



# **2011 Retiree Health Benefits Guide**

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## IMPORTANT PHONE NUMBERS

<b>CONTACT:</b>	<b>FOR INFORMATION ABOUT...</b>	<b>PHONE NUMBER/ WEB ADDRESS:</b>
<b>TI HR Connect</b>	<b>One number to access benefit providers</b>	<b>888-660-1411</b>
<ul style="list-style-type: none"> <li>Blue Cross Blue Shield (BCBS) PPO A &amp; B</li> </ul>	Medical benefits and claim status	888-660-1411
<ul style="list-style-type: none"> <li>BCBS PPO Pharmacy Network Administrator (CVS Caremark)</li> </ul>	Pharmacy benefits and claim status	888-660-1411
<ul style="list-style-type: none"> <li>CIGNA Copay Plan</li> </ul>	Area Served - AZ, Houston/Austin, NC, Dallas/North Texas	888-660-1411
<ul style="list-style-type: none"> <li>MetLife Dental Basic/Dental Plus</li> </ul>	Dental benefits and claim status	888-660-1411
<ul style="list-style-type: none"> <li>TI Benefits Center (through TI HR Connect)</li> </ul>	Billings and coverage status	888-660-1411
<b>Dental Health Maintenance Organization</b>		
Aetna DMO	Dental benefits and claim status	800-772-1416
Employee Assistance Program (EAP) (Magellan Health)	Behavioral health care consultation and counseling	800-888-2273
EyeMed Eye-Care Discount Program	Vision discounts	866-723-0391
LivingFree Smoking Cessation	Smoking cessation program	www.tialumni.org 877-719-9860 (for technical assistance)
Medicare	Medicare benefits and claim status	800-633-4227
Nutrition Network (BCBS PPO participants)	Nutrition counseling / medical nutrition therapy	800-888-9560

Social Security	Social Security benefits	800-772-1213
TI Alumni Association Web site	Retiree benefits	www.tialumni.org
Fidelity NetBenefits® Web site (TI Benefits Web site)	Access health information on-line	netbenefits.fidelity.com

<b>Regional Health Maintenance Organizations (HMOs)</b>	<b>(AREA SERVED)</b>	<b>PHONE NUMBERS:</b>
HMO Blue New England *	(CT, MA, NH, RI)	800-832-3871
HMO Illinois**	(Illinois)	800-892-2803
Kaiser HMO	(Northern and Southern California)	800-464-4000
Optimum Choice (MAMSI) HMO	(DC, DE, MD, VA, WV)	800-815-8958
PacifiCare HMO ***	(California)	800-624-8822
Secure Horizons HMO – Texas	(Dallas/Fort Worth and San Antonio areas)	800-950-9355
Secure Horizons HMO – Rhode Island	(Rhode Island)	888-867-5548

\* Offered by Blue Cross Blue Shield of Massachusetts

\*\* Offered by Blue Cross Blue Shield of Illinois

\*\*\* PacifiCare is a UnitedHealthcare Company

## INTRODUCTION

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This guide is the Summary Plan Description of Texas Instruments Incorporated's (TI's) Extended Health Benefits Coverage, offered through the TI Retiree Health Benefit Plan, as of January 1, 2011. Such coverage is available for (i) qualified TI retirees and their eligible dependents and (ii) qualified dependents of deceased TI retirees. The summary description is written in plain language to help you understand how the plan works

The guide has a summary of each benefit option that should answer many of your questions. It will explain:

- Who is eligible
  - When coverage can start
  - When coverage ends
  - What is not covered
  - How to file claims
  - Who to contact for more information
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# LIFE EVENTS AND SPECIAL CIRCUMSTANCES SUMMARY

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This summary outlines the steps you need to take and some things you should think about when events occur that could affect your coverage.

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<b>EVENT</b>	<b>ACTION REQUIRED</b>	<b>REMINDERS</b>
As an early retired TI employee (with coverage under a TI-sponsored medical plan), you or your enrolled spouse reach age 65.	<p>You should contact Social Security three months before you reach age 65 to enroll in Medicare. Be sure to enroll in Parts A and B.</p> <p>Once you have enrolled in Medicare Parts A and B and have received your Medicare card, contact Fidelity and if covered through the Blue Cross Blue Shield PPO, you will need to call and tell them that you want to verify that they have your Medicare information in their system. At that time, they will ask you for your Medicare number which Medicare calls the Medicare Claim Number located on your Medicare card. They will also ask for the Medicare effective date.</p>	Once you are enrolled in Medicare, send all your medical claims to Medicare first. No claim under the Blue Cross Blue Shield PPO will be accepted until your Medicare claim has been processed.

<b>EVENT</b>	<b>ACTION REQUIRED</b>	<b>REMINDERS</b>
You die while enrolled in TI-sponsored medical or dental coverage.	The survivor should contact the TI HR Connect	Your surviving spouse and any eligible dependents may be able to continue coverage. However, if your surviving spouse remarries, coverage ends. The surviving spouse and/or eligible dependents are no longer eligible to continue coverage under COBRA.
You become divorced while enrolled in TI-sponsored medical or dental.	Contact TI HR Connect Your former spouse's coverage stops — see the COBRA section.	If you remarry, you may enroll your new spouse in TI-sponsored medical or dental within 30 days of your marriage.
You move.	Contact TI HR Connect	If you are covered by a regional HMO and move out of that HMO's service area, you may enroll in the Blue Cross Blue Shield PPO, CIGNA Copay Plan (if available in your area) or a regional HMO, if available in your area. In such cases, you must contact TI HR Connect within 30 days of your move.
You have a question about your TI Retiree Health Benefit Plan bill.	Contact TI HR Connect.	TI HR Connect sends out all medical and dental coverage bills.

## ELIGIBILITY

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### **Notice: Opportunity to Enroll in Medical Coverage in Connection with Extension of Dependent Coverage to Age 26**

Individuals whose medical coverage ended, or who were denied medical coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in medical coverage only under the TI Retiree Health Benefit Plan, provided they have not reached age 26 before January 1, 2011. Individuals may request enrollment for such children for 30 days from the date of notice (**with November 1, 2010, as the effective date of notice**). Enrollment will be effective January 1, 2011. For more information contact the plan administrator at 888-660-1411.

TI Extended Health Benefits Coverage provides access to medical and/or dental coverage after leaving TI. When you terminate employment from TI, you may be eligible for TI Extended Health Benefits Coverage. TI Extended Health Benefits Coverage is offered through the TI Retiree Health Benefit Plan. Please be aware that eligible dependents must be enrolled for the same coverage that the retiree is enrolled in – family members cannot have coverage under different options.

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

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

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

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

- For a rehire that was *not eligible* for TI Extended Health Benefits Coverage upon their most recent termination, the service date will be the rehire date unless the TIER is entitled to prior service credit. Prior service credit is available if the break in service is less than two years, in which case the

Tler will be given an adjusted service date to recognize the full calendar years of prior service time (this only applies for TI Extended Health Benefits Coverage). The retirement status (such as codes R1, R2, etc.) associated with rehires falling under this category will be updated to reflect the most current applicable retirement status based upon the most recent rehire date regardless of the break in service period.

- For a rehire that was *eligible* for TI Extended Health Benefits Coverage upon their most recent termination, prior service credit for TI Extended Health Benefits Coverage will be given using an adjusted service date to recognize the full prior service time (this only applies for TI Extended Health Benefits Coverage). The same retirement status (such as codes R1, R2, etc.) applies to previous terminations and rehires who fall under this category, even if you have had more than one termination and rehire.

