave is 26 workweeks, even if some of the leave taken during the single 12-month period is for military caregiver leave and some of the FMLA leave taken is for an FMLA-qualifying reason other than military caregiver leave. Each period of approved FMLA/CFRA leave will reduce the TIer's FMLA and/or CFRA leave entitlement in the applicable 12-month period.

- If a TIer's need for FMLA/CFRA leave is foreseeable, the TIer must provide notice to the supervisor and make a request for leave through TI HR Connect (and choose the appropriate option for the TIer's type of leave) at least 30 calendar 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 calendar days in advance, the notice/request must be made to the supervisor and TI HR Connect as soon as practicable to give notice. Sedgwick must be notified of each use of approved, intermittent FMLA/CFRA leave and TIers are required to notify their supervisors as soon as is practicable if the dates of FMLA/CFRA leave taken change, are extended or were initially unknown, and normal call-in procedures must be followed.
- When making a request for FMLA or CFRA leave, a TIer does not need to share a medical diagnosis, but must provide sufficient information for a determination to be made whether the leave qualifies for FMLA/CFRA and the anticipated timing and duration of the leave. Sufficient information may include that the TIer is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military caregiver or qualifying exigency leave. TIers also must inform TI if the requested leave is for a reason for which FMLA/CFRA was previously taken or certified. Failure to timely provide requested certifications or periodic recertifications that support the need for FMLA/CFRA leave may result in delay or denial of leave. If Sedgwick determines that a certification is incomplete or insufficient, it will provide written notice indicating what additional information is required.
- If leave is requested for planned medical treatment, the TIer must consult with their supervisor and make a reasonable effort to work out a treatment schedule that does not unduly disrupt TI's operations, subject to the approval of the TIer's health care provider.
- Once Sedgwick becomes aware that a TIer's need for leave is for a reason that may qualify under the FMLA/CFRA, Sedgwick will notify the TIer whether they are eligible for FMLA/CFRA leave. If the TIer is eligible, Sedgwick shall notify the TIer of their rights and responsibilities. If the TIer is not eligible, Sedgwick shall provide a reason for the ineligibility. Sedgwick shall notify TIers if leave will be designated as FMLA/CFRA leave and the amount of leave counted against the TIer's leave entitlement. If Sedgwick determines that a leave is not FMLA/CFRA protected, it shall notify the TIer.
- TIers returning to work after approved FMLA/CFRA leave will be placed in the same or an equivalent position with the same pay, benefits and terms and conditions of employment, except that reinstatement may be denied to key employees if such denial is necessary to prevent substantial and grievous economic injury to the operations of TI.
- A TIer does not need to use their FMLA or CFRA leave entitlement in one block. FMLA leave may be taken intermittently or on a reduced leave schedule when medically necessary in connection with the serious health condition of the TIer, the TIer's family member, or the serious injury or illness of a covered servicemember. FMLA leave due to a qualifying exigency may also be taken on an intermittent basis. CFRA leave may be taken on an intermittent or reduced leave schedule basis. FMLA and CFRA leave may be taken intermittently for the birth of a child in increments no smaller than one workday. FMLA leave may not be taken intermittently for the adoption or foster care placement of a child. CFRA leave may be taken intermittently in connection with the adoption or foster care placement of a child. The basic minimum duration of CFRA leave for the adoption or foster care placement of a child is two weeks, although on any two occasions, Sedgwick will grant a request for a CFRA leave for this purpose for less than two weeks' duration.
- 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, except that a TIer may take FMLA/CFRA leave before the actual placement or adoption if an absence from work is required for the placement to proceed.
- Use of FMLA/CFRA leave shall not result in the loss of any employment benefit that accrued prior to the start of a TIer's leave.

- Health benefits while on FMLA/CFRA leave:
    - TIers' health benefits will be maintained by TI during any period of FMLA/CFRA leave under the same conditions as if the TIer had continued to work.
    - TIers must keep payments for health benefits current while on FMLA/CFRA leave.
    - A TIer who is receiving pay from TI while on FMLA/CFRA 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/CFRA leave, the TIer will be billed on a monthly basis. There is a minimum 30-calendar-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 calendar 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/CFRA leave, and recover these payments upon the TIer's return to work.
    - If health plan coverage for a TIer and/or their 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/CFRA leave for a reason other than: (i) the continuation, recurrence, or onset of a serious health condition of the TIer or the TIer's family member which would entitle the TIer to FMLA/CFRA leave; (ii) the continuation, recurrence, or onset of a covered servicemember's serious injury or illness which would entitle the TIer to FMLA/CFRA 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's behalf during FMLA/CFRA leave.
- Concurrent Leave/Substitution of Paid Leave
    - TIers who are approved for a Disability Pay Continuation (DPC), Workers' Compensation, Paid Parental Leave or a leave of absence under applicable state or local law, will have their leave concurrently designated FMLA/CFRA leave and counted against the TIer's FMLA/CFRA leave entitlement to the extent the leave qualifies for FMLA/CFRA.
    - If a TIer's FMLA/CFRA 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/CFRA leave is for a reason other than 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, or if Time Bank has already been exhausted, FMLA/CFRA leave will be taken as unpaid time off.
- TI will not interfere with a TIer's FMLA/CFRA rights or retaliate against someone for using or trying to use FMLA/CFRA leave, opposing any practice made unlawful by the FMLA/CFRA, or being involved in any proceeding under or related to the FMLA/CFRA.
- Employees may file a complaint with the U.S. Department of Labor, Wage and Hour Division, or may bring a private lawsuit against an employer. If a TIer has a concern regarding FMLA/CFRA leave, they may also contact a manager, supervisor, Sedgwick, HR Representative, or the TI Ethics Office.
- The FMLA does not affect any federal or state law prohibiting discrimination or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

The policies and guidelines stated herein shall be subject to the provisions of the Family Medical Leave Act of 1993, as amended from time to time, and applicable state leave laws, including the California Family Rights Act (CFRA).

Pregnancy Disability Leave for California Employees

(Note: This does not apply to COBRA participants or retirees)

If you are a California employee who is disabled due to pregnancy, childbirth, or a related medical condition, you may take up to a maximum of four months' pregnancy disability leave under California law. Pregnancy disability leave is not for an automatic period of time, but rather for the period of time when you are disabled by pregnancy. Your health care provider determines how much time you will need. Pregnancy disability leave does not need to be taken all at once, but can be taken on an as-needed basis as required by your health care provider, including intermittent leave or a reduced work schedule, all of which counts against your four-month entitlement to leave.

Pregnancy disability leave runs concurrently with family and medical leave under U.S. federal law (FMLA), but not with family and medical leave under California law (CFRA). This means that a TIer who is CFRA-eligible may have the right to take both a pregnancy disability leave and a CFRA leave for the birth of the TIer's child.

- If you need to take a pregnancy disability leave, you must provide reasonable advance notice to your supervisor and Sedgwick, administrator of TI's absence and disability leave program. In addition, you must provide Sedgwick with a health-care provider's statement certifying the date on which you became disabled because of pregnancy and the estimated duration of the leave. TI may additionally require medical certification to support a request for a transfer or an accommodation.
- Pregnancy disability leaves are without pay (unless you are eligible and qualify for benefits under the Disability Benefit Plan). However, you may use accrued Time Bank during the leave in the increments in which it is normally available to you. You may also be eligible for State Disability Insurance benefits.
- The same health benefits that apply to an FMLA/CFRA leave will apply to a pregnancy disability leave.
- TIers returning to work after approved pregnancy disability leave will be placed in the same position (or under limited circumstances, in a comparable position).

Paid Family Leave for California Employees Only

(Note: This does not apply to COBRA participants or retirees)

If you are a TI employee in California, you may be eligible for Paid Family Leave (PFL) benefits from the state of California.

Eligible employees may apply for PFL benefits for the following reasons: to care for a child, spouse, parent, state-registered domestic partner, parent-in-law, grandparent, grandchild or sibling with a serious health condition; to bond with the employee's new child or the new child of the employee's spouse or state-registered domestic partner; 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; or because of certain “qualifying exigencies” related to the foreign deployment of a military member who is the employee’s spouse, domestic partner, child, or parent.

PFL benefits are for a maximum of 8 weeks within a 12-month period on or after July 1, 2020. The weekly benefit amounts that are paid for PFL are the same as those paid for SDI*. Like SDI, there is a 7-calendar-day unpaid waiting period for PFL benefits. Employees may use available Time Bank during this unpaid waiting period.

Employees who have been on California 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.

* Note that additional paid benefits may be available to employees who work in San Francisco who take Paid Family Leave to bond with a child. If you work in San Francisco and plan to take Paid Family Leave to bond with a child, please contact Sedgwick, administrator of TI’s absence and disability leave program, for more information.

Paid Family Leave for New York Employees Only

(Note: This does not apply to COBRA participants or retirees)

If you are a TI employee working in New York, you may be eligible for Paid Family Leave (PFL) benefits.

PFL benefits may be claimed for the following reasons: to care for or bond with a child during the first 12 months after the child's birth, adoption, or placement with the employee in foster care; to care for a child, parent, grandparent, grandchild, spouse, or domestic partner with a serious health condition; or to attend to a qualifying exigency arising out of the fact that the spouse, domestic partner, child or parent of the employee is on active duty in the U.S. Armed Forces, or has been notified of an impending call or order to active duty.

For 2021, PFL benefits are for a maximum of 12 weeks within a 52-week period. PFL will run concurrently with FMLA leave. For more information about New York PFL benefits, visit: paidfamilyleave.ny.gov/.

If the need for PFL is foreseeable, employees should provide TI with 30 days of notice, and if the need for PFL is not foreseeable, employees should provide as much notice as practical. New York employees seeking PFL must submit a completed claim package to MetLife within 30 days of their first day of paid leave with a completed Request for Family Leave Form and supporting documentation for the type of leave requested. A Request for Family Leave Form may be obtained from Sedgwick, administrator of TI's absence and disability leave program, and should be submitted to MetLife.

Pregnancy and Lactation Accommodation

(Note: This does not apply to COBRA participants or retirees)

If you are pregnant, if you have a pregnancy-related medical condition, or if you are recovering from childbirth, you may request reasonable accommodation of your medical needs related to pregnancy, childbirth or related conditions. Potential accommodations which may be requested include but are not limited to a leave of absence, change of job duties, or transfer to a less strenuous or hazardous position. If you would like to request an accommodation, please contact your HR representative, or send an email to accommodation_request@list.ti.com and ask for an accommodation request form. You can also access the accommodation request form online from inside TI's network at myHR > myCompensation & myBenefits > Disability benefits > Request Medical Accommodation.

