

2011 Retiree Health Benefits Frequently Asked Questions

Texas Instruments Incorporated

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2011 ENROLLMENT

Changes for 2011

What are the changes for this year?

For 2011, TI offers the same health coverage options to TI retirees that were available in 2010, with an adjustment to the structure of what were formerly the individual CIGNA HMOs, as explained below.

Also, as part of health care reform legislation passed in 2010, dependent coverage will be available up to age 26 for medical insurance, regardless of student or marital status.

For Medicare eligible Blue Cross Blue Shield participants, effective Jan. 1, 2011, the allowed amount for out-of-network expenses will be based on a percentage of regional Medicare rates. This was previously based on the amount charged by 80 percent of providers in the geographic area.

For pre-Medicare participants, the current four CIGNA HMOs offered by TI are being combined into one CIGNA Copay Plan. This offering will operate similar to an HMO, using CIGNA's nationwide Open Access Plus network, with no requirement to select a primary care provider. If you currently participate in one of the CIGNA HMOs, you will be enrolled automatically in this option, unless you choose another plan during annual enrollment.

If you're currently in an HMO, check with your provider for changes for 2011. TI has been informed that for Medicare-eligible participants, SecureHorizons HMO is eliminating its copay for smoking cessation services. In addition, SecureHorizons participants in Rhode Island will have a 50% copay for chiropractic services, rather than a flat copay of \$15.

For details about changes, refer to the annual enrollment

	<p>packet mailed to your home Oct. 26, which included the annual enrollment special edition of “Connection,” TI’s retiree benefits publication. In a separate mailing you should have also received the 2011 Retiree Health Benefits Guide.</p> <p>Both of these publications are also available in the Reference Materials section of netbenefits.fidelity.com.</p> <p>Important note: If you do not make an active election during annual enrollment, you will remain in the same option you elected for 2010.</p>
<p>What are the changes between the CIGNA Copay Plan versus the current CIGNA HMO arrangement?</p>	<p>The CIGNA Copay Plan does not require a primary care physician.</p> <p>The network used by the plan is the CIGNA Open Access Plus (OAP) In-Network. Some physicians may choose to be in the HMO but not in the OAP, and vice versa.</p> <p>CIGNA will notify everyone who used an HMO provider in the past year who is not contracted as a OAP provider.</p> <p>The OAP is a nationwide network, however it is only offered to TI retirees living in North Texas, Houston, Austin, Arizona or North Carolina - the same areas previously eligible for the HMO.</p> <p>Since it is a nationwide network, if you are traveling in an area that has CIGNA OAP - contracted doctors, you can use them for non-emergency treatment. Additionally, if you have a dependent living in another state, your dependent can access treatment in that state without having to set up "guesting" arrangements.</p>

Premiums	
Are benefit rates increasing for 2011?	<p>Yes. Premiums will be higher in 2011 for coverage under either the Blue Cross Blue Shield PPO, the CIGNA Copay Plan (versus the former CIGNA HMOs) or one of the TI-sponsored regional HMOs.</p> <p>Dental insurance premiums are also increasing for 2010.</p>
Where can I find the 2011 premiums?	<p>An enrollment packet was mailed to your home from the TI Benefits Center on Oct. 26. This packet contains a personal fact sheet which lists the premiums that apply to you.</p> <p>You can also review your premiums on the NetBenefits website at netbenefits.fidelity.com.</p>
Where can I compare my current benefits to my 2011 elections?	<p>You can view your 2010 coverage at netbenefits.fidelity.com. As of Nov. 3, you'll also be able to view your 2011 options.</p>
Default Coverage	
If I don't enroll for my 2011 benefits, what will happen?	<p>You will be automatically enrolled in the same coverage as you currently have for 2010.</p> <p>Note: If you are currently enrolled in CIGNA HMO you will be placed in the CIGNA Copay plan.</p>
NetBenefits	
Where is the link to NetBenefits?	<p>You can go directly to NetBenefits by entering netbenefits.fidelity.com into your web browser address line. There is also a link to NetBenefits on the TI Alumni website at tialumni.org.</p>

Confirmation Statements

<p>How can I get a confirmation of my elections?</p>	<p>Immediately following enrollment on NetBenefits, a confirmation statement will be displayed for you to review and print. After annual enrollment, if you made a change in your benefits (or if you simply click “Save” on the NetBenefits screen without making changes), a confirmation statement will also be mailed to your home address.</p>
<p>When should I expect to receive a confirmation statement in the mail?</p>	<p>Confirmation statements will be mailed in December.</p>

ID Cards

<p>Will we get new health plan cards from Blue Cross Blue Shield for 2011?</p>	<p>Blue Cross Blue Shield (BCBS) PPO will issue new cards for anyone adding or making a change to their PPO coverage. The new cards will be mailed in late December. For HMOs, check with the specific carrier.</p> <p>If you’re supposed to receive a card and haven’t by late January 2011, contact your carrier through TI HR Connect, 888- 660-1411, option 1.</p> <p>If you are a new enrollee and elect retiree-only coverage, you will receive one ID card. If you are a new enrollee and elect other coverage categories, you will receive two ID cards.</p> <p>To request additional ID cards, call Blue Cross Blue Shield customer service through TI HR Connect, 888-660-1411, option 1. There is no charge for additional ID cards. You can also request additional cards by going to the Blue Access website at www.bcbstx.com.</p> <p>For HMOs and other insurance carriers, check with the specific carrier, which you can also contact through TI HR Connect.</p>
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Coverage Changes After Enrollment

How do I make changes after annual enrollment in 2011?	Call the TI Benefits Center through TI HR Connect at 888-660-1411, option 1.
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Verifying Dependents

Do I need to verify that my dependents are still eligible?	Yes. You will be able to view, confirm, and update your dependent data online through NetBenefits or by calling the TI Benefits Center.
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Currently in Treatment

What do I do if I am currently in treatment and want to change to another plan for 2011?	If you change medical plans for 2011 and have an ongoing medical condition, check your new plan to see if your doctors are in the new network. If not, discuss the situation with your medical carrier immediately.
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Automatic Bank Withdrawal with Fidelity

What is an automatic bank withdrawal?	<p>Automatic bank withdrawal (ABW) is a service that will allow you to pay for your monthly coverage by means of an automatic deduction from a designated bank account. The bank deducts the money from the bank account you designate and then the bank transmits the money automatically for you as payment for your monthly coverage.</p> <p>This eliminates the need to write a check each month and the risk of forgetting to pay for your benefits or paying late.</p>
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How can I enroll?	You can enroll online at netbenefits.fidelity.com or by calling the TI Benefits Center at Fidelity through TI HR Connect, 888-660-1411, option 1.
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Mailing Payments to Fidelity

When will I receive the invoice for my January payment?

December 2010.

What is the mailing address for my premium payments?

TI Benefits Center
P.O. Box 770001
Cincinnati, OH 45277

Fidelity Operating Hours

What are the hours of operation at the TI Benefits Center at Fidelity?