*Eligibility and plan rules for 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.*

## **Eligible Dependents**

All eligible dependents must provide a U.S. Social Security Number (SSN) or an Internal Revenue Service Individual Taxpayer Identification Number (ITIN) to receive benefits. You may be required on an annual basis to provide a certification or other proof that your dependents qualify as such under this plan. 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:

- Your legal spouse (only a spouse who qualifies as a spouse under the Federal Defense of Marriage Act will be considered a spouse)
- Your same-gender domestic partner, and
- Your children who meet one of the following requirements and the requirements that apply to the particular benefit in which you want to enroll the child:
  - Your biological children, legally adopted children or children for whom adoption papers were filed

- Stepchildren who live with you and are supported by you
- A child for whom you are legal guardian or managing conservator
- A foster child, placed in your care by a court
- A child covered under a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice
- Your grandchild who lives with you and is claimed by you as a dependent on IRS tax filings or
- A child of your same-gender domestic partner

### **Children - Eligibility for Extended Medical Benefits**

Your eligible dependent children for purposes of participation in extended medical benefits include your son or daughter (including your biological child, stepchild, adopted or foster child, child of your same-gender domestic partner, or other child as defined above) who is under age 26.

This coverage ends on your child's 26th birthday.

#### *Medically Necessary Leave of Absence from School*

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

#### *Extended Medical Benefits If Your Dependent 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 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 TI Benefits Center to find out how to apply for coverage.

## **Children – Eligibility for Extended Dental Benefits**

Your eligible dependent children for purposes of participation in extended dental benefits include your children who are unmarried and do not work on a regular full-time basis.

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

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

If your child meets both of these additional conditions, you must contact the TI Benefits Center before your child's 19th birthday to continue coverage.

### *Extended Dental Benefits If Your Dependent Child is Disabled*

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

## **Same-Gender Domestic Partner**

TI Retirees can enroll their eligible same-gender domestic partners in medical and dental benefits. The retiree, however, must be enrolled in the medical and/or dental plan for the same-gender domestic partner coverage to be effective.

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

- Same gender
- At least 18 years or older
- Unmarried and otherwise legally able to marry
- Not be related by blood

- Financially interdependent
- Share a common residence and intend to do so indefinitely
- Affirm you are in a committed relationship and intend to remain so

## **Qualified Status Change Events**

You can only make appropriate changes in your medical and/or dental coverage, or add or drop dependents, as follows:

- Within 30 days of your first day as a TI retiree
- Within 30 days of a qualified status change, which includes:
  - Changes in legal marital status (judgment, decree or order resulting from a divorce, legal separation or annulment)
  - Changes in number of dependents
  - Changes in employment status (yours or spouse's or same-gender domestic partner's)
  - Changes in dependent eligibility (dependent reaches age 26; meets or fails to meet eligibility requirements)
  - Significant changes in cost of health coverage
  - Loss of other health plan coverage (yours or spouse's or same-gender domestic partner's, or dependents)
  - Changes in residence of the retiree, spouse or same-gender domestic partner, or dependent (move out of an HMO's coverage area)
  - Significant changes in cost of dependent care
  - Entitlement to Medicare or Medicaid by the retiree, spouse or same-gender domestic partner, or dependent
  - Significant curtailment of TI health coverage
  - Loss of coverage under a governmental plan or educational institution plan, including certain other specified governmental plans
  - Changes in legal custody that require health coverage for a child (including a Qualified Medical Child Support Order or a National Medical Support Notice)

- Death of a spouse or same-gender domestic partner/dependent
- Spouse or same-gender domestic partner, or dependent goes on or returns from a strike or lockout
- Expiration of COBRA coverage for spouse or same-gender domestic partner/dependent
- Change made by spouse or same-gender domestic partner/dependent during annual enrollment for plan of the spouse or same-gender domestic partner

**Note: Changes in coverage must be consistent with the change in status.**

- Each year during annual enrollment

## **Other Important Information**

### **ERISA Information**

In addition to your rights and obligations under this retiree health plan, you also have certain rights under the Employee Retirement Income Security Act of 1974 (ERISA). These rights are explained in the ERISA section.

If any conflict should arise between the content of this guide and the plan, or if any point is not covered herein, the terms of the plan will govern in all cases.

### **TI's Right to End or Change the Plans**

This plan has been established with the intention of being maintained for an indefinite period. However, TI, as the Plan Sponsor, has the right to cancel or change the plan or its provisions without notice. This right can be exercised at any time.

### **Plan Interpretation**

TI reserves the right to interpret this ERISA-governed plan and its benefit options (excepting only decisions on benefit coverage in the fully insured benefits), including the plan document and/or contracts. In some of the benefit options, the right to interpret the terms of the option will be exercised by an entity other than TI. Nevertheless, such discretionary interpretations of a plan (including any policies and procedures under which it is operated) will be final and binding.

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

## **MEDICAL— Blue Cross Blue Shield PPOs, CIGNA Copay Plan and Regional HMOs**

**ERISA PLAN, offered through the TI Retiree Health Benefit Plan**

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### **A Quick Look at the Plan**

#### **Pre-Medicare Blue Cross Blue Shield PPOs**

You may choose from two Blue Cross Blue Shield Preferred Provider Organization (PPO) options: PPO A or PPO B. The difference between these options is the deductible amounts, out-of-pocket maximums and the cost for coverage. See page 31 for more details.

#### **Pre-Medicare CIGNA Copay Plan**

Key features of the CIGNA Copay Plan are highlighted below. You will find more detailed information on the following pages.

- New network name: CIGNA Open Access Plus In-Network (OAPIN)
- Offered in AZ, Dallas/North Texas, Houston/Austin, NC
- You no longer have to designate a Primary Care Physician, but you still have to access treatment from a network provider and out-of-network treatment is only covered in the event of an emergency
- Dependents living in another city may access treatment from a CIGNA OAPIN contracted provider without having to establish “guesting” arrangements
- Most services are available after payment of a set dollar copay
- No out-of-pocket maximum required

#### **Pre-Medicare Regional HMOs**

Key features of the regional HMOs available in your area can be viewed on the Fidelity NetBenefits® Web site. You can also call the regional HMO directly. The list of available regional HMOs and contact information can be found in the beginning of this guide.

#### **Medicare-Eligible Blue Cross Blue Shield PPO**

There is an individual \$500 per person calendar year deductible for medical coverage. The family deductible is \$1,000.

## All Blue Cross Blue Shield PPO Participants

- Use of the Employee Assistance Program (EAP) is encouraged to ensure appropriate treatment and referral 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.
- 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.
- Retirees can call Blue Cross Blue Shield through TI HR Connect at 888-660-1411 before incurring a medical expense to verify the following:
  - Whether the treatment is covered
  - When using a non-network doctor, whether your doctor's charges are within the regional out-of-network reimbursement limits. You will need the procedure (CPT) code and the amount the doctor will charge.

## Medicare-Eligible Regional HMOs

Key features of the regional HMOs available in your area can be viewed on the Fidelity NetBenefits® Web site. You can also call the regional HMO directly. The list of available regional HMOs and contact information can be found in the beginning of this guide.

## Enrollment

If you are eligible for TI Extended Health Benefits Coverage, you and your dependents can obtain medical coverage under the Blue Cross Blue Shield PPO, CIGNA Copay Plan (if available in your area) or a regional HMO (if available in your area) on your first day of retirement. To cover yourself and your eligible dependents, you must make an election on the Fidelity NetBenefits® Web site or contact TI HR Connect prior to or within 30 days of your retirement date.