If you are a nursing mother, you have the right to request a lactation accommodation, and you will be provided with a reasonable amount of break time to express milk when you have a need to do so. For more information about how to access and reserve the private Mothers' Rooms provided by TI, type usmothers/ in your Infolink browser. The Mothers' Rooms provided by TI will meet the requirements of the California Labor Code and other state requirements, including privacy, a surface to place a breast pump and personal items, a place to sit, access to electricity, a sink with running water, and a refrigerator for storing breast milk. Should you need a lactation accommodation other than a Mothers' Room, please contact your Human Resources representative.

If you are a nursing mother who is a U.S. TI employee traveling for business domestically or abroad, you can request reimbursement for the cost of shipping milk home. For information about how to request reimbursement, type usmothers/ in your Infolink browser.

TI will not discriminate against any employee due to pregnancy or a condition related to pregnancy, including but not limited to lactation, the need to express breast milk, or the need for an accommodation. California employees have the right to file a complaint with the labor commissioner for any violation of rights provided under Chapter 3.8 of the California Labor Code regarding lactation accommodations.

Paid Parental Leaves

(Note: This does not apply to COBRA participants or retirees)

TI provides paid parental leaves for TIers who become parents as a result of a birth of a child, through adoption or via surrogacy. (Additional time off may be available under the Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA) or other state leave laws for these reasons as well.)

The paid parental leave benefits described below apply to births and adoptions occurring on or after January 1, 2020. For information about the benefits applicable for births or adoptions occurring prior to January 1, 2020, please consult the 2019 Health and Insurance Benefits Summary Plan Description.

For biological births:

- **Birth Mother:**
  - See page 153 regarding paid maternity leave under DPC
  - Up to four weeks (28 consecutive calendar day period) paid parental leave
  - Only one such paid parental leave is permitted per TI employee per calendar year
  - Leave must be completed within 12 months of the birth of the child in order to be paid. It must be taken all at once, not intermittently.
- **Non-birth parent:**
  - Up to four weeks (28 consecutive calendar day period) paid parental leave
  - Only one such paid parental leave is permitted per TI employee per calendar year
  - Leave must be completed within 12 months of the birth of the child in order to be paid. It must be taken all at once, not intermittently.

For adoptions:

- Up to four weeks (28 consecutive calendar day period) paid parental leave
- Only one such paid parental leave is permitted per TI employee per calendar year
- Up to $5,000 reimbursement of eligible expenses per adopted child. If both parents are TI employees, only one such reimbursement is permitted for the couple per adopted child.
- Leave must be completed within 12 months of the placement of the child for adoption in order to be paid. It must be taken all at once, not intermittently.
- The benefit does not apply to the adoption of a spouse's (or domestic partner's) child or children

For births through a surrogate:

- Up to four weeks (28 consecutive calendar day period) paid parental leave
- Only one such paid parental leave is permitted per TI employee per calendar year
- Leave must be completed within 12 months of the birth in order to be paid. It must be taken all at once, not intermittently.

Additional details:

- **If the need for paid parental leave is foreseeable, the TIer must notify their supervisor and request leave by calling TI HR Connect at 888-660-1411 (choose option 5) at least 30 calendar days in advance of the date the TIer intends to begin leave. If the TIer is unable to foresee the need for leave 30 calendar days in advance, the TIer must notify their supervisor and request leave by calling TI HR Connect at 888-660-1411 (choose option 5) as soon as possible and practicable.**

- **Time entry for paid parental leaves will not be required when Sedgwick approves the leave. Sedgwick will feed directly to payroll the appropriate earnings amount to be paid to you while on paid parental leave.**
- Any paid parental leave benefit payments you receive are taxable.
- Must be a TI employee and be in active employment status or on family and medical leave at the time of the birth or placement for adoption.
- 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 time added to your Time Bank.
- If a TI holiday occurs during the time you are taking this leave, this leave will not be extended in any way.
- Paid parental leave will run concurrently under FMLA and any applicable state or local leave laws to the extent permitted by applicable law. Notification and certification requirements for FMLA and any applicable state or local leave laws must be followed.
- Additional unpaid time off may be available under FMLA and any applicable state or local leave laws, if you meet eligibility requirements and have not exhausted your annual entitlement.
- TIers applying for paid parental leave in the event of a birth or adoption must provide documentation of the birth or adoption/placement to support the request.
- TI will not interfere with or deny the right of eligible employees to take paid parental leave, and will not discriminate against TIers for taking or requesting paid parental leave.

For more information, type LOA/ in your Infolink browser.

Disability Benefit Plan – Disability Pay Continuance/Long-Term Disability (DPC/LTD)

(Note: This plan does not apply to COBRA participants or retirees)
ERISA PLAN, offered through the Disability Benefit Plan of Texas Instruments Incorporated

A Quick Look at Disability Pay Continuance (DPC) Benefits

Key features of the DPC benefits offered by the Disability Benefit Plan are:

- Provides you on a temporary basis, COVID-19 DPC benefits during a 14-calendar-day period if you are quarantined (by a health care provider or otherwise self-imposed) and cannot work from home for one or more of the following reasons: (i) you are experiencing one or more COVID-19 symptoms (as defined by the CDC); (ii) you have tested positive for COVID-19; (iii) you have been exposed to someone who has COVID-19; or (iv) you have recently returned from a high-risk country (Level 3 as defined by the CDC) or live with someone who has. COVID-19 DPC benefits are not subject to the disability benefits waiting period. If you require COVID-19 DPC benefits beyond this initial 14-calendar-day period, you may be required to provide medical documentation supporting this additional leave. In addition to qualifying for COVID-19 DPC benefits for the reasons listed above, California employees will also qualify for COVID-19 DPC benefits at their regular rate of pay if they are unable to work because (i) they are subject to a federal, state or local quarantine or isolation order related to COVID-19; (ii) they are advised by a health care provider to self-quarantine or self-isolate due to concerns related to COVID-19; or (iii) they are prohibited from working by TI due to health concerns related to the potential transmission of COVID-19.
- Provides you with income protection for up to 26 disability weeks for occupational and non-occupational illnesses/injuries, including the required disability benefits waiting period (as described below).
- Provides you with income protection for a total of eight disability weeks for maternity leave starting on the date of delivery for delivery dates on or after January 1, 2020. If your date of delivery is on a non-scheduled workday, your paid leave of absence will start on the first lost workday following your date of delivery. Maternity leave is not subject to the disability benefits waiting period. You will also be eligible for up to four weeks (28 consecutive calendar day period) paid parental leave; see page 148 for more details.
- A disability week is defined as any week in which you receive a disability benefit.
- Disability benefits waiting period — DPC benefits are paid after you have been absent from work for a required period of 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) with such absence taken as Time Bank (if available) or as unpaid time, due to a non-occupational illness or injury. *Partial workdays missed are not covered by the disability benefits waiting period requirement. Partial workdays may be taken as Time Bank (if available) or as unpaid time.*
- All DPC payments made after the required disability benefits waiting period 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 DPC benefits will also be certified concurrently for FMLA (and CFRA, if applicable). The required disability benefits waiting period will be coded as FMLA/CFRA leave.
- DPC leave must begin as soon as the disability benefits waiting period has been satisfied. There can be no break in between the end of the disability benefits waiting period and the start of the DPC leave.
- Requests for DPC leave/benefits submitted after the expiration of the disability benefits waiting period may be denied as untimely.

When DPC 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 in DPC Coverage

DPC Basic

- All eligible employees are automatically enrolled for DPC Basic coverage.

DPC Plus

- You may enroll during the first 30 calendar days of your employment without evidence of insurability (EOI). Provided you enroll during your first 30 calendar days of employment, your coverage takes effect retroactively to your first calendar day at work.
- If you do not enroll during your first 30 calendar days of employment, you may enroll in DPC Plus during the annual enrollment period. If you enroll during annual enrollment, an EOI form must be submitted and approved for enrollment in DPC Plus benefits to become effective. You will receive a notification link on the Fidelity NetBenefits® website at netbenefits.com/ti that additional action is required and you can complete the EOI form online. Completing an EOI form is not a guarantee of coverage. Coverage begins on the first calendar day of the calendar 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 disability leave when a coverage change is scheduled to become effective, the TIer must return to active employment at TI for 90 consecutive calendar days before being eligible for the newly elected benefits.
- If a TIer is on another type of leave when a coverage change is scheduled to become effective, the TIer must return to work for one full shift before being eligible for the newly elected benefits.

DPC Cost — Who Pays

TI pays the full plan costs for DPC Basic coverage. You and TI share the plan costs if you elect DPC Plus.

Your DPC Benefits

DPC income protection benefits are calculated:

- For hourly TIers, based on your base rate of pay. Overtime and shift premiums are not included.
- For salaried TIers, based on your base rate of pay, or if you are on an alternative work schedule, your adjusted base rate of pay.
- For sales bonus plan participants, your base rate of pay does not include your sales bonus target amount.
- Using your rate of pay in effect (on last calendar day worked) when your disability starts.

DPC income protection benefits equal:

- 100 percent of base rate of pay for the first 13 weeks of disability (including the required disability benefits waiting period)

- 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
- Please see the section later entitled “DPC Tax Treatment” for information regarding taxation of benefit payments

Your DPC benefit will be reduced by any of the following benefits you are eligible to receive that relate to your disability:

- Social Security Disability Income benefits and/or other Social Security benefits
- Workers' Compensation or other occupational disease benefits
- Disability pay from other sources
- Other governmental benefits
- Automobile No Fault (if required by law)
- Third Party Liabilities
- Mandatory state disability insurance program benefits

Mandatory State Disability Coverage

If you are a TI employee working in a state with a state-sponsored program that provides disability benefits (e.g., California, Hawaii, New Jersey, New York, Puerto Rico, Rhode Island), your TI disability benefits will be offset by the disability benefits payable under the state program for the period during which such benefits are available whether or not you have applied for those benefits. For questions regarding this offset and the procedure for claiming these benefits, contact Sedgwick, administrator of TI’s absence and disability leave program.