You can reach a representative at the TI Benefits Center at Fidelity 8:30 a.m. to 8:30 p.m. Eastern time, Monday through Friday, except for New York Stock Exchange holidays.

An interactive voice response system is available at the benefits center virtually 24 hours a day, excepting occasional maintenance periods.

To reach the TI Benefits Center at Fidelity, call TI HR Connect, 888-660-1411, and select option 1.

BLUE CROSS BLUE SHIELD

Claim Appeals Process

What can I do if the Blue Cross Blue Shield PPO doesn't pay a claim that I believe they should be paying?

A specific procedure is provided for following up on claim issues. See the full process in the Appeals Q&A under the General category of this document.

Coverage

<p>When I become Medicare-eligible, do I need to notify Blue Cross Blue Shield?</p>	<p>Yes. You should call Blue Cross Blue Shield through TI HR Connect, 888-660-1411, option 1, and tell the representative that you want to verify that Blue Cross Blue Shield has your Medicare information in its system. You will be asked for your Medicare number (which Medicare calls the Medicare Claim Number), located on your Medicare card. You will also need to provide your Medicare effective date. There is no paperwork required if you are the TI retiree. However, you must call Blue Cross Blue Shield. If you are calling on behalf of the TI retiree, you may be asked to complete a form. Once you are enrolled in Medicare, send all your medical claims to Medicare first. No claim under the Blue Cross Blue Shield PPO or an HMO will be accepted until your Medicare claim has been processed.</p>
<p>If I'm eligible for Medicare due to disability, do I need to notify Blue Cross Blue Shield?</p>	<p>Yes. You should notify the TI Benefits Center as well as Blue Cross Blue Shield. You can contact both through TI HR Connect, 888-660-1411, option 1, to verify that both Fidelity and Blue Cross Blue Shield have your Medicare information in their systems. You will be asked for your Medicare number (which Medicare calls the Medicare Claim Number), located on your Medicare card. You will also need to provide your Medicare effective date.</p> <p>There is no paperwork required if you are the TI retiree. If you are calling on behalf of the TI retiree, however, you may be asked to complete a form. Once you are enrolled in Medicare, send all your medical claims to Medicare first. No claim under the Blue Cross Blue Shield PPO or an HMO will be accepted until your Medicare claim has been processed.</p>

Coverage Changes for 2011

<p>Are there any changes to plan design for the Blue Cross Blue Shield PPO plan?</p>	<p>For Blue Cross Blue Shield participants, effective Jan. 1, 2011, the allowed amount for out-of-network expenses will be based on a percentage of regional Medicare rates. This was previously based on the amount charged by 80 percent of providers in the geographic area.</p> <p>As in 2010, PPO A offers a lower deductible for a higher monthly premium, while PPO B comes with a lower monthly premium but a higher deductible. Both options provide identical levels of coinsurance and prescription drug coverage. Refer to your enrollment packet or netbenefits.fidelity.com for details.</p>
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Deductible

<p>Does the cost of prescriptions apply to my deductible?</p>	<p>No. Your prescription drug costs apply to the annual pharmacy out-of-pocket maximum, but not to your PPO deductible.</p>
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Definitions

<p>What is a copay/copayment?</p>	<p>A copay or copayment is a flat dollar amount you pay, in addition to any applicable deductible, directly to the doctor or hospital when you receive certain covered services.</p>
<p>What is coinsurance?</p>	<p>Coinsurance is the percentage that TI contributes to your eligible medical expenses after you meet your medical deductible. For example, if the coinsurance amount is “70/30,” that means that the Blue Cross Blue Shield PPO pays 70 percent and you pay 30 percent of the allowable amount for the eligible medical charges.</p>

<p>What is an explanation of benefits (EOB)?</p>	<p>An explanation of benefits, or EOB, is a statement you receive after a claim has been filed on your behalf by the provider (doctor, hospital, etc.) or you file a claim directly with a health plan. This statement is a summary of the action taken on your claim — how much of the bill was paid by the plan and how much is your responsibility to pay (you may already have paid that portion at the time of service). Most HMOs do not send or offer EOBs to their participants.</p>
<p>What is a deductible?</p>	<p>A deductible is the amount you must pay for eligible medical expenses each year before benefits begin. If you have covered dependents, all charges applied toward each individual's deductible will be applied toward the family deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be satisfied for that calendar year. No individual will contribute more than the individual deductible amount towards the family deductible amount.</p>
<p>What is a lifetime maximum?</p>	<p>A lifetime maximum is the maximum amount the plan will pay for covered medical expenses for each covered participant during their lifetime.</p>
<p>What is reasonable and customary?</p>	<p>Some plans set reasonable and customary (R&C) limits on fees that non-network providers charge. They are based on what providers typically charge for that procedure in your geographical area. This might be referred to on your explanation of benefits (EOB) as the "allowable amount" if you are enrolled in the Blue Cross Blue Shield PPO plan.</p> <p>Be aware that, effective Jan. 1, 2011, the allowed amount for out-of-network expenses in the Blue Cross Blue Shield PPO will be based on a percentage of regional Medicare rates. This was previously based on the amount charged by 80 percent of providers in the geographic area.</p>

What is Blue Access?	This is the Blue Cross Blue Shield member access website containing information such as your membership and claims details. Go to www.bcbstx.com to log in.
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Benefits While Traveling

In the Blue Cross Blue Shield PPO, what happens if I get sick while traveling? Am I covered under the PPO?	<p>Inside the United States: If you need another doctor, you can find an in-network doctor by using the “Find a Doctor” option on NetBenefits or by calling Blue Cross Blue Shield through TI HR Connect, 888-660-1411, option 1, or contacting the provider directly.</p> <p>Outside the United States: Your benefits travel with you. For an emergency illness or injury requiring immediate care, you should be treated at the nearest hospital or doctor’s office, regardless of whether that provider is in-network. In the case of services rendered as a result of an accident or medical emergency, benefits will be reimbursed at the in-network benefit level. If hospitalization is required, once you are stable, it might be necessary for you to transfer to a network hospital (if available) to receive the highest level of benefits coverage.</p>
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Dependents

I have an unmarried, dependent child who is a full-time student and will be turning 19 next year. Can she continue to be covered under my medical plan?	Yes. Also, as part of health care reform legislation passed in 2010, dependent coverage will be available up to age 26 for medical insurance, regardless of student or marital status.
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Employee Assistance Program (EAP)