**If you terminate employment on or after January 1, 1998**, to have medical coverage offered through the TI Retiree Health Benefit Plan, you must elect TI Extended Health Benefits Coverage prior to or within 30 days from the date you terminate employment or forego eligibility in the future. You may not opt in and out of TI Extended Health Benefits Coverage; once you elect it, you must continue paying costs without lapse in order to maintain coverage. If you don't enroll in dental coverage through TI Extended Health Benefits Coverage prior to or within 30 days from the date you terminated, you'll be eligible to enroll for coverage later (during annual enrollment or in the event of an appropriate

qualified status change) as long as you're enrolled in medical coverage through TI Extended Health Benefits Coverage.

**If you terminated employment prior to January 1, 1998**, you remain under the enrollment rules in effect when you terminated. You may defer election of TI Extended Health Benefits Coverage at the time of your termination and remain eligible to re-enroll in the plan at any time in the future.

Regardless of your termination date, if you elect coverage, you may also enroll your eligible dependents, unless they are eligible for coverage under another health plan. In this case, you may not cover your dependents under this plan. If a dependent loses eligibility for coverage at a later date, it will be considered a qualified status change, and you may enroll the dependent at that time, as long as you remain enrolled in TI Extended Health Benefits Coverage. You may also add a dependent during any annual enrollment period.

### **Medicare Prescription Drug Coverage Information**

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

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

**• If you terminated employment on or after January 1, 1998:**

- If **you** choose to enroll in Medicare Prescription Drug Coverage, you and any covered family members will lose coverage under the TI Plan, and WILL NOT be eligible to re-enroll at any time. *This means medical and prescription drug coverage under the TI Plan ends for you and any covered family members. Once coverage ends, it cannot be reinstated.* Please plan carefully, because if you enroll for Medicare Prescription Drug Coverage, your family members will be left without medical and prescription drug coverage if they don't have coverage elsewhere.
- If **any of your covered family members** choose to enroll in Medicare Prescription Drug Coverage, they will lose their coverage under the TI Plan. *This means their medical and prescription drug coverage under the TI Plan ends.* If they drop their Medicare

Prescription Drug Coverage, you will be able to re-enroll them for prescription drug coverage through the TI Plan during any annual enrollment period or within 30 days of an appropriate qualified status change (provided that you notify TI through Fidelity NetBenefits® or TI HR Connect within the same thirty day period of the status change), as long as you remain enrolled in the TI Plan. If you drop coverage under the TI Plan, neither you nor your dependents can re-enroll in the TI Plan.

• **If you terminated employment prior to January 1, 1998:**

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

**IMPORTANT NOTE:** If you elect Medicare Prescription Drug Coverage, you cannot elect medical coverage through TI Extended Health Benefits Coverage. If you elect Medicare Prescription Drug Coverage and you terminated employment on or after January 1, 1998, you WILL NOT be eligible to re-enroll in medical coverage through TI Extended Health Benefits Coverage at any time.

For more information see the Overview of Medicare section.

## If You Do Not Enroll

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

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

- Annual medical deductible of \$500 individual/\$1,000 family with an associated in-network out-of-pocket maximum of \$5,000 individual/\$10,000 family.
- In-network physician coinsurance of 90% and in-network hospital coinsurance of 70%.
- Prescription drug coverage with no deductible and with an associated out-of-pocket maximum of \$5,000 individual/\$10,000 family.
- Prescription drug in-network retail coinsurance of 55% and mail-order coinsurance of 60%

If you want to drop coverage, you must contact TI HR Connect.

**Important Note:** If you terminated employment on or after January 1, 1998, and you elected to drop medical coverage at any time for yourself, you WILL NOT be eligible to re-enroll in TI-sponsored medical coverage at any time. If you drop coverage for your eligible dependents you will be able to re-enroll them during any annual enrollment period or within 30 days of an appropriate qualified status change, as long as you remain enrolled in medical coverage offered through the TI Retiree Health Benefit Plan.

**NOTE:** *If you are hospitalized at the end of a plan year and your hospital stay continues or will continue into the next year, you should contact the Claims Administrator for your benefit option (see page 5 for a listing) to understand what process you should follow to be sure your medical expenses will be covered.*

**Important Note: If you terminated employment on or after January 1, 1998,** and you elected to drop medical coverage at any time for yourself, you **WILL NOT** be eligible to re-enroll in TI-sponsored medical coverage at any time. If you drop coverage for your eligible dependents you will be able to re-enroll them during any annual enrollment period or within 30 days of an appropriate qualified status change, as long as you remain enrolled in medical coverage through TI Extended Health Benefits Coverage.

## **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.

## **Changes in Coverage**

You may make changes in your TI Extended Health Benefits Coverage by participating in annual enrollment, or within 30 days of an appropriate qualified status change by processing the Life Event change on the Fidelity NetBenefits® Web site (click on the “What To Do When” link on the “Health & Insurance” tab) or by contacting TI HR Connect. You must print your “Confirmation of Benefit Election” page; this will serve as your confirmation.

## **Medicare “Birthday Kit”**

About 90 days before your 65<sup>th</sup> birthday, TI HR Connect will send you – or your spouse or other dependent – a “birthday kit” that has information on the plans that are available to TI participants who are eligible for Medicare. The kit contains instructions for enrolling in the medical option of your choice.

## **Split-family coverage**

Available medical options vary based on eligibility for Medicare, as follows:

- If you or an eligible family member is eligible for Medicare, but at least one family member isn't eligible for Medicare, special "split-family" rules may apply depending on which plan you are enrolled in. Some HMOs don't allow split-family enrollments.
- When a family member becomes eligible for Medicare, that member must enroll in a Medicare-eligible medical plan through the TI Extended Health Benefits Coverage. All family members who aren't eligible for Medicare can continue to be enrolled in their current medical plan, if it allows split-family enrollments. You must choose two (2) 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're enrolled in a HMO that doesn't allow split-family enrollments, all family members will need to move to another plan.

## **Effective Date of Coverage**

Coverage for you and your dependents will begin retroactive to your retirement date provided you enroll prior to or within the first 30 days of your retirement. Changes made during annual enrollment are effective on the first day of the year following annual enrollment. If adding coverage subject to an appropriate qualified status change, coverage takes effect retroactive to the date of the qualified status change.

## **Newborn or Adopted Children**

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

## **Cost – Who Pays**

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

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

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

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

This cost-sharing policy may change at any time.

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

**IMPORTANT NOTE:** Regardless of when you terminated from TI, if you fail to submit monthly payments within 30 days of the due date, your coverage will end retroactive to the last day of the last month for which 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.

### **Use of Tobacco Products**

Retirees, covered spouses or same-gender domestic partners who use tobacco products pay an additional health care cost. There will be an additional charge of \$30 per month for each covered adult tobacco user, with a maximum of \$60 per month. You are considered a user of tobacco products if you use cigarettes, cigars, pipes or smokeless tobacco (snuff) at any time, even occasionally. You must be tobacco-free for six months before you are considered a non-user. If it is unreasonably difficult due to a health factor for you, your covered spouse or same-gender domestic partner to meet the requirement to be tobacco-free for six months (or if it is medically inadvisable for you to attempt to stop using tobacco products), you may participate in the LivingFree Program to avoid this additional cost. You can avoid paying the additional cost for as long as you participate in the LivingFree Program, regardless of whether you actually stop using tobacco products. To change your tobacco user status, contact the TI Benefits Center. The additional cost does not apply to residents of Kentucky. For more information see the LivingFree Program section.