Criteria for DPC Certification

To start receiving DPC after the required disability benefits waiting period, 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 health care provider) current objective medical evidence needed to approve your disability leave request
- Be under the care of a licensed health care provider (e.g., M.D., chiropractor, nurse practitioner, physician’s assistant, etc.)
- Receive examinations and treatment from health care providers, as required, and provide evidence of such treatment upon request
- A Release of Information (ROI) form must be signed by you and returned to Sedgwick

Note: Medical-related absences extending beyond the required disability benefits waiting period must be certified by Sedgwick to continue to receive DPC benefits. All DPC benefits after the required disability benefits waiting period 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 workdays missed are not covered by the disability benefits waiting period requirement. Partial workdays may be taken as Time Bank (if available) or as unpaid time.* You must work with Sedgwick to obtain the required certification.

Maternity Leave

Paid disability leave of absence for the birth of a child is a total of eight weeks starting on the date of delivery for delivery dates on or after January 1, 2020. If your date of delivery is on a non-scheduled workday, your paid leave of absence will start on the first lost workday following your date of delivery. Maternity leave is not subject to the disability benefits waiting period. The length of benefit duration must be supported in the same manner as any disability. Other requirements are the same as for DPC benefits. You will also be eligible for up to four weeks (28 consecutive calendar day period) paid parental leave for births occurring on or after January 1, 2020; see page 148 for more details.

As soon as you are medically cleared to return to work from DPC/maternity leave, but no later than one week before your estimated/scheduled return to work date, you must notify your supervisor and Sedgwick.

On the calendar day you return to work, you must call Sedgwick to confirm that you have returned to work.

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 disability leave/disability information must be provided for new claims. If you have a new disability leave, you must also satisfy a new disability benefits waiting period to support this new leave. 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 leave will start if you returned to active employment at TI for a period of 90 or more consecutive calendar days.

Continuation of Other Benefits

While you are receiving DPC benefits, your coverage under the following plans/benefit options may continue (as long as you pay the associated costs):

- Blue Cross Blue Shield HDHP or PPO, or regional HMO
- Delta Dental (Basic/Plus)/DHMO
- Group Life Insurance
- AD&D Insurance
- Vision
- DPC/LTD
- Health Care Flexible Spending Account
- Dental/Vision Flexible Spending Account (HSA-Compatible)
- Dependent Daycare Flexible Spending Account

Coverage under these plans/benefit options for your enrolled dependents also continues. Benefit costs for these plans/benefit options will be deducted from your DPC check.

You will continue to earn service credit (if applicable) for the TI Employees Pension Plan and TI equity programs.

Returning to Work from DPC Leave

As soon as you are medically cleared to return to work from DPC leave, you must notify your supervisor and Sedgwick. You must also provide Sedgwick with written medical clearance documentation from your health care provider that indicates the date you can return to work and work restrictions, if any. All work

restrictions must detail the work restrictions/limitations and include the effective time frame. If you receive medical clearance to return to work with restrictions/limitations, you cannot return to work until Sedgwick obtains confirmation from TI that the restrictions/limitations can be accommodated.

On the calendar day you return to work, you must call Sedgwick to confirm that you have returned to work.

Texas Instruments is committed to providing reasonable accommodations to help otherwise qualified employees with a disability perform their essential job functions. If you would like to request an accommodation, please send an email to accommodation_request@list.ti.com and ask for an accommodation request form. You can also access the accommodation request form online from inside TI's network at myHR > myCompensation & myBenefits > Disability benefits > Request Medical Accommodation.

Partial DPC Benefits

This program is available for instances of partial disability, during the participant's approved DPC leave.

Coverage

- A full-time TIer or part-time TIer on an alternative work schedule (minimum 20-hours-a-week schedule) with DPC coverage is eligible to obtain partial disability benefits.
- With the approval of Sedgwick and the approval of the employee's supervisor, a TIer may be accommodated to work partial hours with the intent to transition back to active employment at TI.
- Partial disability is defined as an illness or injury that results in the employee being unable to work all of their normal shift.
- Partial disability must be approved in 30-calendar-day increments, not to exceed a cumulative total of 90 consecutive calendar days.
- The weeks on partial disability apply toward the 26 disability weeks for DPC benefits.
- The weeks on partial disability apply toward long-term disability eligibility.
- Partial disability days apply toward FMLA and any applicable state or local leave laws, such as CFRA.
- Other requirements are the same as for regular DPC benefits.

Intermittent DPC Benefits

This program is available for instances of intermittent disability, during the participant's approved DPC leave.

Coverage

- A full-time TIer or part-time TIer on an alternative work schedule (minimum 20-hours-a-week schedule) with DPC coverage is eligible to obtain intermittent disability benefits.
- With the approval of Sedgwick and the approval of the employee's supervisor, a TIer may be accommodated to work intermittent hours.
- Intermittent absences are defined as episodic absences taken in separate periods of time, for regularly scheduled medical treatments/special tests rather than one continuous period of time.
- The weeks on intermittent disability apply toward the 26 disability weeks for DPC benefits.

- The weeks on intermittent disability apply toward long-term disability eligibility.
- Intermittent disability workdays apply toward FMLA/CFRA time.
- Other requirements are the same as for regular DPC benefits.

DPC Tax Treatment

TI pays the full cost for DPC Basic coverage. The cost of this coverage is not taxable to you.

TI pays some of the cost of your DPC Plus coverage, if elected. In accordance with U.S. federal tax law, you will be taxed for the costs of DPC benefits paid by TI. The percentage of the DPC Plus costs which are paid by you are paid on a before-tax basis.

Any DPC benefit payments you receive are taxable.

You should consult with your tax advisor regarding the taxability of any benefits you receive.

Claiming Your DPC Benefits

If you believe you are eligible for DPC benefits, these are the steps you must follow:

- Notify your supervisor immediately on any workday you are absent.
- Call TI HR Connect at 888-660-1411 (choose option 5) to provide disability leave/disability information after your first workday missed if you expect to miss time from work beyond the required disability benefits waiting period. *Partial workdays missed are not covered by the disability benefits waiting period requirement. Partial workdays may be taken as Time Bank (if available) or as unpaid time.*
- Sedgwick, administrator of TI's absence and disability leave program, will contact you regarding your responsibility to contact your health care provider in order to obtain medical information for disability certification, determine medical qualification and set approval of the disability leave.
- Sedgwick must approve or deny your request for disability leave after you have satisfied the required disability benefits waiting period. You will be required to work with Sedgwick.
- You and your supervisor will be notified of approval dates for the disability leave (including partial or intermittent disability leave). If an extension is needed, you must contact Sedgwick.
- You will be required to submit medical information that supports your continuing disability.
- You may be required to undergo an examination by a health care provider chosen by Sedgwick.
- Partial or intermittent DPC benefits are paid after the expiration of the required disability benefits waiting period and the start of the approved DPC leave.

Deadline for Filing DPC Claims

If you become disabled and wish to claim disability benefits, you must call TI HR Connect at 888-660-1411 (choose option 5) to request disability leave as soon as possible. Any DPC claim(s) filed after the disability benefits waiting period may be denied as untimely.

When DPC Benefit Payments Stop

Benefit payments and your disability leave ends when:

- You are not disabled

- You fail to give proof that you are still disabled
- You refuse to be examined, you fail to submit updated medical information (including proof of compliance with your treatment plan) or you fail to follow treatment instructions from health care providers
- You die
- You work outside of TI for pay or profit without prior approval of the Claims Administrator
- You fail to provide prompt notification of any change in your health status
- We are unable to contact you due to your failure to notify TI of your change in residence
- You have received 26 weeks of DPC benefits

Termination of DPC Coverage

To the extent permitted by applicable law, your DPC coverage will terminate on the earliest of the following dates:

- The date you terminate employment or retire from TI. For employees in Hawaii and New Jersey, coverage continues for two weeks past termination of employment date unless you will begin coverage immediately under another plan. Employees in New York have coverage for four weeks past termination of employment date.
- The date you are placed on an unpaid leave of absence other than FMLA or another type of unpaid non-military leave required by applicable law (benefits are automatically reinstated upon return to work)
- On your job release date
- The last calendar day of the period for which you paid disability benefit costs, if enrolled in DPC Plus
- The date you are no longer in an eligible class of covered TIers (please see the Eligibility section on page 8 for more information)
- The date TI discontinues the Disability Benefit Plan or DPC
- The date you submit a claim or enrollment materials that include a misrepresentation or false/fraudulent statement

A Quick Look at Long-Term Disability (LTD) Benefits

Key features of the Long-Term Disability (LTD) benefits offered by the Disability Benefit Plan are:

- 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 calendar day of employment
- Benefits are payable after 26 weeks of full, partial or intermittent DPC benefits.
- There are two options for coverage:
    - LTD Basic — 50 percent of your basic monthly earnings reduced by other income benefits listed on page 158
    - LTD Plus — 66 2/3 percent of your basic monthly earnings reduced by other income benefits listed on page 158
- The maximum monthly benefit is $25,000

When LTD 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 in LTD Coverage

- You may enroll during the first 30 calendar days of your employment without evidence of insurability (EOI). Provided you enroll during your first 30 calendar days of employment, your coverage takes effect retroactively to your first calendar day at work.
- If you do not enroll during your first 30 calendar days of employment, you may enroll in LTD benefits or change from LTD Basic to LTD Plus during the annual enrollment period. If you enroll during annual enrollment, an EOI form must be submitted and approved for enrollment in LTD benefits or change from LTD Basic to LTD Plus to become effective. You will receive a notification link on the Fidelity NetBenefits® website at netbenefits.com/ti that additional action is required and you can complete the EOI form online. Completing an EOI form is not a guarantee of coverage. Coverage begins on the first calendar day of the calendar 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 LTD coverage.
- TIers on disability leave during annual enrollment may not enroll in LTD Basic or LTD Plus or increase their coverage from LTD Basic to LTD Plus for the following year.
- If a TIer is on a disability leave when a coverage change is scheduled to become effective, the TIer must return to active employment at TI for 90 consecutive calendar days before being eligible for the newly elected benefits.
- If a TIer is on another type of leave when a coverage change is scheduled to become effective, the TIer must return to work for one full shift before being eligible for the newly elected benefits.