Do I need to call the Employee Assistance Program prior to receiving behavioral health care?	No. The EAP is no longer the gatekeeper of behavioral health. Participants are encouraged to call the Employee Assistance Program (EAP) at 800-888-CARE (2273) for in network referrals and treatment.
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<i>Explanation of Benefits (EOB)</i>	
If the Blue Cross Blue Shield explanation of benefits (EOB) is online, are retirees also sent a paper copy?	Yes. Retirees may, however, elect to suppress obtaining hard copies of EOBs through the mail. This is done via Blue Access. You can get to Blue Access from the NetBenefits website by clicking "BCBS", or go to www.bcbstx.com to log in.
<i>Filing Claims</i>	
Where can I obtain forms to file my claims?	<ul style="list-style-type: none"> • Contact Blue Cross Blue Shield through TI HR Connect, 888-660-1411, option 1. • Download forms from the NetBenefits website.
<i>ID Cards</i>	
Will my Social Security number be on my ID card?	No. Legislation in some states prohibits the use of Social Security numbers on ID cards and explanations of benefits (EOBs). Blue Cross Blue Shield changed member subscriber numbers (Social Security numbers) to unique identification numbers.
I've lost my Blue Cross Blue Shield ID card. What do I do?	<p>Call Blue Cross Blue Shield via TI HR Connect, 888-660-1411, option 1. Your call will then be routed to Blue Cross Blue Shield Customer Service and you can request a new ID card to be sent to you.</p> <p>If you are currently enrolled in the Blue Cross Blue Shield PPO, you can go to the Blue Access site by logging in at www.bcbstx.com, or you can access it through the NetBenefits website – on the “Health & Insurance” page, click the “Details” link in the Medical line.</p>
<i>Lifetime Maximum</i>	
Does the lifetime maximum include claims incurred while I was an active employee?	Yes. The lifetime maximum includes all claims on which the plan has made payments, both as an active employee and as a retiree.

Network vs. Non-Network	
What's the difference between in-network and non-network?	Blue Cross Blue Shield has a network of doctors and hospitals with which they have negotiated rates. You are free to choose any doctor or hospital. However, when using network providers for your medical care, you will receive the network (highest) level of benefits and you will not have to file your own claims – the network provider will file the claims for you.
Online Account Access	
Do retirees have online access to their Blue Cross Blue Shield accounts?	Yes. Once enrolled in the Blue Cross Blue Shield PPO, retirees may access claims and membership information via Blue Access, available by logging in at www.bcbstx.com . In addition, members may obtain duplicate copies of their explanations of benefits (EOBs) as well as temporary health ID cards.
How do I get to Blue Access?	If you are currently enrolled in the Blue Cross Blue Shield PPO, you can go to the Blue Access site by logging in at www.bcbstx.com , or you can access it through the NetBenefits website – on the “Health & Insurance” page, click the “Details” link in the Medical line.
How do I view my online claims history for CVS Caremark?	To view your CVS Caremark claims history online, log on to the CVS Caremark website (caremark.com). Click on “Manage Your Online Account with Caremark”. Then click “View Prescription History.” Click the orange "Prescription Report" button. Next, select the participant, time period and columns to view. Then click the orange "View Report" button. The document will be a PDF that can be saved or printed.
Out-of-Pocket Maximum	
How does an annual out-of-pocket maximum work?	The out-of-pocket maximum is the annual limit you would pay for most eligible plan expenses in a calendar year, after the deductible is met. After the out-of-pocket maximum is reached, the Blue Cross Blue Shield PPO pays 100 percent of most covered charges for the rest of

	<p>the plan year. The out-of-pocket maximum for medical expenses does not include deductibles, hospital copays, any behavioral health care expenses, custodial care, charges not covered by the plan or that exceed plan limits, pharmacy expenses, or non-network expenses that exceed reasonable and customary or other plan limits. There is a separate out-of-pocket maximum for pharmacy expenses. The out-of-pocket maximum for pharmacy expenses does not include deductibles or the cost difference you pay if a brand-name drug is received when a generic is available.</p>
<p>What is the annual out-of-pocket maximum for pharmacy in the Blue Cross Blue Shield PPO?</p>	<p>For Medicare-eligible participants: The annual out-of-pocket maximum for pharmacy is \$5,000/individual, \$10,000/family.</p> <p>If a generic drug is available and a brand-name drug is purchased instead, you'll pay the coinsurance for the brand-name drug cost, plus the cost difference between the brand-name and generic drug. The cost difference does not apply towards the pharmacy out-of-pocket maximum — you still pay the difference, even if your out-of-pocket pharmacy maximum has been met.</p> <p>For pre-Medicare participants: The annual out-of-pocket maximum for pharmacy is \$5,000/individual, \$10,000/family.</p> <p>If a generic drug is available and a brand-name drug is purchased instead, you'll pay the coinsurance for the brand-name drug cost, plus the cost difference between the brand-name and generic drug. The cost difference does not apply towards the pharmacy out-of-pocket maximum — you must still pay the difference, even if your out-of-pocket pharmacy maximum has been met. The out-of-pocket pharmacy maximum does not include deductibles.</p>

<i>Pre-Existing Conditions</i>	
Does the Blue Cross Blue Shield PPO have a pre-existing clause?	The plan does not impose any limitations on pre-existing conditions.
<i>Preventive Services</i>	
Where can I find details about what preventive benefits are covered under the Blue Cross Blue Shield PPO?	This information can be viewed in the 2011 Retiree Health Benefits Guide under “Preventive Health Care.”
<i>Primary vs. Secondary Coverage</i>	
How does the Blue Cross Blue Shield PPO coordinate benefits with a plan, other than Medicare or another group plan provided by an employer (i.e. HMO)?	If you have a private plan such as those available through the American Association of Retired Persons (AARP), other than Medicare or another group plan provided by an employer (i.e. HMO), the Blue Cross Blue Shield PPO will not coordinate benefits as secondary payer and will ignore the private plan.
<i>Provider</i>	
How can I determine if my doctor is on the Blue Cross Blue Shield PPO?	On NetBenefits, select the “Find a Provider” option. You can also call Blue Cross Blue Shield through TI HR Connect at 888-660-1411, option 1.
How often are the lists of Blue Cross Blue Shield providers updated?	The Blue Cross Blue Shield provider listings are generally updated monthly. We recommend that you also confirm a provider’s status with Blue Cross Blue Shield customer service or contact the provider directly.

<p>Can I nominate a doctor for the Blue Cross Blue Shield PPO? How?</p>	<p>Yes. You can fill out a provider nomination form and mail it to Blue Cross Blue Shield. You can find the form on NetBenefits by clicking the link, “All Health and Insurance Forms.” Nominating a provider does not guarantee that he or she will join the network.</p>
<p>Same-Gender Domestic Partner</p>	
<p>Is my same-gender domestic partner eligible for benefits?</p>	<p>Retirees can enroll their eligible same-gender domestic partners in medical and dental. However, the retiree must be enrolled in the medical and/or dental plan for the same-gender domestic partner coverage to be effective. Certain criteria must be met; see the “Eligibility” section in the 2011 Retiree Health Benefits Guide for details.</p>
<p>Referrals</p>	
<p>If I want to see a specialist, is a doctor referral required in the Blue Cross Blue Shield PPO?</p>	<p>No. In the Blue Cross Blue Shield PPO, you do not need a referral to a specialist. You can visit any doctor or hospital, but you will receive the highest level of benefits coverage when using in-network providers. For behavioral health care, see the earlier question regarding Employee Assistance Plan (EAP) referral and Blue Cross Blue Shield Precertification requirements.</p>
<p>OTHER CARRIERS</p>	
<p>CVS Caremark</p>	
<p>How do I reach CVS Caremark?</p>	<p>CVS Caremark customer service can be reached at 800-552-8159.</p>
<p>How can I get my CVS Caremark prescriptions through the mail-order program?</p>	<p>To participate in the CVS Caremark mail-order program you must complete the mail service order form. The form can be accessed on the CVS Caremark website (caremark.com). Enter your log-in information. Click “Start a New Prescription.” Then click “Mail Service Order Form.” Complete the form and mail it to CVS Caremark. Or you can contact CVS Caremark directly through TI HR Connect, 888-660-1411, option 1.</p>