## **Blue Cross Blue Shield PPO**

### **Deductibles and Coinsurance**

A deductible is the amount you must pay for eligible expenses each year before most benefits begin. Coinsurance is the percentage that TI contributes to your eligible medical expenses after you meet your deductible (unless otherwise noted). Coinsurance amounts will depend on how, where and the kind of treatment provided. For an explanation of out-of-pocket expenses for medical or surgical treatment (which includes behavioral health care), call Blue Cross Blue Shield through TI HR Connect at 888-660-1411. Your out-of-pocket expenses will be less if you use network providers.

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

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

### **Networks**

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

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

**Network providers/locations are subject to change without notice.**

## Network/Non-Network

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

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

## No-Access to Network

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

The listing of *participating* providers can be found on [www.bcbstx.com](http://www.bcbstx.com).

### Notes:

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

## Your Benefits

### What is Covered under the Blue Cross Blue Shield PPO

The plan covers only those services for medical, surgical and behavioral health care that meet the following conditions:

- The service rendered is medically necessary for the treatment of your injury, disease or pregnancy
- The service rendered is delivered by an eligible provider (for medical this is a licensed physician acting within the scope of his license, not a resident physician or intern; for behavioral health this is licensed physician or Ph.D. psychologist)

- The service rendered is covered under the plan

Medically necessary expenses are those services or supplies which are necessary for the diagnosis, care or treatment of an illness and which are determined to be widely accepted professionally in the U.S. as effective, appropriate, and essential, based on recognized standards of the health care specialty involved. You or your provider can contact Blue Cross Blue Shield to confirm an eligible expense.

### **Covered Amounts – Network Doctor**

The amount the provider charges for the service is referred to as the billed amount. This amount does not take into account any discounts negotiated with BCBS. The allowed amount is the amount covered by the plan, as agreed to by the participating provider. You or your provider can contact Blue Cross Blue Shield to confirm an eligible expense.

Case Management, which is a collaborative process provided as a service to you and your family to facilitate the communication and coordination of care options, may also be available to you. You or your provider can contact Blue Cross Blue Shield's Case Management Department for assistance with determining available resources and coordination of care options. Case management can be of assistance for catastrophic injuries (such as head, spinal cord, burns, amputations, crush injuries) and catastrophic illnesses (such as strokes, cancer, HIV/AIDS, transplant, aneurism, muscular dystrophy, multiple sclerosis, organ transplants). You can contact Blue Cross Blue Shield's Case Management Department by calling Blue Cross Blue Shield through TI HR Connect at 888-660-1411.

### **Allowable Charges**

An allowable charge is the usual cost for comparable treatment in a local geographic area.

### **Allowable Amount**

The Allowable Amount is the maximum amount of benefits the Claims Administrator will pay for Eligible Expenses you incur under the Plan. The Claims Administrator has established an Allowable Amount for Medically Necessary services, supplies, and procedures provided by Providers that have contracted with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan, and Providers that have not contracted with the Claims Administrator or any other Blue Cross and/or Blue Shield Plan. When you choose to receive services,

supplies, or care from a Provider that does not contract with the Claims Administrator, you will be responsible for any difference between the Claims Administrator's Allowable Amount and the amount charged by the non--contracting Provider. You will also be responsible for charges for services, supplies, and procedures limited or not covered under the Plan, any applicable Deductibles and Co-share amounts.

### **Network Doctor**

A network doctor contracts with BCBS to receive reimbursement based on the allowable charge.

### **Non-Network Doctor**

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

### **No Access**

Regional out-of-network reimbursement limits do not apply for Tiers and dependents in areas without a network. Rather, a no-access-to-network benefit (same as in-network benefit) will be offered for the PPO.

### **How Regional Out-of-Network Reimbursement Limits are Determined**

If you seek treatment from an out-of-network provider, you will be responsible for paying the amounts that exceed regional out-of-network reimbursement limits (formerly referred to as reasonable and customary). The regional out-of-network reimbursement limit is set at a percentage of the Medicare rate in a geographic area. For example, this means that if the Medicare rate for a particular procedure in an area is equal to or less than \$900, then \$1,800 (200% of \$900) would be the most that would be reimbursed for that procedure, or the allowable charge. You would be responsible for charges over \$1,800, in addition to your deductible and coinsurance.

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

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

- 1) Call your doctor's office and ask for
  - The CPT Code of each procedure (including the office visit)
  - Your doctor's fee for each procedure
  - The zip code of your doctor's office
- 2) Call Blue Cross Blue Shield
  - Give the doctor's zip code and each CPT Code and fee to the Blue Cross Blue Shield Benefits Representative
  - You will be told if the fees are within the reimbursement limits. If they are more than the allowable charge, 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 regional out-of-network reimbursement limit, you will be responsible for the difference.**

### **Expenses that are Not Covered**

Expenses for treatment provided which are not covered:

- Charges for services considered not medically necessary
- Charges for procedures or services not covered by the plan
- Charges that are more than the regional out-of-network reimbursement limits
- Charges for procedures or services delivered by an ineligible provider

### **Pre-Existing Conditions**

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

### **Certificate of Group Health Plan Coverage**

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

## Pre-Medicare Participants – Deductibles, Copays and Coinsurances in the Blue Cross Blue Shield PPOs

Retirees share the cost of coverage through deductibles, copays and coinsurance; the following chart highlights coverage amounts.

Benefit	Network	Non-Network
<b>Deductibles/Copays</b>		
Annual Deductible — Medical/Behavioral Health Care	PPO A option: \$300 individual / \$600 family PPO B option: \$500 individual / \$1,000 family	
Annual Deductible — Pharmacy	No deductible	
Annual Hospital Copay	\$0	\$300
<b>Coinsurance</b>		
Doctor <sup>2</sup>	90%	50%
Hospital (inpatient) & All Outpatient Care <sup>5</sup>	70%	50%
Nutrition	90%	N/A
Behavioral Health Care (doctor/outpatient)	90%	50% <sup>3,4</sup>
Behavioral Health Care (hospital/inpatient)	70%	50% <sup>3,4</sup>
Annual Out-of-Pocket Maximum for Medical/Behavioral Health Care <sup>1</sup>	PPO A option: \$3,000 ind/\$6,000 family PPO B option: \$5,000 ind/\$10,000 family	PPO A option: \$4,500 ind/\$9,000 family PPO B option: \$7,500 ind/\$15,000 family
Annual Out-of-Pocket Maximum for Pharmacy <sup>6</sup>	\$5,000 individual / \$10,000 family	

<sup>1</sup> The out-of-pocket maximum for medical/behavioral health care does not include your deductibles, hospital copays, any behavioral health care costs, custodial care, charges not covered by the plan or exceeding regional out-of-network reimbursement limits or other plan limits, or any pharmacy costs.

<sup>2</sup> 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.

<sup>3</sup> Non-network behavioral health care reimbursement amounts are set at the average network negotiated rates for inpatient care and regional out-of-network reimbursement limits for outpatient covered expenses.

<sup>4</sup> Non-network behavioral health care must be provided by a licensed M.D. or Ph.D. psychologist.

<sup>5</sup> Outpatient care may include labs, radiology facilities, physical therapists and home health care providers.

<sup>6</sup> The 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.

### **Medicare-Eligible Participants – Deductibles, Copays and Coinsurances in the Blue Cross Blue Shield PPO**

Retirees share the cost of coverage through deductibles, copays and coinsurance, the following chart highlights coverage amounts.