LTD 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 LTD Benefits

LTD income protection 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 reduced by other income benefits listed below
- If you elect LTD Plus — your monthly benefit will be equal to 66 2/3 percent of your basic monthly earnings reduced by other income benefits listed below
- Please see the section later entitled “LTD Tax Treatment” for information regarding taxation of benefit payments

Basic monthly earnings means:

- Hourly — straight-time hourly rate of pay multiplied by 173.3 hours (if you are on an alternative work schedule, the hours in this formula will be adjusted)
- Salaried — monthly rate of base salary

Your basic monthly earnings do not include overtime, shift premium or any other additional compensation. For sales bonus plan participants, your monthly salary does not include your sales bonus target amount.

Your LTD benefit will be reduced by any of the following benefits you are eligible to receive that relate to your disability:

- Social Security Disability Income benefits and/or other Social Security benefits
- Workers' Compensation or other occupational disease benefits
- Disability pay from other sources
- Other governmental benefits
- Automobile No Fault (if required by law)
- Third Party Liabilities
- Mandatory state disability insurance program benefits

LTD benefits begin after you have been on DPC leave for a total of 26 disability 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 calendar day worked) when your disability starts. Your LTD benefit will continue as long as you remain disabled or totally and permanently disabled (see definition below under the Totally and Permanently Disabled section) and do not age out of LTD benefits. If your disability began on or before your 60th birthday, LTD benefits are payable up to the end of the calendar month in which you reach age 65. If your disability began after your 60th birthday, LTD benefits are payable until the earlier of the end of the calendar month in which you reach age 70 or reach 5 years from the beginning of your disability.

You are considered 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 disabled (as defined above). It may be necessary to submit a doctor's certification of your continued disability on request or your LTD benefits will stop.

Totally and Permanently Disabled

You may be considered totally and permanently disabled (TPD) for a 48 month period where because of your disability you are wholly and continuously unable to perform the essential functions of your job or be reasonably accommodated for a job that pays a minimum of 75% of your base pay before the disability leave. To be determined TPD you must provide the appropriate medical documentation (evidence of examination and treatment from health care providers) and be awarded Social Security disability income benefits.

Once you have been on leave of absence for 48 months, your employment with TI will generally terminate. *The 48 months begins with the commencement of your disability.* 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
- Possible one-year extension of your termination date to satisfy eligibility requirements for TI-sponsored early or normal retirement benefits under the TI Employees Pension Plan or retiree health benefits

How Long Benefits are Payable

You must file for Social Security Disability Insurance (SSDI) benefits within 12 months from the onset of your disability and 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 Claims 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 continuation of benefits not to exceed six months.

You must also provide medical documentation upon request to support your LTD benefits.

If your disability began on or before your 60th birthday, LTD benefits are payable up to the end of the calendar month in which you reach age 65. If your disability began after your 60th birthday, LTD benefits are payable until the earlier of the end of the calendar month in which you reach age 70 or reach 5 years from the beginning of your disability.

When LTD Benefit Payments Stop

Benefit payments and your disability leave ends when:

- You are not disabled
- You fail to give proof that you are still disabled
- You refuse to be examined, you fail to submit updated medical information (including proof of compliance with your treatment plan) or you fail to follow treatment instructions from health care providers
- You become eligible for long-term disability benefits through another employer plan
- 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 Sedgwick annually
- You die

- You become self-employed or employed by a party other than TI without prior approval of the Claims Administrator
- You fail to provide prompt notification of any change in your health status
- We are unable to contact you due to your failure to notify TI of your change in residence
- The date you exhaust the disability benefits available to you

Termination of LTD Coverage

To the extent permitted by applicable law, your LTD coverage will terminate on the earliest of the following dates:

- The date you terminate employment or retire from TI (coverage ends, LTD benefits can continue if awarded SSDI)
- The date you are placed on an unpaid leave of absence other than FMLA or another type of unpaid non-military leave required by applicable law (benefits are automatically reinstated upon return to work)
- On your job release date
- The last calendar day of the period for which you paid disability benefit costs
- The date you are no longer in an eligible class of covered TIers (please see the Eligibility section on page 8 for more information)
- The date TI discontinues the Disability Benefit Plan or LTD
- The date you submit a claim or enrollment materials that include a misrepresentation or false/fraudulent statement
- The end of the calendar day before your 70th birthday

Return to Work

Disabilities resulting from unrelated causes must be separated by a return to work of at least one full shift to be considered as separate claims.

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 disability, unless you return to active employment at TI for 90 or more consecutive calendar days.

Once you have returned to active employment at TI for 90 or more consecutive calendar days, 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/benefit options may continue (as long as you pay the associated costs) for a maximum of 48 months (during LOA):

- Blue Cross Blue Shield HDHP or PPO, or regional HMO
- Delta Dental (Basic/Plus)/DHMO
- Group Life Insurance
- AD&D Insurance
- Vision
- Health Care Flexible Spending Account
- Dental/Vision Flexible Spending Account (HSA-Compatible)

Coverage under these plans/benefit options for your enrolled dependents also continues. Benefit costs for these plans/benefit options will be billed. The TI Benefits Center at Fidelity will bill you for benefit costs. If

you do not pay your bill by its due date, your coverage will be dropped effective as of your last paid through date.

You will continue to earn service credit (if applicable) for the TI Employees Pension Plan and TI equity programs for a maximum of 48 months (during LOA).

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 active employment at TI
- Approved by Sedgwick

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 your monthly rate 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 disabled. TI will reduce or recover your LTD benefits in such cases to prevent overpayment.

Partial LTD Benefits

This program is available for instances of partial disability, during the participants' approved LTD leave.

Coverage

- A full-time TIer or part-time TIer on an alternative work schedule (minimum 20-hours-a-week schedule) with LTD coverage is eligible to obtain partial disability benefits.
- With the approval of Sedgwick and the approval of the employee's supervisor, a TIer may be accommodated to work partial hours with the intent to transition back to active employment at TI.
- Partial disability is defined as an illness or injury that results in the employee being unable to work all of their normal shift.
- Partial disability must be approved in 30-calendar-day increments, not to exceed a cumulative total of 90 consecutive calendar days.
- The weeks on partial disability apply towards the 48 months of disability benefits permitted prior to termination of employment.
- Partial disability days may apply towards any applicable state or local leave laws, such as CFRA.
- Other requirements are the same as for regular LTD benefits.

LTD Tax Treatment

TI pays 50 percent of your Basic coverage cost, if elected. In accordance with U.S. federal tax law, you will be taxed for the costs of LTD benefits paid by TI. The 50 percent of the LTD costs which are paid by you are paid on an after-tax basis.

TI pays some of the cost of your Plus coverage cost, if elected. In accordance with U.S. federal tax law, you will be taxed for the costs of LTD benefits paid by TI. The percentage of the LTD costs which are paid by you are paid on an after-tax basis.

LTD benefit payments received are taxable to the extent benefits are attributable to the cost of coverage paid by TI. The costs of disability coverage are waived when LTD benefit payments begin.

You should consult with your tax advisor regarding the taxability of any benefits you receive.

Claiming Your LTD 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 continue to work with Sedgwick, that you expect to be absent longer than six months.
Your health care provider	Your health care provider will be asked to submit medical information which supports your continuing disability. You may be required to submit to a physical examination by a doctor designated by Sedgwick. Prompt response by you and your health care provider 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 LTD Claims

The deadline for filing any LTD claim is 90 calendar days after the end of the DPC leave. Any claim(s) filed after the 90-calendar-day period may be denied as untimely.

Right to Recover DPC/LTD Disability Benefit Overpayments

If you receive a benefit payment greater than that which should have been paid per the Disability Benefit Plan, TI has the right to recover such overpayments, including the right to reduce future benefits and make payroll deductions.

DPC/LTD Exclusions and Limitations

The Disability Benefit Plan does not cover disability contributed to or caused by:

- Injuries related to any accident or incident that occurred while you were driving intoxicated, or while under the influence of any substance, regardless of whether the substance is legal or illegal
- Intentionally self-inflicted injuries, suicide or attempted suicide, while sane or insane or intoxicated or under the influence of any substance, regardless of whether the substance is legal or illegal
- Elective cosmetic surgery or cosmetic treatment
- Alcoholism or chemical dependency unless you are in an alcoholism or chemical abuse rehabilitation program which is approved by the Claims Administrator
- 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 Claims Administrator in its sole and absolute discretion
- Accidental injury or occupational disease incurred or commenced in the course of employment with a company other than TI
- Your committing or attempting to commit, an assault, battery (or similar unlawful act) or felony

- Insurrection, rebellion or taking part in a riot or similar civil commotion
- War, declared or undeclared, or any act or hazard of war or in any combat or police action

Additionally, the Disability Benefit Plan does not cover:
- Any period of disability during which you are not under the care of a health care provider
- Procedures not covered under the applicable benefit option under the TI Employees Health Benefit Plan

Claim Denial and Appeal Information for DPC/LTD Disability Benefits

If a Claim is Denied

If the Claims Administrator denies your claim for disability benefits, in either whole or part, a notice will be provided to you within a reasonable period, but no later than 45 calendar days from the calendar day your claim was received by the Claims Administrator. This notice, which will be provided in a culturally and linguistically appropriate manner, will include: (i) a full discussion of all of the reasons related to the denial of your benefit claim, (ii) reference to the specific plan provisions upon which the denial is based, (iii) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, (iv) an explanation of the claims review procedures and the time limits applicable to such procedures, including a statement of the right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974 if the claim is denied on review, and (v) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim. Such notice may also include an explanation of the basis for disagreeing with or not following (i) the views of your treating health care professional(s) and vocational professional(s), (ii) any disability determination made by the Social Security Administration, and (iii) the conclusion of any medical or vocational expert, which the Claim Administrator consults regarding your claim, regardless of whether the advice was relied upon in making the benefit determination. The notice will also include any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the denial determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist.

In certain instances, the Claims Administrator may not be able to make a determination within 45 calendar days from the calendar day your claim for disability benefits was received. In such situations, the Claims Administrator may extend the 45-calendar-day period for up to 30 calendar days as long as the Claims 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-calendar-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 Disability determination. This initial 30-calendar-day extension may be extended for up to 30 additional calendar days based on the same criteria described above.

If the time needed by the Claims 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 Claims Administrator has to decide the claim will be suspended on the date on which the Claims Administrator sends the notification to you until you properly respond. You will have up to 45 calendar days in which to respond. If you fail to respond within the 45-calendar-day period, the Claims Administrator will make the determination based upon the information then available.