CIGNA Copay Plan

<p>What are the changes between the CIGNA Copay Plan versus the current CIGNA HMO arrangement?</p>	<p>The CIGNA Copay Plan does not require a primary care physician.</p> <p>The network used by the plan is the CIGNA Open Access Plus (OAP) In-Network. Some physicians may choose to be in the HMO but not in the OAP, and vice versa.</p> <p>CIGNA will notify everyone who used an HMO provider in the past year who is not contracted as a OAP provider.</p> <p>The OAP is a nationwide network, however it is only offered to employees living in North Texas, Houston, Austin, Arizona or North Carolina - the same areas previously eligible for the HMO.</p> <p>Since it is a nationwide network, if you are traveling in an area that has CIGNA OAP - contracted doctors, you can use them for non-emergency treatment. Additionally, if you have a dependent living in another state, your dependent can access treatment in that state without having to set up "guesting" arrangements.</p>
<p>Will my doctor still be in the new CIGNA Copay Plan?</p>	<p>If you are currently in one of the CIGNA HMOs, it is likely that your current primary care provider is in the CIGNA Copay Plan, which uses the CIGNA Open Access Plus network. CIGNA will notify all members who were treated by providers in the past year who are not in the Open Access Plus network.</p>
<p>How do I know if my doctor is in the CIGNA Copay Plan?</p>	<p>Go to cigna.com and enter your doctor's information in the Find A Doctor section.</p>
<p>How do I change my Primary Care Physician?</p>	<p>One of the advantages of CIGNA's Open Access Plus network is that it does not require designation of a Primary Care Physician. You will not be asked for a designation during enrollment and your ID card will not list a Primary Care Physician.</p>

<p>Do I still need to set up “guesting” arrangements with CIGNA for my dependent child going to school out-of-state?</p>	<p>No. CIGNA Open Access Plus is a national network. If your child gets treatment from a CIGNA Open Access Plus network provider, he or she will receive network benefits. No benefits are paid if your child gets treatment from an out-of-network provider, except in the case of a qualified emergency.</p>
<p>I understand the CIGNA Open Access network is a national network. How does that affect me? Am I eligible?</p>	<p>The CIGNA Copay Plan is only offered to employees and pre-65 retirees living in the same locations that previously had HMO coverage through CIGNA (Dallas/North Texas, Houston, Austin, Arizona or North Carolina). If you are enrolled in the CIGNA Copay Plan and travel to another city or state, you may be able to access treatment for non-emergency services if the Open Access Plus Network has contracted with providers in that area. Previously, the only covered services outside your home network were for qualified emergency services.</p>
<p>In the CIGNA Copay Plan, what happens if I get sick while traveling? Am I covered?</p>	<p>If you are enrolled in the CIGNA Copay Plan and travel to another city or state, you may be able to access treatment for non-emergency services if the Open Access Plus Network has contracted with providers in that area.</p> <p>If you are traveling in a foreign country or there are no Open Access Plus Network providers in the area where you are traveling, the only services covered would be for qualified emergency treatment.</p>
<p>What can I do if the CIGNA Copay Plan doesn't pay a claim that I believe they should be paying?</p>	<p>There is a formal appeal process in place should CIGNA deny payment on a claim. You must first submit a written appeal to CIGNA. If CIGNA initially upholds the denial of your claim, you may then submit a written appeal to CIGNA for a second-level appeal. See the Health and Insurance Benefits Guide for additional information, including time requirements. The guide is available on this Web page from the left column, under Benefits Guides.</p>
<p>Will we get new medical ID cards</p>	<p>CIGNA will be issuing new ID cards to all enrollees with new provider network information. The insurance carriers</p>

CIGNA for 2011?	will be mailing new ID cards, if required, in late December. If you have questions about your ID cards, please contact the insurance carrier. You can contact CIGNA directly at 800-244-6224. You can also register on mycigna.com.
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BLUE CROSS BLUE SHIELD: MEDICARE-ELIGIBLE PARTICIPANTS

Coverage

What happens if a service is not covered by Medicare, but is covered by Blue Cross Blue Shield?	Once Blue Cross Blue Shield receives the Medicare denial of that service, Blue Cross Blue Shield will process the claim as if Blue Cross Blue Shield is primary.
If I am 65 and Medicare is primary, do I have to carry TI coverage to have my spouse covered who is under 65?	Yes. The retiree has to be insured by TI for any coverage to be available to their spouse and/or eligible dependents.

Filing Claims

Do I need to file my own claims?	Ask your provider about filing your claim for you. If the provider is filing your claim, there is no further action required on your part. If the provider is not filing the claim for you, you must file the claim. You must first file the claim with Medicare. Upon receiving your explanation of benefits (EOB) from Medicare, you should then file a claim with Blue Cross Blue Shield and attach the EOB from Medicare to it.
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Medicare Part B

What if I do not enroll in Medicare Part B?	If you do not enroll in Medicare Part B, Blue Cross Blue Shield PPO will estimate what Medicare Part B would have paid and will continue to pay as secondary insurance. You must enroll in Medicare Part B if you want to realize the full benefit under the Blue Cross Blue Shield PPO.
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Provider

What if my provider accepts Medicare but isn't a BCBS PPO provider?	Your Blue Cross Blue Shield coverage will be reduced to reflect out-of-network benefits.
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Blue Cross Blue Shield PPO vs. Medicare Part D

Why should I want to have the Blue Cross Blue Shield PPO when I'm retired and am Medicare-eligible?	<p>For some individuals, the TI prescription drug portion of medical coverage through TI Extended Health Benefits Coverage might be a better option than the Medicare Prescription Drug Coverage option. Depending on your prescription drug needs, each plan has its own advantages.</p> <p>The Blue Cross Blue Shield PPO offers the following benefits:</p> <ul style="list-style-type: none"> • Annual out-of-pocket maximums • Coverage when you travel outside of the United States • Other additional coverage not provided by Medicare (contact Blue Cross Blue Shield for detailed coverage information).
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CARRIER CHANGE