<b>Benefit</b>	<b>Network</b>	<b>Non-Network</b>
<b>Deductibles/Copays</b>		
Annual Deductible — Medical/Behavioral Health Care	\$500 individual / \$1,000 family	
Annual Deductible — Pharmacy	No deductible	
Annual Hospital Copay	\$0	\$300
<b>Coinsurance</b>		
Doctor <sup>2</sup>	90%	50%
Hospital (inpatient) & All Outpatient Care <sup>5</sup>	70%	50%
Nutrition	90%	N/A
Behavioral Health Care (doctor/outpatient)	90%	50% <sup>3,4</sup>
Behavioral Health Care (hospital/inpatient)	70%	50% <sup>3,4</sup>
Annual Out-of-Pocket Maximum for Medical <sup>1</sup>	\$5,000 ind/\$10,000 family	\$7,500 ind/\$15,000 family
Annual Out-of-Pocket Maximum for Pharmacy <sup>6</sup>	\$5,000 individual / \$10,000 family	

<sup>1</sup> The out-of-pocket maximum for medical/behavioral health care does not include your deductibles, hospital copays, any behavioral health care costs, custodial care, charges not covered by the plan or exceeding regional out-of-network reimbursement limits or other plan limits, or any pharmacy costs.

<sup>2</sup> 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.

<sup>3</sup> Non-network behavioral health care reimbursement amounts are set at the average network negotiated rates for inpatient care and regional out-of-network reimbursement limits for outpatient covered expenses.

<sup>4</sup> Non-network behavioral health care must be provided by a licensed M.D. or Ph.D. psychologist.

<sup>5</sup> Outpatient care may include labs, radiology facilities, physical therapists and home health care providers.

<sup>6</sup> The 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 Limits

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

Benefit	Lifetime Limit
Behavioral Health Care – Inpatient <sup>1</sup> – Outpatient <sup>2</sup>	Included in Medical Limit
Medical <sup>3</sup>	\$2,000,000 network \$1,000,000 non-network

<sup>1</sup> Cases meeting specific criteria will be case-managed by Magellan Behavioral Health.

<sup>2</sup> Covered expenses include network and non-network expenses. Medication checks will be reimbursed under the Blue Cross Blue Shield medical benefit.

<sup>3</sup> The medical lifetime limit of \$1,000,000 non-network, applies to the total \$2,000,000 network medical lifetime limit.

## Adult Preventive Health Care

Preventive health care is designed to help retirees take an active role in managing their health and well-being. Targeted preventive care services help detect risks and health problems early when they are easiest to treat.

The periodic preventive health office visit and screening tests recommended for your age and gender are covered at 100%. No copay, coinsurance or deductibles apply. **Coverage is limited to one preventive health office visit per year.** Preventive services by non-network providers are covered at 100% of regional out-of-network reimbursement limits.

Preventive services and the recommended frequency are specified in the following chart.

## Preventive Services Covered by the Blue Cross Blue Shield PPO

*Recommendations are based on national preventive guidelines.*

Preventive Health Office Visit	Ages Covered	Recommended Frequency	Gender	
			M	F
Health History & Lifestyle Counseling	18 and older	Annually	X	X
Blood Pressure Check	18 and older	Annually	X	X
Cancer Screen Exams (visual and/or Palpation)				
- Digital Rectal	40 and older	Annually	X	X
- Oral, Skin and Breast	18 and older	Annually	X	X
- Testicular	18 and older	Annually	X	
- Vaginal and Cervical	18 and older	Annually		X
Screening Tests	Ages Covered	Recommended Frequency	Gender	
			M	F
Breast Cancer Screen (screening mammogram)	35 and older	Annually		X
Colonoscopy*	50 and older	Every 5 years	X	X
EKG	35 and older	Once only	X	X
Fasting Glucose	18 and older	Annually	X	X
Flexible Sigmoidoscopy	50 and older	Every 5 years	X	X
Papanicolaou (Pap) Test (including Thin Prep™ and HPV testing)	18 and older	Annually		X
Prostate Specific Antigen (PSA)	50 and older	Annually	X	
Stool Blood Test	45 and older	Annually	X	X
Blood Count	18 and older	Annually	X	X
Lipid Panel (tests for Total, HDL, LDL Cholesterol and Triglycerides)	18 and older	Annually	X	X
Urinalysis	18 and older	Annually	X	X

Immunizations	Ages Covered	Recommended Frequency	Gender	
			M	F
Flu Vaccine	18 and older**	Annually	X	X
Gardasil <sup>®</sup> (HPV) vaccine	18 to 26	One series		X
Hepatitis A	18 and older	One series	X	X
Hepatitis B	18 and older	One series	X	X
Measles/Mumps/Rubella	18 and older	One series	X	X
Meningococcal	18 and older	One series	X	X
Pneumococcal	18 and older	One series	X	X
Rubella	18 and older	Once only	X	X
Shingles vaccine (Zostavax <sup>®</sup> , for example)	60 and older	Once only	X	X
Tetanus	18 and older	Every 10 years	X	X
Varicella Zoster (Chicken Pox)	18 and older	One series for those not previously immunized	X	X

\* Colonoscopy not paid as screening, when performed within 5 years following Flexible Sigmoidoscopy screening

\*\* Flu vaccine provided for dependents ages 0 to 18 under the Well-Baby, Well-Child Care benefits

## Flu Vaccinations

At most sites, Tiers have the convenience of receiving free onsite flu vaccinations. Your eligible spouse or same-gender domestic partner and dependents have access to free onsite flu vaccinations if they are enrolled in the Blue Cross Blue Shield HDHP or PPO. Or, you, your spouse and dependents can receive your annual flu vaccination at your doctor's office or a TI-preferred health clinic. Children between the ages of 9 and 17 can receive a flu vaccination on-site with parental consent. Children under the age of 9 should receive the flu vaccination from their physician. Such vaccination and accompanying office visit are covered at 100%. If a non-network provider provides the vaccination, services are covered at the regional out-of-network reimbursement limit. Spouses and dependents participating in the CIGNA Copay Plan or in an HMO should contact the carrier to obtain a flu vaccination under carrier guidelines.

## Well-Baby, Well-Child Care

### Preventive Health Care for Infants and Children (0 Months-18 Years)

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

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

### Well-Baby, Well-Child Care

#### Immunizations and Lab Tests Covered by the Blue Cross Blue Shield PPOs

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

Hematocrit	0 to 18	Annually
Hemoglobin	0 to 18	Annually
Lead Screening	2 to 6	Once only
Urinalysis	0 to 18	Annually
* If your doctor chooses, tetramune can be given instead of DTP and HiB		

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

### **Well-Baby, Well-Child Checkups**

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

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

### **Inpatient Maternity Admissions**

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

### **Emergency Care**

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

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

### **Behavioral Health Care**

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

- Psychological problems
- Prescription drug abuse
- Alcohol abuse and addiction
- Mental illness

- Family/relationship concerns
- Parenting issues/concerns
- Stress, depression or anxiety
- Illegal drug abuse or addiction
- Elder Care issues/concerns

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

### What Happens When You Call the EAP?

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

<b>Behavioral Health Care Options</b>	
<b>Network Benefits</b>	<b>Non-Network Benefits</b>
<p>You may contact the EAP at 800-888-CARE (2273) or access an in-network provider on your own.</p> <p>If you contact the EAP, the EAP will provide free short-term counseling designed to assist you with your problem(s) and recommend a treatment plan at no charge to you.</p> <p>The EAP will refer you to a Behavioral Health Care Network provider when other <i>medically necessary</i> care is needed.</p> <p>Coinsurance for doctor services is 90% and for hospital care is 70% of covered expenses, after the medical deductible (up to plan limits).</p>	<p>Select your own behavioral health care provider — licensed M.D. or Ph.D. psychologist.</p> <p>Coinsurance is 50% of average network negotiated rates for inpatient care and 50% of regional out-of-network reimbursement limits for outpatient care.</p> <p>Coinsurance is applied to covered expenses, after the medical deductible (up to plan limits).</p>