Disability Benefit Plan Claim Appeals

If your claim that you are entitled to disability benefits according to the terms of the Disability Benefit Plan is denied, you may appeal the 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 180 calendar days of the date you received your notification of the denial and should be mailed, emailed or faxed to:

National Appeals Unit
P.O. Box 14446
Lexington, KY 40512
Email: ClaimInfo@sedgwickcms.com
Fax: 888-488-9536

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 initial determination of your claim. An independent and impartial individual will determine your disability appeal. To the extent that the determination of whether you are disabled involves a medical judgment, the Claims 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. You have a right to review and respond to new or additional evidence or rationales considered, relied upon, generated by or at the direction of the Claims Administrator while your appeal is pending. This new information will be provided to you as soon as possible, and you will have a reasonable opportunity to respond.

If, after reviewing your appeal and any additional information that you have submitted, the Claims Administrator denies your claim for disability benefits, a notice will be provided to you within a reasonable period, but not later than 45 calendar days from the calendar day your appeal request was received. In certain instances, the Claims Administrator may not be able to make a determination within the 45 calendar days. Here, the Claims Administrator, in its sole and absolute discretion, may extend the 45 calendar day period for up to 45 additional calendar days, as long as the Claims Administrator provides you with a written notice within the initial 45 calendar day period that explains (i) the reason for the extension, and (ii) the date on which a decision is expected.

Any denial notice, which will be provided in a culturally and linguistically appropriate manner, will include: (i) a full discussion of all of the reasons related to the denial of your benefit claim, (ii) reference to the specific plan provisions upon which the denial is based, (iii) a statement that you are entitled 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) a description of the voluntary second level appeal process and the your right to obtain information about such procedures, (v) a statement of your right to bring an action under Section 502(a) of the Employee Retirement Income Security Act of 1974, and (vi) a description of any applicable contractual limitations period that applies to a claimant's right to such a claim, including the calendar date on which the contractual limitations period expires. Such notice may also include an explanation of the basis for disagreeing with or not following (i) the views of your treating health care professional(s) and vocational professional(s), (ii) any disability determination made by the Social Security Administration, and (iii) the conclusion of any medical or vocational expert, which the Claim Administrator consults regarding your claim, regardless of whether the advice was relied upon in making the benefit determination. The notice will also include any internal rules, guidelines, protocols, standards or other similar criteria relied upon in making the denial determination, or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist, and a description of any contractual limitations period that applies to your right to bring an action under ERISA, including the calendar date on which the limitations period expires.

Voluntary Second Level Disability Benefit Plan Claim Appeals

You may file a voluntarily second level appeal of the denial of your claim appeal, in either whole or part, by the Claims Administrator by requesting a review of your claim by the Disability Claim Appeal

Committee. Your written request for an appeal must be received by the within 90 calendar days of the date you received your notice that the Claims Administrator denied your claim and should be mailed to:

TI Disability Benefit Plan
Disability Claim Appeal Committee
P.O. Box 650311, MS 3905
Dallas, TX 75265

The remainder of your voluntary second level appeal will be handled as discussed above. If the Disability Claim Appeal Committee denies your second level appeal, in either whole or part, written notice will be provided to you within a reasonable period, but not later than 30 calendar days from the calendar day your request for a review was received.

If your claim for benefits is denied after you have used all of your required appeal rights under the Plan (which excludes the voluntary appeal) or your claim is not processed according to the disability claim rules, you have a right to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act of 1974, as amended, in federal court.

Any civil action must be brought within one (1) year of the date your claim for disability benefits was denied in the final level of the appeal process outlined above. If your claim involves an appeal of the termination of your disability benefits, any civil action must be brought within one (1) year of the date on which your appeal of the termination of your disability benefits was denied by the Plan. If your claim involves an appeal of your right to receive disability benefits as a result of offsetting benefits, any civil action must be brought within one (1) year of the date on which your appeal of your right to receive disability benefits was denied by the Plan. You may not file a civil action after the expiration of this deadline.

Workers’ Compensation

(Note: This does not apply to COBRA participants or retirees)

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 calendar day of employment as a TIer.

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. Workdays missed during this waiting period following an on-the-job injury or illness is paid through the normal payroll distribution process at your base rate of pay. This time does not reduce your Time Bank balance.

Following the waiting period, tax-free Workers' Compensation 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 for workdays missed must meet DPC/LTD criteria to be eligible for DPC/LTD.

During the first six months of a work-related disability for workdays missed, 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 HR Connect at 888-660-1411 (and choose the option to report an on the job injury).

You will be contacted by the Zurich American Insurance Company and/or a TI Absence & Disability Management team representative to gather more information if needed for review of your claim.

If your Workers' Compensation 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 or retirees)
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 (rounded to the nearest $1,000) or minimum of $50,000 up to $2.5 million in coverage. Evidence of insurability is not required for Basic Life.
- **TIer-Paid Additional Life Insurance (Supplemental Life):** 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. Evidence of insurability may be required for Supplemental Life.

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.
- To enroll in Supplemental Life coverage within the first 30 calendar days of your employment, you must make an election on the Fidelity NetBenefits® website at netbenefits.com/ti or contact the TI Benefits Center at Fidelity.
- You are eligible for up to $300,000 of Supplemental Life coverage on your date of hire without providing proof of insurability if you enroll within the first 30 calendar days of your employment.
- You will be required to provide proof of insurability for Supplemental Life coverage if you enroll after your first 30 calendar days of employment.
- You can make changes to your Supplemental Life coverage during annual enrollment or upon the occurrence of an appropriate qualified status change. Please see the Introduction section for information about qualified status changes.
- You are not allowed to change your Supplemental Life coverage while you are on a leave of absence. When you return from your leave of absence, you will have 30 calendar days to change your Supplemental Life coverage.

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 or minimum of $50,000 in life insurance coverage.
- You may purchase Supplemental Life 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. In addition, evidence of insurability, if any, required for the purchase of Supplemental Life coverage must be provided at your expense. You pay the costs for Supplemental Life on an after-tax basis.

Your Benefits

The TI Group Term Life Insurance benefit provides insurance that is based on your annual base salary, excluding overtime, shift differentials and bonuses. If you are a sales bonus plan participant, your annual base salary includes your sales bonus target amount.

You can choose the amount of life insurance coverage that best fits your needs, up to $2.5 million of combined Basic and Supplemental Life coverage.

TI-Paid Insurance (Basic Life)

TI will pay for your Basic Life coverage up to one times your annual base salary (rounded to the nearest $1,000) or minimum of $50,000. (Basic Life and Supplemental Life combined cannot exceed $2.5 million.)

TIer-Paid Additional Life Insurance (Supplemental Life)

You may purchase Supplemental Life coverage in an amount up to eight times your annual base salary (rounded to the nearest $1,000). (Basic Life and Supplemental Life combined cannot exceed $2.5 million.)

Evidence of Insurability (EOI)

You are not required to complete an EOI form if: (1) you are currently enrolled in Supplemental Life insurance coverage and increase such coverage by one-time your annual base salary during annual enrollment or upon the occurrence of an appropriate qualified status change provided total coverage after the increase does not exceed $300,000 or (2) you elect Supplemental Life coverage for the first time within 30 calendar days of your first calendar day as a TI employee provided the amount of coverage elected does not exceed $300,000. If you do not satisfy either of these conditions, you will be required to complete an EOI form. You are not allowed to change your Supplemental Life coverage while you are on a leave of absence. When you return from your leave of absence, you will have 30 calendar days to change your Supplemental Life coverage.

If applicable, you will receive a notification link on the Fidelity NetBenefits® website at netbenefits.com/ti that additional action is required and you can complete the EOI form online. Completing an EOI form is not a guarantee of coverage. You can be denied life insurance coverage in excess of $300,000 due to your medical history or a current medical condition. If you do not provide evidence of your good health, or if such evidence of good health is not accepted as satisfactory, your Supplemental Life coverage will be limited to $300,000.

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 provided you are actively working.

Imputed Income — An IRS-Required Tax

If your total group basic 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 reported to the IRS) and subject to tax.

The IRS sets the value of group term basic 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." While you did not actually receive this amount, 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 Earnings 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 (and reported to the IRS). 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 (LTD) benefits 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 and/or additional life insurance (Supplemental Life) you have currently, plus any spouse/domestic partner or child life insurance you have currently, to personal policies. You are also eligible to continue your additional life insurance (Supplemental Life) 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 888-252-3607 for portability details.

Beneficiary Information

Designation of Beneficiaries

On your date of hire, you should make a beneficiary election on the Fidelity NetBenefits® website at netbenefits.com/ti. This allows you to name the beneficiaries you wish to receive your life insurance. The beneficiary is the same for Basic Life and Supplemental Life. 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 Fidelity NetBenefits® website or contact the TI Benefits Center at Fidelity. 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 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.

Neither TI nor MetLife guarantees nor assumes any obligation for the validity or sufficiency of any assignment.

Spouse/Domestic Partner Life Insurance

You may also elect life insurance coverage for your covered spouse or domestic partner. You are the beneficiary of any spouse/domestic partner life insurance coverage you elect.

Coverage for your spouse/domestic partner includes options of $5,000, $10,000, $25,000, $50,000, $100,000, $150,000 or $200,000. Maximum coverage is the lesser of 7 times employee annual base salary or $200,000. Coverage is available for your spouse/domestic partner only if you have at least the basic life insurance for yourself.

Provisions Applicable to Coverage on Your Spouse/Domestic Partner in Excess of $50,000

You must, at your expense, give MetLife evidence of the good health of your covered spouse/domestic partner in order for your covered spouse/domestic partner 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/domestic partner 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 covered spouse/domestic partner on the later of:

- The date the evidence of the good health of your covered spouse/domestic partner is accepted by MetLife as satisfactory
- The effective date of your life insurance coverage

If you do not give MetLife evidence of the good health of your covered spouse/domestic partner, 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 covered spouse/domestic partner 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 calendar days of the date of their employment to choose spouse/domestic partner life insurance coverage. Other TIers may elect spouse/domestic partner life insurance during annual enrollment or within 30 calendar days of an appropriate qualified status change.

Your Cost

Spouse/domestic partner life insurance costs are based on the amount of coverage elected and your spouse's/domestic partner’s age. You pay the costs for spouse/domestic partner life insurance on an after-tax basis.