Transition of Care

I want to keep my doctor and he is not participating in my newly available HMO option. How do I get transition of care information when I change my medical plan?	<p>If any of the following conditions apply to you, you might be eligible to remain with your current doctor for a transition period of up to three months:</p> <ul style="list-style-type: none"> • Extensive therapy such as chemotherapy • A terminal illness • Awaiting a transplant • Behavioral health issues (beyond EAP) • Surgery scheduled for the first quarter of 2011 • Pregnancy, with expected delivery in the first quarter of 2011. <p>If you have other ongoing medical conditions and your current doctor is not in the new network, you may be eligible for other assistance. Your new medical plan administrator will be able to help you find an appropriate</p>
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	<p>doctor in the network so that your care can be continued without disruption.</p> <p>You can get the transition of care form(s) for your new medical plan administrators by contacting them directly. Return the forms to your new medical plan administrator in early December. If you are hospitalized at the end of the year and your hospital stay continues into 2011, you should contact both your 2010 medical plan administrator and your 2011 medical plan administrator to understand what procedures need to be followed.</p>
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DENTAL

Enrolling in Dental Coverage

<p>Can I elect dental only through TI Extended Health Benefits Coverage?</p>	<p>Yes. You can elect dental only, without enrolling in medical coverage.</p>
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<p>If I do not elect dental coverage at the time of retirement, will I be able to elect it at a later date?</p>	<p>If you terminated employment on or after Jan. 1, 1998, and you don't enroll in dental coverage through TI Extended Health Benefits Coverage prior to or within 30 days from the date you terminated, you'll be eligible to enroll for coverage later (during annual enrollment or in the event of an appropriate qualified status change) as long as you're enrolled in medical coverage through TI Extended Health Benefits Coverage.</p> <p>If you terminated employment prior to Jan. 1, 1998, and you do not elect dental coverage at the time of retirement, you can elect dental coverage at a later date.</p> <p>Regardless of your termination date, if you elect coverage, you may also enroll your eligible dependents, unless they are eligible for coverage under another health plan. In this case, you may not cover your dependents under this plan. If a dependent loses eligibility for coverage at a later date, it will be considered a qualified status change, and you may enroll the dependent at that</p>
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	time, as long as you remain enrolled in TI Extended Health Benefits Coverage. You may also add a dependent during any annual enrollment period.
I was told that if I'm on MetLife Dental Plus and then sign up for MetLife Dental Basic, I can't sign back up for Dental Plus again. Is that true?	This is not true. MetLife Dental Basic and MetLife Dental Plus should both be displayed as available options for 2011. During annual enrollment you can change the dental coverage between the available choices. Please be aware that switching from MetLife Dental Basic to MetLife Dental Plus does not allow increased orthodontia benefits. In addition, please note there are cost differences between the two plans.
<i>Annual Maximum</i>	
What is the annual maximum for MetLife Dental?	The annual maximum for Dental Basic is \$1,000 and the annual maximum for Dental Plus is \$1,500. Orthodontia services are covered at 50 percent up to the lifetime maximum of \$1,000 for Dental Basic and 50 percent up to the lifetime maximum of \$1,500 for Dental Plus.
<i>Network Providers</i>	
What is the advantage of using a network provider in the MetLife dental plans?	Dentists in the MetLife network must negotiate their rates, resulting in lower fees for you and TI. Reasonable and customary limits do not apply if you use network providers. There is not a penalty or coinsurance difference if you do not use a MetLife dentist, but reasonable and customary limits do apply.
What is "reasonable and customary"?	The reasonable and customary charge is the usual cost for comparable treatment in a local geographic area.

Claims History

How do I view my online claims history for MetLife?

To view your MetLife claims history online, log on to the MetLife MyBenefits website (metlife.com/mybenefits). First-time users will need to register with MyBenefits. This will require a user to select a unique user name and password and answer an identity-verification question. A user will be able to reset a forgotten password and/or user name online by correctly answering the required question.

GENERAL

Appeals

What is the process for filing an appeal when I have a problem?

For any problem involving a TI health benefit, follow these steps:

- 1. Discuss the issue with customer service** for the health plan carrier (such as Blue Cross Blue Shield, CIGNA, CVS Caremark, etc.)
- 2. Call the TI Benefits Center.** Call TI HR Connect, 888-660-1411, option 1, to get help from a representative at the TI Benefits Center at Fidelity. Representatives are available Monday through Friday, 8:30 a.m. to 8:30 p.m. Eastern time, except for New York Stock Exchange holidays.
- 3. File a claim or an appeal with your health-plan carrier.** Each health-plan carrier must follow a government-regulated process for responding to appeals.

Check the details for the plan in question in TI's 2011 Retiree Health Benefits Guide.

Changing Contact Information

What is the process to change my personal information, including phone number and address? Does this also affect the information

If you move, you must contact the TI Benefits Center within 30 days of your move. You will need to contact the TI Benefits Center directly to understand how a change of address may change your benefits. Additionally, if you have a temporary address during part of the year, don't forget to notify the U.S. Postal Service

<p>that TI retains?</p>	<p>so that correspondence from TI and the TI Benefits Center is forwarded to you.</p> <p>Contact Fidelity to change your address through either the NetBenefits website or TI HR Connect, 888-660-1411, option 1.</p>
<p><i>Customer Service</i></p>	
<p>When I call the TI Benefits Center through TI HR Connect will I be talking to a TI employee?</p>	<p>No, but TI Benefits Center representatives are trained to answer questions regarding the TI health care plans, as well as the defined pension plans and the defined contribution plans. Representatives in the TI Benefits Center are available Monday through Friday, 8:30 a.m. to 8:30 p.m. Eastern time, except for New York Stock Exchange holidays.</p>
<p><i>Death Certificate</i></p>	
<p>Why do you need a copy of a death certificate to cancel the insurance coverage on my deceased spouse?</p>	<p>A death certificate is not required to cancel health insurance coverage on a deceased spouse. Please contact the TI Benefits Center via TI HR Connect, 888-660-1411, option 1, to speak to a representative and report the death and update your coverage.</p>
<p><i>Definitions</i></p>	
<p>What is Medicare Part A and Part B?</p>	<p>Medicare Part A is hospital insurance that helps pay for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care. Medicare Part B is the part of Medicare that covers doctors' services and outpatient hospital care. It also covers other medical services that Part A does not cover, such as physical and occupational therapy.</p>
<p>What is split-family coverage?</p>	<p>If you and your spouse are both pre-Medicare, you must enroll in the same pre-Medicare plan option. If you and your spouse are both Medicare-eligible, you must enroll in the same Medicare-eligible plan option. Split-family coverage is available only if you and your spouse have different Medicare eligibility statuses.</p>