## **Behavioral Health Care Services Not Covered under the Blue Cross Blue Shield PPO**

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

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

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

## **Second Surgical Opinion (Optional)**

### **How a Second Opinion is Handled**

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

A surgical opinion covers:

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

The surgical opinion must:

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

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

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

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

## **Other Covered Expenses — Blue Cross Blue Shield PPO**

Other covered expenses under the Blue Cross Blue Shield PPO include:

- Room and board at the semiprivate room rate and other medically necessary services and supplies the hospital furnishes to the patient
- Room and board at the private room rate is only covered if isolation is medically required, the illness is imminently terminal or if no semiprivate rooms are available
- Outpatient charges
- Charges made by an RN or a nursing agency for skilled nursing care if approved in advance
- Drugs and medicines that by law require a physician's prescription
- Diagnostic laboratory and X-ray examinations, radium and radioactive isotope therapy
- Anesthesia and oxygen
- Rental or purchase of durable medical or surgical equipment necessary for the medical or surgical treatment of a covered disease or injury
- Medically necessary local ambulance or air ambulance service to the nearest facility offering medically required services
- Artificial limbs and artificial eyes when part of an approved treatment plan
- Up to 48 hours of hospitalization following a vaginal delivery and 96 hours following a Cesarean-section delivery
- Blood transfusions
- Birth control pills, injections or devices that are medically prescribed and not considered experimental or investigational (See Exclusions and Limitations)
- Physical therapy up to \$2,000 per calendar year that is prescribed as to type, frequency and duration by the attending medical doctor and from which there is the reasonable expectation of functional improvement
- Reconstructive breast surgery following mastectomy, including reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications of all

stages of mastectomy, including swelling associated with the removal of lymph nodes

### **Allergy Testing and Treatment**

The Blue Cross Blue Shield PPO will reimburse up to \$1,000 maximum per person per calendar year for allergy testing and treatment.

Benefits for allergy testing and treatment:

- Pre-Medicare participants - Network coinsurance is 90%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

### **Chiropractic Services**

The Blue Cross Blue Shield PPO will reimburse up to \$1,000 maximum per person per calendar year for chiropractic treatment. To be covered, visits must be for the treatment of:

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

Benefits for chiropractic services:

- Pre-Medicare participants - Network coinsurance is 90%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

### **Durable Medical Equipment**

If you require durable medical equipment, the following applies:

- Pre-Medicare participants - Network coinsurance is 90%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

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

## **Home Health Care**

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

### **Conditions to Meet for Home Health Coverage**

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

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

### **Benefits for Home Health Services**

The benefits include:

- Part-time or intermittent home nursing care by an RN or LVN
- Part-time or intermittent home health-aide services that consist primarily of caring for the individual
- Physical, occupational and speech therapy
- Medical supplies, drugs and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital. This is only to the extent that they would have been covered under this plan if the individual had remained in the hospital.
- Services for orthotics or prosthetic devices are covered by the plan
- Pre-Medicare participants - Network coinsurance is 90%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

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

### **Services Not Covered by the Home Health Coverage**

Home health care expenses not covered:

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

### **Custodial Care Program**

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

Charges incurred for the care of a long-term or chronic physically disabled person (as the result of retarded development or bodily infirmity) in his or her home will be considered covered medical expenses. Blue Cross Blue Shield will cover 50% of a participant's custodial care charges after the deductible is met. Regardless of the provider, benefits are calculated the same way under the custodial care program. This program is subject to the following:

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

## **Hospice Care Program**

If you or any of your covered dependents should become terminally ill (that is, six months or less to live), you may be eligible for a variety of hospice services and supplies. You must use a Blue Cross Blue Shield network provider to receive network reimbursement. Contact Blue Cross Blue Shield for additional information.

Benefits for hospice care:

- Network coinsurance is 70%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met
- Combined annual or lifetime maximum inpatient and outpatient hospice benefit is \$20,000

## **Benefits for Hospice Care Services**

Benefits include:

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

## **Services Not Covered under Hospice Care**

Services not included under hospice care:

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

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

## **Injuries to Teeth**

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

## **Dietitian Consultations**

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

### **Who is Eligible for Dietitian Consultations**

For you or your covered family members to be eligible, you must be a Blue Cross Blue Shield PPO participant and have a diagnosis such as (but not limited to):

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

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

## **Dietitian Consultations Available**

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

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

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

### **Cost**

Pre-Medicare participants - The coinsurance is 90% of the cost after the deductible is met for benefits in the Nutrition Network.

Medicare-eligible participants - The coinsurance is 90% of the cost after the deductible is met for benefits in the Nutrition Network.

**Dietitian visits outside the network are not covered.**

### **Outpatient Physical Therapy Benefits**

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

- Pre-Medicare participants - Network coinsurance is 90%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

Blue Cross Blue Shield will reimburse up to \$2,000 maximum per person per calendar year for outpatient physical therapy.

## **Skilled Nursing Facility**

The Blue Cross Blue Shield PPO will reimburse a combined annual network and non-network maximum of 100 days per person calendar year for a skilled nursing facility. Care must be non-custodial.

Benefits for a skilled nursing facility:

- Pre-Medicare participants - Network coinsurance is 70%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 70%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met. The \$300 annual hospital copay will also apply.

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

## **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 Blue Cross Blue Shield for additional information.

## **Transplant Network**

The Transplant Network is a subset of the Blue Cross Blue Shield PPO network and consists of healthcare 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 Blue Cross Blue Shield to determine whether you reside in a Transplant Network geographic area.

Non-network coinsurance is 50%. The Blue Cross Blue Shield PPO will reimburse up to \$10,000 for non-network services.

## **Treatment for Loss or Impairment of Speech**

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

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

Benefits for outpatient treatment for loss or impairment of speech:

- Pre-Medicare participants - Network coinsurance is 90%, after the deductible is met
- Medicare-eligible participants - Network coinsurance is 90%, after the deductible is met
- Non-network coinsurance is 50%, after the deductible is met

## **Exclusions and Limitations**

### **Services that are Not Covered under the Plan**

The plan does not cover:

- Experimental or investigational treatment
  - Experimental or investigational treatment includes procedures, treatments, care, services and supplies which do not represent a commonly accepted form of treatment; are not generally accepted by the medical community in the United States as effective, appropriate and essential for the treatment of a diagnosed condition; or are not proven effective in the treatment of an illness
  - A drug, device, procedure, service, or treatment is experimental or investigational if it is, or it includes, a drug, device, procedure, service or treatment:
    - (1) that cannot be lawfully marketed for the proposed use without approval of the U.S. Food and Drug Administration and which has not been so approved for marketing at the time the drug or device is furnished or which was not identified in the American Hospital Formulary Service or the United States

Pharmacopoeia Dispensing Information as appropriate for the proposed use;

- (2) which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function, or a drug, device, treatment or procedure which is used with a patient informed consent document which was reviewed and approved (or which is required by federal law to be reviewed and approved) by the treating facility's Institutional Review Board or other body serving a similar function;
- (3) which Reliable Evidence shows is the subject of an on-going Phase I, II or III clinical trial or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;
- (4) which the prevailing opinion among experts, as shown by Reliable Evidence, is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis;
- (5) that is less effective than conventional treatment methods;
- (6) for which a review of the number of patients who have received indicates that the patients who have received the treatment or procedure, received it during Phase I, II or III of the clinical trial of the development of the treatment or procedure;
- (7) that is currently undergoing review by the Institutional Review Board (or similar body) for the treating health care facility; or
- (8) for which language appearing in the consent form or in the treating Hospital's or Physician's protocol for treatment indicates that the Hospital or the Physician regards the treatment or procedure as experimental.