Evidence of Insurability (EOI)

During annual enrollment or upon the occurrence of an appropriate qualified status change, if you elect spouse/domestic partner life insurance of greater than $50,000, an EOI for your spouse/domestic partner will be required. If applicable, you will receive a notification link on the Fidelity NetBenefits® website at netbenefits.com/ti that additional action is required and you can complete the EOI form online. Completing an EOI form is not a guarantee of coverage. Your spouse/domestic partner can be denied life

insurance coverage in excess of $50,000 due to their medical history or a current medical condition. If they do not provide evidence of your good health, or if such evidence of good health is not accepted as satisfactory, their Supplemental Life coverage will be limited to $50,000.

Imputed Income — An IRS-Required Tax

If you choose spouse/domestic partner life insurance, you will be subject to imputed income, which will be added to your W-2 Form (and reported to the IRS) and subject to tax.

Living Needs Benefit

If you, or your covered spouse/domestic partner, are terminally ill and expected to die within 24 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 (Supplemental Life) combined is $250,000. No Living Needs Benefit will be payable if the amount of covered spouse/domestic partner 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 who are under age 26.

You are the beneficiary of any child life insurance you elect. Coverage is available for your children only if you have at least the basic life insurance for yourself.

Eligible Dependents

Your eligible dependents who are under age 26 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 domestic partner
- Your grandchild who lives with you and is claimed by you as a dependent on IRS tax filings

If Your Dependent Child is Disabled

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

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 calendar 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 or 60 calendar days depending on the type qualified status change. Please see the Introduction section for information about whether your specific qualified status change is subject to either the 30 or 60 calendar day requirement.

Two TIers Who Are Married (or in a Domestic Partnership)

If you are married to (or in a domestic partnership with) another TIer, only one TIer may enroll the eligible child dependents. Both TIers may enroll their eligible spouse (or domestic partner) in spouse life insurance.

Your Cost

You pay the costs for child life insurance on an after-tax basis.

Suicide Exclusion

Employee Additional (Supplemental Life, not Basic Life), Spouse/Domestic Partner 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.

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.

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 calendar days from receipt of the claim.

You can obtain the Life Insurance claim form and instructions by contacting MetLife at 800-638-6420. The claim should be sent to:

MetLife
Group Life Claims
P.O. Box 3016
Utica, NY 13504

Payment Methods

If the benefit amount payable to a beneficiary is $5,000 or more, the claim may be paid by the establishment of a Total Control Account (TCA). The TCA is a settlement option or method used to pay claims in full. MetLife establishes an interest-bearing account that provides your beneficiary with immediate access to the entire amount of the insurance proceeds. MetLife pays interest on the balance in the TCA from the date the TCA is established, and the account provides for a guaranteed minimum rate. Your beneficiary can access the TCA balance at any time without charge or penalty, simply by writing drafts in an amount of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately if they wish. Please note the TCA is not a bank account and not a checking, savings or money market account.

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 calendar days from the calendar 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 email) 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), (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 calendar days from the calendar day your claim for benefits was received. In such situations, the Claims Administrator, in its sole and absolute discretion, may extend the 90-calendar-day period for up to 180 calendar days, as long as the Claims Administrator provides you with a written notice within the initial 90-calendar-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 calendar 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
P.O. Box 6100
Scranton, PA 18505

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 email) will be provided to you within a reasonable period of time, but not later than 60 calendar days from the calendar 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 calendar days from the calendar 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-calendar-day period for up to 120 calendar days, as long as the Claims Administrator provides you with a written notice within the initial 60-calendar-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.

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under Section 502(a) of ERISA if you file such complaint in a federal court within one (1) year of the date such claim for life insurance benefits was denied in the final level of the appeal process outlined above.

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

Termination of Coverage

Your TI group term life insurance coverage will terminate on the earliest of the following:

- When your employment ends (including death)
- When you retire
- When you are no longer in an eligible class of covered TIers
- When you fail to pay your required cost. If you are on an unpaid leave of absence, you will be billed and you must pay your required costs. Otherwise, your supplemental life insurance coverage will be canceled for non-payment. The resumption of any supplemental coverage will require re-enrollment and may require evidence of insurability.
- The date the group insurance contract is canceled

Your dependent life insurance coverage will terminate on the earliest of the following:

- The date the dependent ceases to be your eligible dependent
- When you fail to pay your required cost. If you are on an unpaid leave of absence, you will be billed and you must pay your required costs. Otherwise, your spouse/domestic partner life insurance coverage will be canceled for non-payment. The resumption of any spouse/domestic partner coverage will require re-enrollment and may require evidence of insurability.
- Date of their death
- 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 calendar 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 calendar 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 calendar day after the date your TI group term life insurance ends.

Death Within 31 Calendar Days of Termination

If you or your dependents should die during the 31-calendar-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 (Supplemental Life) 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/domestic partner must request to continue dependent life insurance coverage on their life through portability if your spouse/domestic partner 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 888-252-3607. You must apply for portability within 31 calendar days after your life insurance has been terminated; the 31-calendar-day period is also known as the request period.

The maximum amount of additional life insurance (Supplemental Life) 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 (Supplemental Life) 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 Calendar Days of the Date Your Life Insurance Ends

If you die within 31 calendar 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 calendar 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.

UnitedHealthcare Global

When a TIer is covered by TI-paid basic life insurance, UnitedHealthcare Global provides 24-hour, worldwide provider referral service to obtain medical assistance and evacuation for TIers and dependents accompanying a TIer on leisure/personal travel who are 100 miles or more from their home or in another country.

UnitedHealthcare Global is not a medical insurance plan and does not provide medical benefits. Therefore, if there is a need for medical assistance while in your home country, you must first access or initiate care through your medical insurance plan.

Accidental Death and Dismemberment (AD&D)

(Note: This benefit does not apply to COBRA participants or retirees)
THIS BENEFIT IS PART OF AN ERISA PLAN

A Quick Look

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 domestic partner at 60 percent of your coverage
- Dependent children are automatically covered for 10 percent of the TIer's coverage (rounded to the nearest $500), up to $50,000

When You May Enroll

New hires have 30 calendar 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.

Two TIers Who Are Married (or in a Domestic Partnership)

If you are married to (or in a domestic partnership with) another TIer, you may not enroll your eligible spouse (or domestic partner) in AD&D coverage if they are covering themselves under AD&D.

If both parents are TIers and both are covered by AD&D, coverage for the dependent children will be 10 percent of the parent with the highest benefit amount (rounded to the nearest $500), up to $50,000. This coverage is provided whether or not you insure your spouse or domestic partner.

Cost — Who Pays

Your cost for employee or employee + spouse (or domestic partner) coverage is based on each $1,000 of coverage.

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.

Sales bonus plan participants — Your annual base salary includes your sales bonus target amount.

When your salary changes, your AD&D coverage changes at the same time.

Coverage for Spouse or Domestic Partner

If your spouse or domestic partner is not eligible for coverage as a TI employee, you may choose to insure them for 60 percent of your coverage (rounded to the nearest $1,000). You may enroll your spouse or domestic partner within 30 calendar 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 (for more information, please see the Introduction section where Eligible Dependents are defined) 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 for the dependent children will be 10 percent of the parent with the highest benefit amount (rounded to the nearest $500), up to $50,000. This coverage is provided whether or not you insure your spouse or domestic partner.

Benefit Schedule

If injuries result in death or dismemberment to you, your covered spouse or domestic partner or your eligible children within 365 calendar 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
Hand	50% of principal sum
Foot	50% of principal sum
Arm	50% of principal sum
Leg	50% of principal sum
Sight of one eye	50% of principal sum
Thumb and index finger of the same hand	25% of principal sum
Speech and hearing (of both ears)	Principal sum
Speech or hearing (of both ears)	50% of principal sum
Paralysis of both arms and both legs (quadriplegia)	Principal sum
Paralysis of both legs (paraplegia)	75% of principal sum
Paralysis of both arms (diplegia)	75% of principal sum
Paralysis of the arm and leg on either side of the body (hemiplegia)	75% of principal sum
Paralysis of one arm or leg (uniplegia)	50% of principal sum
Any combination of loss of hand/foot or eye	Principal sum
Hearing in one ear	10% of principal sum

Limitations

If you should suffer more than one of the covered losses from any one accident, you could receive more than one benefit not to exceed the principal sum.

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 the Insurance Company's 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 domestic partner die as the result of the same covered accident, your spouse's or domestic partner's benefit is automatically raised to your benefit amount. The deaths must occur within 365 calendar days of the accident. The combined benefits (you and your covered spouse or domestic partner) cannot equal more than $1,000,000. However, if you and your spouse (or employee and domestic partner) are both TIers, benefits for each one will be equal to the principal sum amount, and no increase will apply.

Continuation of Insurance Benefits

If you select AD&D coverage for your dependents and you suffer an injury resulting in a covered loss which is payable under the accidental death benefit, all coverages under this policy which were in force on the date of the loss, with respect to covered persons other than the you, will be continued automatically for 365 calendar days after the date of the loss at no additional cost.

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.

Coma Benefit

The plan includes a coma benefit that will pay a monthly benefit equal to one percent of your principal sum; the monthly benefit payment will begin on the 31st day of the coma and continue up to a maximum of 100 months. Coma must begin within 365 calendar days of the covered accident.

COBRA Benefit

If the plan pays your death benefit due to a covered accident, the plan also includes a COBRA benefit that will pay a benefit the lesser of ten percent of your principal sum up to a maximum of $10,000 or the actual cost to the surviving covered family members to continue medical coverage for one year under the TI medical plan.

Exposure and Disappearance Coverage

If a covered person is exposed to weather because of an accident and this results in a covered loss, the plan will pay applicable principal sum, subject to all policy terms.

If the conveyance in which a covered person is riding disappears, is wrecked, or sinks, and the covered person is not found within 365 calendar days of the event, the plan will presume that the person lost their life as a result of injury. If travel in such conveyance was covered under the terms of the policy, the plan will pay the applicable principal sum, subject the all policy terms. The plan has the right to recover the benefit if they find that the covered person survived the event.

Home Alteration and Vehicle Modification Benefit

The plan includes a home alteration and vehicle modification benefit that pays a benefit for the onetime cost of the alteration/modification of up to ten percent of your principal sum to a maximum of $10,000. This benefit is provided when you are required to use a wheelchair to be mobile on a permanent basis as a result of your covered accident for which the plan paid an accidental dismemberment or loss of use benefit.

Rehabilitation Benefit

If therapy is prescribed within 90 calendar days from your covered accident, the plan includes a rehabilitation benefit that pays a benefit up to ten percent of your principal sum to a maximum of $10,000 for reasonable and customary expenses incurred within two years from the date of your covered accident.