Enrollment

<p>If my spouse and I are both enrolled in an HMO, when I become Medicare-eligible does my spouse have to change to the PPO?</p>	<p>This is termed a “split-family coverage” situation. Available medical options vary based on eligibility for Medicare, as follows:</p> <ul style="list-style-type: none">• If you or a family member is eligible for Medicare, but at least one family member is not eligible for Medicare, special split-family rules may apply depending on which plan you are enrolled in. Some HMOs do not allow split-family enrollments.• When a family member becomes eligible for Medicare, that member must enroll in a Medicare-eligible medical plan through TI Extended Health Benefits Coverage. All family members who are not eligible for Medicare can continue to be enrolled in their current medical plan, if it allows split-family enrollments. You must choose two medical plan options -- one for those who are eligible for Medicare and one for those who are not.• When a family member becomes eligible for Medicare and you are enrolled in an HMO that does not allow split-family enrollments, all family members must move to another plan.
<p>If I do not make any elections for enrollment, what will happen to my coverage?</p>	<p>If you do not make an election for health benefits changes by the enrollment deadline, you will be automatically enrolled in the coverage you had in 2010. If you have no coverage in 2010, you will be assigned no coverage in 2011. Note: Your 2010 category of coverage (for example, you + family) will automatically be carried forward for 2011.</p> <p>Once annual enrollment is over, you will not be able to change your coverage until the next annual enrollment period, unless you have an appropriate qualified status change. Changes in coverage must be consistent with the change in status. You must make changes within 30 days of a qualifying event.</p> <p>If you want to drop coverage, you must contact the TI Benefits Center.</p>

	<p>IMPORTANT NOTE: If you terminated employment on or after Jan. 1, 1998, you may not opt in and out of medical coverage through the TI Employees Health Benefit Plan. If you elect to drop coverage, you will not be eligible to re-enroll in a TI-sponsored medical plan at any time.</p>
<p><i>Changing Benefits Coverage</i></p>	
<p>How do I report a life event (for example, birth, adoption, death, marriage, divorce, etc.) and change my benefits elections?</p>	<p>Except as 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:</p> <ul style="list-style-type: none"> • Within 30 days of your first day as a TI retiree • Each year during annual enrollment • Within 30 days of a qualified status change, which includes changes in: <ul style="list-style-type: none"> a. Legal marital status b. Number of dependents c. Dependent eligibility (when a dependent meets or fails to meet eligibility requirements) d. Death of a spouse or same-gender domestic partner/dependent e. Spouse or same-gender domestic partner/dependent annual enrollment <p>A full list of qualified status changes can be found in the 2011 Retiree Health Benefits Guide.</p> <p>Note: Changes in coverage must be consistent with the change in status. You must make your election changes within 30 days of the qualifying event.</p> <p>To request a change, contact the TI Benefits Center at Fidelity through TI HR Connect, 888-660-1411, option 1. You can also make the change on the NetBenefits website under the “Your Profile” link.</p> <p>If you move, you must contact the TI Benefits Center. If</p>

	<p>you are covered by an HMO and move out of that HMO's service area, you may enroll in the Blue Cross Blue Shield PPO or another HMO, if available in your area. In such cases, you must contact the TI Benefits Center within 30 days of your move.</p>
<p><i>Billing for TI Extended Health Benefits Coverage</i></p>	
<p>When will I be billed for my TI Extended Health Benefits Coverage?</p>	<p>Billing notices will be generated on the 10th of the month and mailed on the 15th of the month for plan premiums due the first of the month. For example, the January billing notices will be generated on Dec. 10, 2010, and mailed Dec. 15, 2010, for January plan premiums due on Jan. 1, 2011.</p> <p>Regardless of when you terminated from TI, if you fail to submit monthly payments within 30 days of the due date, your coverage will end retroactive to the last day of the month for which payment was received. If your coverage is dropped because of non-payment, you will not be eligible to re-enroll in a TI-sponsored health plan at any time.</p>
<p><i>Generic Drugs</i></p>	
<p>My doctor prescribed a brand-name drug and I can't take the generic drug in its place. Do I still need to pay the higher coinsurance or copay?</p>	<p>Participants enrolled in the Blue Cross Blue Shield PPO will pay the appropriate coinsurance. If a generic drug is available and a brand-name drug is purchased instead, you'll pay the coinsurance for the brand-name drug cost plus the cost difference between the brand-name and generic drug.</p> <p>If you are an HMO participant, please contact your current carrier for details on their process.</p>

ID Cards

<p>What do I do if I have to go to the doctor and I have not received my medical ID cards?</p>	<p>If you don't receive your card in January 2011, verify your address information on the Fidelity NetBenefits website at netbenefits.fidelity.com or call the TI Benefits Center through TI HR Connect, 888-660-1411, option 1.</p> <p>If your address information is correct, contact your health plan through TI HR Connect to request replacement cards be mailed to you.</p>
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Medigap

<p>What is Medigap insurance?</p>	<p>There are ten standardized Medigap plans, labeled by letters A through J. Each plan has a different set of benefits. Plan A covers only the basic (core) benefits. These basic benefits are included in all the plans. Each plan after A adds benefits to the basic plan.</p> <p>Different types of standardized Medigap plans are sold in Massachusetts, Minnesota, or Wisconsin.</p> <p>You buy a Medigap policy from an insurance company and pay them the premium for the plan you select. This premium is in addition to the Medicare Part B premium you pay to Medicare.</p> <p>If you buy a Medigap policy, it only covers your individual health care costs. It doesn't cover any health care costs for your spouse. He or she would have to buy a personal policy.</p> <p>Medigap policies only help pay health care costs if you have the Original Medicare Plan. You don't need to buy a Medigap policy if you're enrolled in a Medicare Advantage (formerly known as Medicare + Choice) Plan.</p>
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<p>I am over 65 -- is the Blue Cross Blue Shield PPO equivalent to a Medigap policy?</p>	<p>No. A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. To buy a Medigap policy, you must be enrolled in Medicare Part A and Part B.</p>
<p><i>PPO vs. HMO vs. Copay Plan</i></p>	
<p>What is the difference between a PPO and an HMO?</p>	<p>Under a PPO (preferred provider organization), you have the freedom to choose any provider when you need care as long as you are willing to pay more for a non-network provider. There is also no need for physician referrals under a PPO plan. You can make an appointment directly with a specialist.</p> <p>Under an HMO (health maintenance organization), you must use HMO network providers to receive benefits, and your medical care must typically be provided by a primary care physician (PCP) who will arrange for referrals to specialists and coordinate any hospital services.</p>
<p>What is the difference between an HMO and the CIGNA Copay Plan?</p>	<p>The CIGNA Copay Plan does not require a primary care physician.</p> <p>The network used by the plan is the CIGNA Open Access Plus (OAP) In-Network. Some physicians may choose to be in the HMO but not in the OAP, and vice versa.</p> <p>CIGNA will notify everyone who used an HMO provider in the past year who is not contracted as a OAP provider.</p> <p>The OAP is a nationwide network, however it is only offered to TI retirees living in North Texas, Houston, Austin, Arizona or North Carolina - the same areas previously eligible for the HMO.</p> <p>Since it is a nationwide network, if you are traveling in an</p>