“Reliable Evidence” means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, treatment or procedure; or the written informed consent form used by the treating facility or by another facility studying substantially the same drug, device, treatment or procedure with respect to the condition of the covered person in question.

The Claims Administrator, in its judgment, may deem an experimental service to be covered under this Plan for treating a life threatening sickness or condition if it is determined by the Claims Administrator that the experimental service at the time of the determination: (i) is proven to be safe with promising efficacy; and (ii) is provided in a clinically controlled research setting; and (iii) uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health. For purposes of this section, “life threatening” is used to describe sicknesses or conditions which are more likely than not to cause death within one year of the date of the request for treatment.

- Cosmetic surgery or treatment, except:
  - for correcting damage caused by accidental injury when the surgery is performed within a one-year period following the date of the accident that causes the injury
  - reconstructive breast surgery following mastectomy as described in the Other Covered Expenses section
- Occupational illness or injuries
- Exercise programs or vitamins
- Routine health checkups and tests not specified in preventive care
- Fitting or cost of eyeglasses, except when needed because of an injury to the eye
- Hearing aids and exams
- Eye exams made for or in connection with treating or diagnosing astigmatism, myopia or hyperopia
- Dental work and dental X-rays, except for accidental injury
- Treatment not prescribed by a licensed physician or dentist
- Charges for services of a resident physician or intern
- Charges that a covered individual is not legally obligated to pay

- Charges for education, special education or job training
- Non-network doctor fees above regional out-of-network reimbursement limits
- Sonograms during pregnancy, unless medically necessary
- Charges for, or related to, sex change surgery or treatment of gender identity disorder
- Charges for, or associated with, artificial insemination, in-vitro fertilization, embryo transfer procedures, transsexual surgery, sexual dysfunction, promotion of fertility through extra-coital reproductive technologies or reversal of sterilization
- Charges for fertility and/or infertility medications
- Birth control devices which are experimental/investigational or can be purchased without a prescription
- Providers not covered include, but are not limited to, massage therapists, exercise physiotherapists and acupuncturists. Acupuncture is only covered when used in lieu of anesthesia for surgery.
- Speech therapy is not covered for any of the following reasons:
  - Speech dysfunctions that are self-correcting
  - Services which maintain function that are neither diagnostic or therapeutic
  - Any procedure which may be carried out by someone other than a licensed/certified Speech Therapist
- Foot orthotics are not covered, unless prescribed for diabetes
- **Select** Specialty Medications (including self-administered and physician administered injectables, along with certain oral medications) are covered exclusively under the Pharmacy Network administered by CVS Caremark. These select Specialty Medications are not eligible for coverage by Blue Cross Blue Shield. For more information refer to the Specialty Medications part of the Pharmacy Network section.

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

## Know Your Benefits

To get the most from your benefits:

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

## Claiming Benefits

### When You Must File Your Claims

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

### Payment of Hospital Expenses

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

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

### Payment of Doctor Expenses

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

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

Blue Cross Blue Shield PPO claim forms can be found on the Fidelity NetBenefits® Web site. From the “Home Page” tab, select the “Health & Insurance” tab. You can click on the “Forms” link in the View column or select “All

Health & Insurance Forms” at the bottom of the benefit summary. You can also contact Blue Cross Blue Shield directly through TI HR Connect at 888-660-1411 or you can go to the [www.bcbstx.com](http://www.bcbstx.com) Web site. Fill in the patient information section on the claim form. The completed form should be submitted directly to Blue Cross Blue Shield, along with your itemized bills, for reimbursement.

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

### **If You Need Help Filing a Claim**

If you have any questions concerning your claim or need help filing your claim, call Blue Cross Blue Shield, 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 Blue Cross Blue Shield at the following address:

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

## **Blue Cross Blue Shield Claim Denial and Appeal Information**

### **If a Claim is Denied**

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

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

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

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

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

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

## **Blue Cross Blue Shield PPO Claim Appeals**

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

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

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

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

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

If, after reviewing your appeal and any further information that you have submitted, Blue Cross Blue Shield denies your appeal, either in whole or in part,

you must appeal Blue Cross Blue Shield's denial by requesting a review of your claim by the Plan Administrator. Your written request for an appeal must be received by the Plan Administrator within 90 days of the date you received your notice that Blue Cross Blue Shield denied your claim. The remainder of your second-level appeal will be handled as discussed above. Your request for a second-level appeal should be mailed to:

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

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

The notice describing Blue Cross Blue Shield's or the Plan Administrator's decision will describe (i) the specific reason or reasons for its 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, (iv) a description of any voluntary appeals procedures, if any, and your right to obtain information about such procedures, and (v) your right to bring a cause of action for benefits under section 502(a) of ERISA. If you do not agree with any of the Claim or Plan Administrator's decisions you must exhaust all levels of appeals provided by the Plan before you can proceed to court.

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

## **Additional Information**

Blue Cross Blue Shield PPO is administered by Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield

Association. Blue Cross and Blue Shield of Texas provides claims payment services only and does not assume any financial risk or obligation with respect to claims.

### **Right to Recovery**

By accepting the payment and/or reimbursement of benefits made by the plan, the retiree or other covered individual agrees that payments made by the plan are made on the condition and understanding that the plan will be fully reimbursed to the extent of benefits paid by the plan to or for the benefit of the retiree or other covered individual.

In the event of injury or illness caused by a third party, if that responsible party or their insurer has not made payments to a retiree or other covered individual, or his or her estate, the plan has a right to collect health care-related expenses from the applicable third party. If payment has been made to the retiree or other covered individual, the plan has the right to collect any amount paid by the responsible third party or that responsible party's insurer to the retiree or other covered individual, any such amount being held by the retiree or other covered individual being held in a constructive trust on behalf of the plan with the plan being entitled to first reimbursement. This is the case, regardless of whether the retiree or other covered individual has been fully compensated or made whole, and regardless of the fault of the retiree or other covered individual.

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

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

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

If you have coverage under Medicare or another group health plan, the Blue Cross Blue Shield PPO, like most medical plans, has a Coordination of Benefits (COB) provision. Under this provision, one of your plans is considered primary and the other secondary. Medicare is primary for all retirees age 65 and older. The primary plan pays your expenses first.

For all retirees, the Blue Cross Blue Shield PPO annual and maximum benefit amounts will be reduced each time a secondary claim is submitted, regardless of whether the Blue Cross Blue Shield PPO pays toward the claim. Even if BCBS does not make a payment on eligible charges, BCBS credits the member's account with applicable deductible and coinsurance. Once the BCBS

coinsurance accrues to the annual out-of-pocket maximum, eligible charges thereafter are considered at 100 percent of the allowed amount for the remainder of the calendar year.

How COB is determined depends on your age and retirement date:

- **If you retired on or after January 1, 1988, or you became either age 65 or eligible for Medicare after this date**, Maintenance of Benefits provisions are in effect. In this case, when the Blue Cross Blue Shield PPO is secondary, Blue Cross Blue Shield PPO Plan will compare the Medicare allowed amount and the Blue Cross Blue Shield allowed amount, and use the lesser of the two in calculating secondary plan benefits. **If the primary plan has paid the same or more than the Blue Cross Blue Shield PPO, the Blue Cross Blue Shield PPO will not pay on the claim.**
- **If you were either age 65 or eligible for Medicare and retired before January 1, 1988**, the Blue Cross Blue Shield PPO is secondary and will pay covered medical expenses up to 100 percent of the charges incurred, subject to plan limits. This means the Blue Cross Blue Shield PPO will pay the remainder of covered expenses incurred by you or your dependent that are not paid by Medicare.