Safety Device Benefit

If the plan pays your death benefit due to a covered accident, the plan also includes a safety device benefit that pays an:

- Air bag benefit equal to five percent of your principal sum, up to a maximum of $10,000, provided that you were protected by an approved safety device, as per manufacturer's instructions
- Seat belt benefit equal to twenty percent of your principal sum, up to a maximum of $40,000, provided that you were wearing an approved safety device, as per manufacturer's instructions
- Helmet motorcycle benefit equal to ten percent of your principal sum, up to a maximum of $10,000 and a minimum of $1,000, provided that you were wearing an approved safety device, as per manufacturer's instructions

Higher Education Benefit

If the plan pays your death benefit due to a covered accident, the plan also includes a higher education benefit that will pay a benefit equal to ten percent of your principal sum to a maximum of $10,000. This amount will be paid for each year the dependent child(ren) continues their 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 the accident, or
- Who are high school seniors and attend an institution of higher learning within 12 months of the date of the accident

If you have no dependent children who qualify, 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, 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 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 effective as of your last paid through date unless otherwise required by law. Payroll deductions will resume once you return to work.

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 (except for accidental ingestion of contaminated foods); medical or surgical treatment of illness or disease; complications following the surgical treatment of illness or disease; committing or attempting to commit a felony; voluntary intake or use by any means of (i) any drug, medication or sedative (unless it is taken or used as prescribed by a physician or taken as directed for "over the counter"), or (ii) alcohol in combination with any drug, medication or sedative or (iii) poison, gas or fumes; flying in any aircraft being used for test or experimental purposes or any aircraft that requires a special permit or waiver from the authority 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 (including the District of Columbia), the covered person's country of residence, and the following countries: Afghanistan and Iraq.

The policy may impose further limitations and exclusions. *These additional limitations and exclusions may not be included above*. If you have any questions about coverage, contact MetLife.

Beneficiary Information

Designation of Beneficiaries

On your date of hire, you should make a beneficiary election on the Fidelity NetBenefits® website at netbenefits.com/ti. 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 Fidelity NetBenefits® website at netbenefits.com/ti or contact the TI Benefits Center at Fidelity. 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. MetLife (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, MetLife will pay benefits according to the life insurance beneficiary designees. If no life insurance beneficiary has been designated, MetLife will use the succession rules in its policy to determine beneficiary (spouse or domestic partner, child or children, mother or father, sisters or brothers, estate).

Spouse or domestic partner and dependent child benefits are automatically paid to the TIer.

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 AD&D 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.

If you should have a loss that is covered by the plan, you or your beneficiary (claimant) must notify the TI Benefits Center at Fidelity through TI HR Connect at 888-660-1411, who will notify MetLife of the coverage and provide claimant contact information. MetLife will contact the claimant and mail the claim forms. The claimant must complete the forms and return them to MetLife. Claim should be sent to:

MetLife Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100

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 MetLife.

Your request for benefits must be made within 90 calendar days of the date of the covered loss. Claims submitted after this deadline will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of covered loss and the proof was provided as soon as reasonably possible, but no later than twelve months of the date of the covered loss. You may be requested to furnish proof of your continuing disability from time to time. Any and all requests will come directly from MetLife.

Payment of Claim

On receipt of the claim form and any attachments, MetLife will review the claim. If MetLife 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 calendar days from the calendar 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 email) 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), (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 calendar days from the calendar day your claim for benefits was received. In such situations, the Claims Administrator, in its sole and absolute discretion, may extend the 90-calendar-day period for up to 180 calendar days, as long as the Claims Administrator provides you with a written notice within the initial 90-calendar-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 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 calendar 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
P.O. Box 6100
Scranton, PA 18505-6100

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 email) will be provided to you within a reasonable period of time, but not later than 60 calendar days from the calendar 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 calendar days from the calendar 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-calendar-day period for up to 120 calendar days, as long as the Claims Administrator provides you with a written notice within the initial 60-calendar-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.

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under Section 502(a) of ERISA if you file such complaint in a federal court within one (1) year of the date such claim was denied in the final level of the appeal process outlined above.

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

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 and death)
- The end of the period for which costs are paid

When Dependent Coverage Stops

Coverage for your spouse or 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 domestic partner coverage

- The date your spouse or domestic partner or dependent coverage is canceled
- The date of their death
- The date an individual is no longer your spouse, domestic partner or your eligible dependent child

Portability

If your insurance ends because your employment ends or you retire, or you cease to be in a class eligible for such insurance, you must request to continue your AD&D coverage and/or your dependent AD&D coverage through portability if you want to continue the coverage.

If you die, or your marriage ends in divorce or annulment, your spouse/domestic partner must request to continue dependent AD&D insurance coverage through portability if your spouse/domestic partner 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, 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 AD&D 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 888-252-3607. You must apply for portability within 31 calendar days after your AD&D insurance has been terminated; the 31-calendar-day period is also known as the request period.

The amount of AD&D insurance available through portability is:

- for you, is a minimum of $10,000 and up to a maximum of $2,000,000;
- for your spouse/domestic partner, is a minimum of $2,500 and up to a maximum of $250,000; and
- for your dependent children, is a minimum of $1,000 and up to a maximum of $25,000.

When a request to continue insurance coverage for you and/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.

Business Travel Medical

(Note: This benefit does not apply to COBRA participants or retirees)
THIS BENEFIT IS PART OF AN ERISA PLAN

A Quick Look

Key features of the TI Business Travel Medical benefit, administered by UnitedHealthcare Global (UHCG), are:

- The plan covers all TIers and dependents accompanying a TIer on authorized business travel who are outside of their home country for less than 180 consecutive calendar days
- UnitedHealthcare Global provides worldwide urgent and emergency care due to accident or illness
- Approved medical and dental claims for urgent and emergency care are paid in full

Eligibility

The plan covers all TIers worldwide and dependents who are outside of their home country for less than 180 consecutive calendar days. 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

UnitedHealthcare Global (UHCG) provides worldwide urgent and emergency care due to accident or illness for TIers and dependents accompanying a TIer on business travel who are outside of their home country for less than 180 consecutive calendar days. TIers should contact UHCG prior to seeking care (unless the medical care is an emergency) for referral to an in-network provider.

This coverage also includes the following:

- Worldwide medical and dental referrals
- Personal travel outside of their home country for up to 7 days, immediately before, during or after the business travel
- Emergency medical evacuation
- Travel back to home country for medical treatment or recovery
- Assist in the replacement of corrective lenses and medical devices
- Continuous medical updates as permitted to family, TI and personal physician
- Round-trip transportation due to medical necessity for immediate family members to join the TIer outside of their home country
- One-way transportation to return dependent child(ren) to their home country
- Hotel arrangements for convalescence outside of their home country
- Return of mortal remains to home country

Please see the insurance policy or contract for the maximum benefits and/or limitations. You may obtain a copy of such documentation by contacting UHCG at 866-870-3475 or 763-274-7364.

Country Conditions

You can check the conditions of the country you are traveling to by logging on to https://infolink.sc.ti.com/business_rooms/travel/p/planning (under Safety, click on UnitedHealthcare Global Travel Portal).

You can also contact UHCG at 866-870-3475 or 763-274-7364, 24-hours a day/every day of the year. For reference, the Group ID number is 911870. You can also contact UHCG via email at businesstravel@uhcglobal.com.

Exclusions and Limitations

You are not covered by the plan during any trips if the travel is related to unauthorized TI business or if you are traveling in your home country. Additionally, your treatment or service may be limited by the terms of the insurance policy and/or contract. Please see the insurance policy or contract for details. You may obtain a copy of such documentation by contacting UHCG at 866-870-3475 or 763-274-7364.

Claiming Benefits

When you need assistance, you should contact UHCG at 866-870-3475 or 763-274-7364, 24-hours a day/every day of the year. For reference, the Group ID number is 911870. You can also contact UHCG via email at businesstravel@uhcglobal.com. If you contact UHCG prior to service, UHCG will provide direct payment to U.S. in-network providers and non-U.S. providers where possible.

If you don't contact UHCG prior to service, then you must fill out a claim form to be reimbursed. The claimant must complete the forms and return them to UnitedHealthcare Global. To obtain a claim form contact UHCG. Claims can be submitted online at members.uhcglobal.com, via email at businesstravel@uhcglobal.com, by fax to 248-524-5729 or by mailing to:

UnitedHealthcare Global
PO Box 740836
Atlanta, GA 30374-0836 USA

NOTE: All claims are administered by the Claims Administrator, UnitedHealthcare Global (UHCG). TI has not reserved the right to interpret the terms of the plan or policy with respect to fully-insured benefits. All Business Travel Medical benefits are provided solely through the insurance policy issued by UnitedHealthcare Insurance Company. 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.

Termination of Coverage

Your Business Travel Medical benefit coverage will terminate on the earliest of the following dates:

- The date you cease to be an employee (including death)
- The date the policy is canceled by TI or the insurance company

Business Travel Accident Insurance

(Note: This benefit does not apply to COBRA participants or retirees)
THIS BENEFIT IS PART OF AN ERISA PLAN

A Quick Look

Key features of the TI Business Travel Accident insurance benefits are highlighted below:

- The plan covers all TIers
- You are covered on your first calendar 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, subject to a minimum of $250,000 and up to a maximum of $1,000,000

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 from your supervisor to travel before departure. Side trips (not exceeding 30 calendar 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.*

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 calendar days.

Amount of Coverage

Your coverage (called the principal sum) is equal to five times your annual base salary, subject to a minimum of $250,000 and a maximum of $1,000,000.

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 one foot plus the loss of sight of one eye	Principal sum
Speech and hearing	Principal sum
Use of all four limbs	Principal sum
Speech or hearing	50% of principal sum
Either one hand or one 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	75% of principal sum
Use of one limb	50% of principal sum
Thumb and index finger of the same hand	25% of principal sum
Hearing in 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 the Insurance Company's competent medical authority to be permanent, complete and irreversible.

Loss of speech and hearing means total and permanent loss.

Coma Benefit

The plan includes a coma benefit that will pay a monthly benefit, after thirty-one consecutive calendar days in a Coma, if the coma resulting from a covered accident began within 365 calendar days of the covered accident, equal to one percent of your principal sum to a maximum of 100 months.

Exposure and Disappearance Coverage

If a covered person is exposed to weather because of an accident and this results in a covered loss, the plan will pay applicable principal sum, subject to all policy terms.