	<p>area that has CIGNA OAP - contracted doctors, you can use them for non-emergency treatment. Additionally, if you have a dependent living in another state, your dependent can access treatment in that state without having to set up "guesting" arrangements.</p>
<i>Finding a Doctor</i>	
<p>How can I obtain a provider listing?</p>	<p>You can find a provider listing on the NetBenefits website, under the "Find a Provider" link. Or call your medical carrier through TI HR Connect, 888-660-1411, option 1.</p>
<i>Provider vs. Carrier</i>	
<p>What is the difference between a provider and a carrier/supplier?</p>	<p>In general, a provider is considered to be your doctor, hospital or pharmacist (a person or place that treats your illness) while a carrier/supplier is your health plan or insurance carrier that administers or pays the claims based on the design of the plan (such as Blue Cross Blue Shield, CIGNA, MetLife or Aetna).</p>
HEALTH MAINTENANCE ORGANIZATIONS (HMOs)	
<i>Coverage</i>	
<p>I am under 65 and thinking of changing to a participating HMO. Will my medication be covered?</p>	<p>To determine if your medication is covered under the HMO, go to the HMO's website or contact the HMO directly. The HMO website can be accessed by going to the NetBenefits website and selecting the link showing your HMO plan options. In addition, if you are not currently enrolled in an HMO, you can view HMO contact information during annual enrollment for 2010 benefits on the NetBenefits Plan Comparison tool. If you are already enrolled in an HMO plan, you will be able to call TI HR Connect, 888-660-1411, option 1, to be connected with your HMO.</p>

<i>Provider</i>	
If I change to an HMO, what if my current doctors are not in their plan?	Check the HMO’s Website to determine if your primary care and other doctors are covered by their plan. You should also confirm with the physician’s office if they will accept your HMO coverage. If your doctors are not in the HMO, you will need to select new physicians if you change to the HMO.
MEDICARE PRESCRIPTION DRUG COVERAGE	
<i>General</i>	
What is Medicare Prescription Drug Coverage?	Medicare Prescription Drug Coverage is the new voluntary outpatient prescription drug benefit (available starting Jan. 1, 2006) administered by private health insurance companies.
If I meet TI eligibility requirements, how do I enroll in TI Extended Health Benefits Coverage?	<p>During Nov. 2-16, 2010, you can enroll by phone or through the Fidelity NetBenefits website at netbenefits.fidelity.com. More information is available through the TI Alumni Association website at tialumni.org.</p> <p>Phone users only: For phone enrollment, call the TI Benefits Center at Fidelity through TI HR Connect, 888-660-1411, option 1. Representatives will be available Monday-Friday, 8:30 a.m. to 8:30 p.m. Eastern time, except New York Stock Exchange holidays.</p>
What are the dates for enrollment in Medicare Prescription Drug Coverage?	The Medicare Prescription Drug Coverage enrollment is Nov. 15, 2010, through Dec. 31, 2010. For detailed enrollment information regarding Medicare Prescription Drug Coverage, please visit the Medicare website at medicare.gov or call 800-MEDICARE (800-633-4227).

<p>If I am enrolled or plan to enroll in one of TI's HMO plans, how does Medicare Prescription Drug Coverage impact me?</p>	<p>If you are enrolled or plan to enroll in one of the TI-sponsored Medicare Advantage Plans -- SecureHorizons HMO - Texas or SecureHorizons HMO - Rhode Island -- they will continue to serve as your prescription drug providers. Both plans have confirmed that their coverage is, on average, at least as good as Medicare's Prescription Drug Coverage. The TI-sponsored Medicare Advantage Plans already provide prescription drug coverage, so you will not be able to enroll in a different Medicare Prescription Drug Plan without dropping the TI-sponsored Medicare Advantage Plan.</p>
<p>Contacting Medicare and Social Security</p>	
<p>How do I contact Medicare?</p>	<p>You may contact Medicare at 800-MEDICARE (800-633-4227) or visit the Medicare website at medicare.gov.</p>
<p>How do I contact the Social Security Administration?</p>	<p>You may contact the Social Security Administration (SSA) at 800-772-1213 or visit the website at socialsecurity.gov.</p>
<p>TI Benefits and Medicare Part D</p>	
<p>Can I choose to keep my medical coverage through TI Extended Health Benefits Coverage in 2011?</p>	<p>Yes. You may elect to keep your medical coverage through TI Extended Health Benefits Coverage in 2011. However, Medicare-eligible TI retirees and/or Medicare-eligible dependents will not be able to participate in medical coverage through both TI Extended Health Benefits Coverage and Medicare Prescription Drug Coverage.</p>
<p>Can I be in medical coverage through TI Extended Health Benefits Coverage and have Medicare Prescription Drug Coverage?</p>	<p>No. You will not be allowed to be enrolled in medical coverage through TI Extended Health Benefits Coverage and Medicare Prescription Drug Coverage.</p>

<p>If I choose Medicare Prescription Drug Coverage, can my spouse or dependent that is not Medicare-eligible remain in medical coverage through TI Extended Health Benefits Coverage?</p>	<p>No. To maintain coverage of your spouse or dependent in medical coverage through TI Extended Health Benefits Coverage, you also must remain in medical coverage through TI Extended Health Benefits Coverage.</p>
<p>What will happen if I accidentally enroll in medical coverage through TI Extended Health Benefits Coverage and Medicare Prescription Drug Coverage?</p>	<p>If you enroll in medical coverage through TI Extended Health Benefits Coverage and Medicare Prescription Drug Coverage the following will happen:</p> <p>You will be dropped from TI Extended Health Benefits Coverage.</p> <ul style="list-style-type: none"> • If you terminated prior to Jan. 1, 1998, you will lose medical benefits for the remainder of the year and will be eligible to re-enroll in a TI-sponsored health plan during any annual enrollment or within 30 days of an appropriate qualified status change. • If you terminated on or after Jan. 1, 1998 you will not be able to re-enroll in a TI-sponsored health plan at any time.
<p>How do I know if my prescription drug coverage is, on average, “as good as” Medicare’s Prescription Drug Coverage?</p>	<p>Health plans are required to provide a creditable prescription drug coverage notice to all Medicare-eligible participants stating whether the plan is, on average, proven to be at least as good as Medicare Prescription Drug Plans.</p> <p>You should have received a Creditable Prescription Drug Coverage notice in the mail. It is important that you keep a copy of the notice so you can prove to Medicare that you had continuous coverage, if you ever choose to enroll in Medicare Prescription Drug Coverage.</p>

<p>I am currently enrolled in medical coverage through TI Extended Health Benefits Coverage. How will I know whether to sign up for the Medicare Prescription Drug Coverage benefit in November?</p>	<p>TI will continue to provide medical coverage through TI Extended Health Benefits Coverage which is considered to be at least as good as Medicare’s Prescription Drug Coverage.</p> <p>If you can afford medical coverage through TI Extended Health Benefits Coverage you can keep it and not enroll in Medicare Prescription Drug Coverage. If you later lose your retiree coverage, you can enroll in the Medicare Prescription Drug Coverage without a penalty (as long as you are not without drug coverage for more than 63 days).</p> <p>If medical coverage through TI Extended Health Benefits Coverage is too expensive for you, you can drop medical coverage and enroll in a Medicare Prescription Drug Coverage plan. If you decide to drop medical coverage through TI Extended Health Benefits Coverage you will receive a creditable prescription drug coverage notice to prove that your prior coverage is considered to be at least as good as Medicare’s Prescription Drug Coverage.</p> <p>Be aware that:</p> <ul style="list-style-type: none"> • If you terminated employment on or after Jan. 1, 1998, you will not be eligible to re-enroll in medical coverage through TI Extended Health Benefits Coverage at any time. • If you elect Medicare Prescription Drug Coverage you and your dependents will be dropped from medical coverage through TI Extended Health Benefits Coverage. This means that you and your covered family members will lose both your TI medical and prescription coverage
<p>Why might I want to choose Medicare Prescription Drug Coverage instead of a medical coverage through TI Extended Health Benefits Coverage?</p>	<p>For some individuals, Medicare Prescription Drug Coverage may be a better option than the TI prescription drug portion of medical coverage through TI Extended Health Benefits Coverage. Depending on your prescription drug needs and your cost, each plan has its own advantages.</p>

<p>Do I need to enroll in Medicare Prescription Drug Coverage if I have medical coverage through TI Extended Health Benefits Coverage?</p>	<p>No. You CANNOT enroll in Medicare Prescription Drug Coverage if you want to maintain your medical coverage through TI Extended Health Benefits Coverage.</p>
<p>Can TI tell me which plan is better for me?</p>	<p>No. Under the Medicare Modernization Act, companies are not allowed to provide guidance to participants that would persuade them to take one plan over another. Thus, TI can only provide information and each retiree must make his or her own decision about which option best meets his or her needs.</p>
<p><i>Dependents</i></p>	
<p>What if I cover a dependent?</p>	<p>It is important to consider how much you are spending to cover your dependent with medical coverage through TI Extended Health Benefits Coverage and compare that to the expected cost of a replacement plan under Medicare's Prescription Drug Coverage.</p> <p>Retirees covering dependents who are not Medicare-eligible may want to maintain medical coverage through TI Extended Health Benefits Coverage in order to maintain medical coverage for these dependents. If a Medicare-eligible TI retiree chooses Medicare Prescription Drug Coverage, his or her dependents will no longer be able to receive medical coverage through TI Extended Health Benefits Coverage. Please plan carefully because this change may leave your family members without medical and prescription drug coverage if they don't have coverage elsewhere.</p>
<p><i>Creditable Coverage</i></p>	
<p>Why is creditable prescription drug coverage important?</p>	<p>If you have creditable prescription drug coverage, you will not be penalized if you choose to enroll in Medicare Prescription Drug Coverage after the initial enrollment period. If you do not have creditable prescription drug coverage, your Medicare Prescription Drug Coverage</p>

	<p>premium will go up one percent for every month you delay enrolling. If you have creditable coverage and lose it, you will have 63 days to enroll in Medicare Prescription Drug Coverage without penalty.</p>
<p>Re-enrollment</p>	
<p>Can I get back into medical coverage through TI Extended Health Benefits Coverage if I elect a Medicare Prescription Drug Plan?</p>	<p>If you enroll in the Medicare Prescription Drug Coverage and would like to re-enroll in the TI Extended Health Benefits Coverage the following will happen:</p> <p style="padding-left: 40px;">You will be notified by the TI Benefits Center and given notice that if you do not drop Medicare Prescription Drug Coverage you will be dropped from the plan.</p> <p style="padding-left: 40px;">If no action is taken, you will be dropped from the TI Extended Health Benefits Coverage. If you terminated prior to Jan. 1, 1998, you will lose medical benefits for the remainder of the year and will be eligible to re-enroll in a TI sponsored health plan during any annual enrollment or within 30 days of an appropriate qualified status change. If you terminated on or after Jan. 1, 1998, you will not be able to re-enroll in a TI sponsored health plan at any time.</p>
<p>How will Medicare administer its prescription drug plan?</p>	<p>For current information on Medicare Prescription Drug Coverage, read Introducing Medicare’s New Coverage for Prescription Drugs, which is available at the Medicare website at medicare.gov or by calling 800-MEDICARE (800-633-4227).</p>
<p>Financial Assistance from Medicare</p>	
<p>Is assistance available for participants with limited income and resources?</p>	<p>Medicare Prescription Drug Coverage will provide extra financial assistance to individuals with limited income and resources. Individuals who might be eligible for limited income assistance may have already received a letter from the Social Security Administration. This letter provides information on how to apply for extra financial help toward the cost of the Medicare Prescription Drug Coverage. Any retiree receiving the limited income assistance letter should fill out the application to</p>

	<p>determine his or her individual costs for Medicare Prescription Drug Coverage before making a decision. Filling out the application does not sign you up for Medicare Prescription Drug Coverage. If you feel you may be eligible for limited income and resources assistance, but you did not receive an application, you may contact SSA at 800-772-1213 or visit the website at socialsecurity.gov. For more information, call 800-MEDICARE (800-633-4227) or log on to the Medicare website at medicare.gov.</p>
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TI RETIREE MEDICAL CAP

Rationale

<p>Why does TI have a cap?</p>	<p>The rising cost of medical benefits for TI retirees caused TI to change its cost-sharing policy back in 1992. Costs for retiree medical benefits have continued to rise over the years. In order to remain competitive and still offer a comprehensive health plan for retirees, TI has to share some of the cost with its retirees.</p>
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<p>How did TI come up with the amount of its retiree medical cap?</p>	<p>Based on TI health plan costs in 1992, TI calculated the maximum it would contribute toward premiums for post-1992 retirees with at least 30 years of service at \$6,000 for pre-Medicare retirees and \$1,800 for Medicare-eligible retirees.</p> <p>After reviewing TI health plan costs again in 2004, TI made the decision to raise the caps to \$11,000 for pre-Medicare retirees and \$4,000 for Medicare-eligible retirees with at least 30 years of service. TI's maximum contribution is prorated for retirees with service between 15 and 30 years. TI does not contribute to spouse and dependent premiums for post-1992 retirees.</p>
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<i>Future Changes</i>	
Will the amount of the cap change in the future?	No. TI will not make further increases in the cap.
What can I do to help TI control health care costs?	<p>Taking steps to control your health care costs is a win-win activity for both you and TI. Here are some ways you can help:</p> <ul style="list-style-type: none"> - Take care of yourself. Exercise regularly, eat healthy, and get regular check-ups. - Ask about generics when filling a prescription. - Do not smoke. - Adhere to treatment plans for chronic conditions. - Prepare and ask questions at doctor visits.
Does the retiree medical cap have anything to do with all of the Medicare changes I've heard about?	No. The retiree medical cap increase is a separate issue.

Retiree medical coverage is neither fixed nor guaranteed. TI reserves the right to amend, modify or terminate the plan under which the retiree medical coverage is provided at any time, including at any time after an individual has retired and to apply such changes to any or all retirees.