If the conveyance in which a covered person is riding disappears, is wrecked, or sinks, and the covered person is not found within 365 calendar days of the event, the plan will presume that the person lost their life as a result of a covered injury. If travel in such conveyance was covered under the terms of the policy, the plan will pay the applicable principal sum, subject to all policy terms. The plan has the right to recover the benefit if they find that the covered person survived the event.

Home Alteration and Vehicle Modification Benefit

The plan includes a home alteration and vehicle modification benefit that pays a benefit for the onetime cost of the alteration/modification of your primary residence or motor vehicle of up to ten percent of your principal sum to a maximum of $25,000. This benefit is provided when you are required to use a wheelchair to be mobile on a permanent basis as a result of your covered accident for which the plan paid an accidental dismemberment or loss of use benefit.

Rehabilitation Benefit

The plan includes a rehabilitation benefit that pays a benefit up to ten percent of your principal sum to a maximum of $10,000 for reasonable and customary expenses for rehabilitative training incurred within two years from the date of your covered accident.

Safety Device Benefit

If the plan pays your death benefit due to a covered accident, the plan also includes a safety device benefit that pays an additional benefit equal to twenty-five percent of your principal sum up to a maximum of $50,000 provided that you were:

- Operating or riding as a passenger in or on any private passenger automobile, motorcycle, scooter, moped, bicycle, boat or seagoing vessel, sailboard, personal watercraft, all-terrain vehicle, all-terrain cycle, snowmobile or while participating in downhill skiing, snowboarding, horseback riding, water skiing or other towed activities and
- Wearing or protected by, as per manufacturer's instructions an approved safety device

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

The plan 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 (except for accidental ingestion of contaminated foods); medical or surgical treatment of illness or disease; complications following the surgical treatment of illness or disease; flying in any aircraft being used for test or experimental purposes or any aircraft that

requires a special permit or waiver from the authority that has jurisdiction over civil aviation, even if granted; or any type of active military service.

In addition, the plan 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 (including the District of Columbia), the covered person's country of residence, and the following countries: Afghanistan and Iraq.

Multiple Accident Limitations

The maximum payable under the 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 their losses compare with the losses of all other TIers involved.

Beneficiary Information

Designation of Beneficiaries

Zurich American Insurance Company (the insurer) will make prompt payment directly to the named Life beneficiary unless a written notice of an adverse claim is received before making a payment. If no life insurance beneficiary has been designated, Zurich American Insurance Company will use the succession rules in its policy to determine beneficiary (spouse or domestic partner, child or children, mother or father, sisters or brothers, estate).

For TIers not on a U.S. benefit plan, Zurich American Insurance Company will pay benefits according to the succession rules (spouse, child or children, mother or father, sisters or brothers, estate).

Claiming Benefits

NOTE: All claims are administered by Zurich American Insurance Company. 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 Insurance Company. 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 by the plan, you or your beneficiary (claimant) must notify the TI Benefits Center at Fidelity through TI HR Connect at 888-660-1411, who will notify Zurich American Insurance Company of the coverage and provide claimant contact information. Zurich American Insurance Company will contact the claimant and mail the claim forms. The claimant must complete the forms and return them to Zurich American Insurance Company. Claims should be sent to:

Zurich American Insurance Company
P.O. Box 968041
Schaumburg, IL 60196-8041

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 Insurance Company.

Your request for benefits must be made within 90 calendar days of the date of the covered loss. Claims submitted after this deadline will neither invalidate nor reduce any claim if it was not reasonably possible to furnish the proof of covered loss and the proof was provided as soon as reasonably possible. 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 Insurance Company.

Payment of Claim

On receipt of the claim form and any attachments, Zurich American Insurance Company will review the claim. If Zurich American Insurance Company 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 Business Travel Accident insurance must be submitted to the Zurich American Insurance Company (the insurer) at the time and in the manner prescribed by the insurer.

If the insurer 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 calendar days from the calendar day your claim was received by the insurer. This notice (which will be provided to you in writing by mail, or hand delivery, or through email) will describe (i) the insurer's determination, (ii) the basis for the determination (along with appropriate references to pertinent benefit provisions on which the denial is based), (iii) the procedure you must follow to obtain a review of the determination, including a description of the appeals procedure and (iv) your right to bring a cause of action for benefits under Section 502(a) of ERISA. This notice will also explain, if appropriate, how you may properly complete your claim and why the submission of additional information may be necessary.

In certain instances, the insurer may not be able to make a determination within 90 calendar days from the calendar day your claim for benefits was received. In such situations, the insurer, in its sole and absolute discretion, may extend the 90-calendar-day period for up to 180 calendar days, as long as the insurer provides you with a written notice within the initial 90-calendar-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 for Business Travel Accident insurance is denied, you must appeal the insurer's denial by requesting a review of your claim by the insurer. Your written request for an appeal must be received by the insurer within 60 calendar days of the date you received your notification of the insurer's denial. Your request for an appeal should be mailed to:

Zurich American Insurance Company
P.O. Box 968041
Schaumburg, IL 60196-8041

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 insurer's initial determination of your claim.

If, after reviewing your appeal and any further information that you have submitted, the insurer 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 email) will be provided to you within a reasonable period of time, but not later than 60 calendar days from the calendar day your request for a review was received by the insurer. 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 calendar days from the calendar day your request for a review was received by the insurer. In such situations, the insurer, in its sole and absolute discretion, may extend the 60-calendar-day period for up to 120 calendar days, as long as the insurer provides you with a written notice within the initial 60-calendar-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 insurer 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.

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under Section 502(a) of ERISA if you file such complaint in a federal court within one (1) year of the date such claim was denied in the final level of the appeal process outlined above.

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

Termination of Coverage

Your Business Travel Accident benefit coverage will terminate on the earliest of the following dates:

- The date you cease to be an employee (including death)
- The date the policy is canceled by TI or the insurance company

Important

This is a brief description of the coverage provided through the Business Travel Accidental Death & Dismemberment plan. If any conflict should arise between the contents of this summary and the policy or if any point is not covered herein, the terms of the policy shall govern in all cases.

UnitedHealthcare Global

UnitedHealthcare Global provides 24-hour, worldwide provider referral service to obtain medical assistance and evacuation for TIers and dependents accompanying a TIer on business travel who are 100 miles or more from their home or in another country.

UnitedHealthcare Global is not a medical insurance plan and does not provide medical benefits. Therefore, if there is a need for medical assistance while in your home country, you must first access or initiate care through your medical insurance plan.

More information is available online, type travelmedical/ in your Infolink browser.

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 (TI Flexible Benefits Plan)
  - Disability Benefit Plan of Texas Instruments Incorporated (Disability Plan)
  - 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
Corporate Financial Services
50 South LaSalle Street
Chicago, Illinois 60603

Plan Year

January 1 through December 31

Sponsoring Employer

Texas Instruments Incorporated
12500 TI Boulevard
Dallas, Texas 75243

Agent for Service of Legal Process

Cynthia Trochu, Secretary
Texas Instruments Incorporated
12500 TI Boulevard
Dallas, Texas 75243

Plan Administrator:

Texas Instruments Incorporated Welfare Benefits Plan
Attn: Plan Administrator
P.O. Box 650311, MS 3905
Dallas, Texas 75265

Claims Administrators/Insurance Companies:

The Administration Committee is the appointed Plan Administrator for purposes of claim appeals related 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 and Blue Shield of Texas. This option is self-insured by TI, and TI is responsible for payment of such claims.

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

HDHP: Blue Cross Blue Shield HDHP benefits are administered by Blue Cross and Blue Shield of Texas. This option is self-insured by TI, and TI is responsible for payment of such claims.

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

HMO: HMO benefits are fully-insured and claims are administered by the HMO.

Kaiser Northern California
1950 Franklin Street
Oakland, CA 94612

Dental: The Dental benefit is self-insured and claims are administered by Delta Dental.

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

DHMO: The DHMO benefit is fully-insured and claims are administered by Aetna.

Aetna
2777 Stemmons Freeway, #300
Dallas, TX 75207

AD&D: The Accidental Death & Dismemberment benefit is fully-insured and claims are administered by Metropolitan Life Insurance Company.

Accidental Death & Dismemberment Policy
Metropolitan Life Insurance Company
200 Park Avenue
New York, New York 10166
Policy # 94758

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 Sedgwick.

National Appeals Unit
P.O. Box 14446
Lexington, KY 40512

TI Flexible Benefits Plan: The TI Flexible Benefits Plan (which is part of the Texas Instruments Incorporated Welfare Benefit Plan and includes the Health Care Flexible Spending Account, Dental/Vision Flexible Spending Account, and Dependent Daycare Flexible Spending Account) is self-insured and claims are administered by HealthEquity.

TI Flexible Benefits Plan
HealthEquity, Inc.
15 W Scenic Pointe Drive, Ste 100
Draper, UT 84020

VSP: The VSP benefit is a voluntary benefit paid for solely by employees, and is fully-insured. Claims are administered by VSP.

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

Group Term Life: The Group Term Life benefits are fully-insured and claims are administered by Metropolitan Life Insurance Company.

Group Term Life Insurance
Metropolitan Life Insurance Company
200 Park Avenue
New York, New York 10166
Policy # 94757

Business Travel Accident: The Business Travel Accident benefits are fully-insured and claims are administered by Zurich American Insurance Company.

Business Travel Accidental Death and Dismemberment Insurance
Zurich American Insurance Company
Accident & Health Special Risk
1299 Zurich Way
Schaumburg, IL 60196
Policy # GTU-2620651

Business Travel Medical: The Business Travel Medical benefits are fully-insured and claims are administered by UnitedHealthcare Global.

Business Travel Medical
UnitedHealthcare Global
PO Box 740836
Atlanta, GA 30374-0836 USA

Your Rights Under ERISA

As a participant in any or all of the plans described in this Summary Plan Description, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan(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 summary 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 summary annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people that are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Continue Group Health Plan Coverage

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Enforce Your Rights

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time frames.

Additional Rights Under ERISA

Under ERISA, there are steps you can take to enforce the above listed rights. For instance, if you request a copy of Plan documents or the latest summary annual report from the Plan and do not receive them within 30 calendar days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a calendar day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or part and you have exhausted your administrative appeals, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order and you have exhausted your administrative appeals, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or you are discriminated against for asserting your rights and you have exhausted your appeals, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the appropriate Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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