### **If You Have Other Private Medical Insurance**

The Blue Cross Blue Shield PPO will not coordinate with other private health insurance plans such as those available through the American Association of Retired Persons (AARP). If you carry insurance, other than Medicare or another group plan provided by an employer, the Blue Cross Blue Shield PPO will ignore the private plan.

### **Medicare Coverage at Age 65**

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

**Even if you do not enroll in Medicare Part B, the Blue Cross Blue Shield PPO will continue to pay secondary and Blue Cross Blue Shield will estimate the portion that would have been paid by Medicare. If you decline enrollment in Medicare Part B, you should consider re-enrolling in Medicare Part B immediately to minimize Medicare's late enrollment penalty.**

For additional information see Overview of Medicare section.

## **Birthday Rule**

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

## **Termination of Coverage**

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

- Date you die
- Date the plan is discontinued or amended to eliminate TI Extended Health Benefits Coverage
- 30 days following the due date of a required cost, if any, if it remains unpaid. See important note in Cost – Who Pays section.

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

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

## **Death**

If you die, coverage for your eligible dependents may be elected under TI Extended Health Benefits Coverage, as long as they continue to be eligible for dependent coverage. TI will bill the dependents for the cost of their coverage. If your surviving spouse remarries, coverage will end and the surviving spouse and/or eligible dependents are no longer eligible to continue coverage under COBRA.

**If you terminated employment on or after January 1, 1998** - TI Extended Health Benefits Coverage must be elected within 30 days of your death, by at least one survivor. If your survivors do not enroll in dental coverage through TI Extended Health Benefits Coverage within 30 days of your death, they will only be eligible to enroll for dental coverage in the event of an appropriate qualified status change or during annual enrollment as long as they are enrolled in medical coverage through TI Extended Health Benefits Coverage. If none of your

survivors enroll in medical coverage through TI Extended Health Benefits Coverage, or if they all opt out at a later date, none of the survivors will be eligible to enroll for medical or dental coverage through TI Extended Health Benefits Coverage in the future.

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

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

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

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 at the end of this section.

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

## **Pharmacy Network**

CVS Caremark administers an extensive nationwide network to provide TI with network discounts for prescription medications. Your out-of-pocket expense will vary based on whether your drug is filled in-network, out-of-network or through mail-order (CVS Caremark Home Delivery service).

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

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

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

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

### Prescription Benefits

The pharmacy coinsurance rates provided below represent the amounts paid by the TI Retiree Health Benefit Plan.

Type	In-Network Coinsurance	Out-of-Network Coinsurance	Mail-Order Program Coinsurance
Generic Drugs	55% of the total drug cost, for up to a 30-day supply	50% of the total drug cost, for up to a 30-day supply	60% of the total drug cost, for up to a 90-day supply
Brand-name Drugs (generic available)	55% of the total drug cost, for up to a 30-day supply.  You also pay the cost difference between the brand-name and generic drug*	50% of the total drug cost, for up to a 30-day supply.  You also pay the cost difference between the brand-name and generic drug*	60% of the total drug cost, for up to a 90-day supply.  You also pay the cost difference between the brand-name and generic drug*
Brand-name Drugs (no generic available)	55% of the total drug cost, for up to a 30-day supply	50% of the total drug cost, for up to a 30-day supply	60% of the total drug cost, for up to a 90-day supply
Annual pharmacy out-of-pocket maximum**	\$5,000 individual / \$10,000 family		

\* If a generic is available and a brand-name drug is purchased instead, you pay the appropriate coinsurance for the brand-name drug cost plus the cost difference between the brand-name and generic drug. The cost difference does

not apply towards the pharmacy out-of-pocket maximum — you must still pay the difference, even if your out-of-pocket pharmacy maximum has been met.

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

You can receive the highest benefit from this program by doing the following:

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

### **Quality Care**

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

### **Lost or Stolen Medication**

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

### **Covered Drugs Subject to Prior Authorization**

Prior Authorization determines benefit coverage or the appropriateness of drug therapy based on strict FDA approved criteria for drugs that would otherwise not be covered by the Plan. Your pharmacist will inform you at the point-of-sale if your drug requires Prior Authorization and instruct you to have your physician contact the CVS Caremark Prior Authorization Unit. You may contact CVS Caremark Customer Care through TI HR Connect at 888-660-1411 if you have questions regarding whether your drug requires prior authorization.

## **Covered Drugs Subject to Dispensing Limitations**

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

## **Specialty Medications**

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

Specialty medications may be dispensed up to a 30-day supply quantity only. The coinsurance for specialty medications will be 90% of the discounted drug cost. If you choose a brand-name drug when there is a generic available, you will also pay the cost difference between the brand-name and generic drug. Additionally, specialty medications are required to be filled through the CVS Caremark SpecialtyRx Pharmacy. CVS Caremark SpecialtyRx is a complete source for 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 CaremarkConnect at 800-237-2767.

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

## Claiming Pharmacy Benefits

### When You Must File Your Pharmacy Claims

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

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

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

CVS Caremark claim forms can be found on the Fidelity NetBenefits® Web site. From the “Home Page” tab, select the “Health & Insurance” tab. You can click on the “Forms” link in the View column or select “All Health & Insurance Forms” at the bottom of the benefit summary. You can also obtain a claim form by contacting CVS Caremark Customer Care through TI HR Connect at 888-660-1411 or you can go to the [www.caremark.com](http://www.caremark.com)® Web site. The completed form should be submitted directly to CVS Caremark, along with your receipts, for reimbursement.

### If You Need Help Filing a Claim

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

Claims should be sent to:

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

## Pharmacy Claim Denial and Appeal Information

### If a Pharmacy Claim is Denied

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

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

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

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

If your claim for pharmacy benefits involves an ongoing course of treatment to be provided over a period of time or number of treatments (also known as concurrent care), any reduction or termination of such medical care (other than by a plan amendment or termination) before the end of the period of time or

number of treatments constitutes an adverse benefit determination. CVS Caremark will notify you of any such reduction or termination in time to allow you to appeal and obtain a determination on review before the benefit is reduced or terminated.

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

### **CVS Caremark Claim Appeals**

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

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

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

If your appeal involves a determination based in whole or part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or not medically necessary or appropriate), CVS Caremark will consult with a health care professional with the appropriate training and experience in the field of medicine at issue in your appeal. The health care professional consulted will be an individual who is

neither an individual who was consulted in connection with the initial determination that is the subject of the appeal nor the subordinate of any such individual. CVS Caremark will provide you with the name of any medical or vocational experts whose advice was sought in connection with your appeal.

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

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

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

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

The notice describing CVS Caremark's or the Plan Administrator's decision will describe (i) the specific reason or reasons for its 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, (iv) a description of any voluntary appeals procedures, if any, and your right to obtain information about such procedures, and (v) your right to bring a cause of action for benefits under section 502(a) of ERISA. If you do not agree with any of the Claim or Plan Administrator's decisions you must exhaust all levels of appeals provided by the Plan before you can proceed to court.

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

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

# **EXTENDED MEDICAL – CIGNA Copay Plan**

**(uses the CIGNA Open Access Plus In-Network (OAPIN))**

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## **Important Information**

This summary of the CIGNA Copay Plan option has been provided by CIGNA and modified, in part, by Texas Instruments Incorporated in accordance with information contained elsewhere in the 2011 Retiree Health Benefits Guide. This summary is intended to describe the benefits Texas Instrument Incorporated has made available to participants in the TI Retiree Health Benefit Plan under the CIGNA Copay Plan option.

This is not an insured benefit plan. The benefits described in this section are self-insured by Texas Instruments Incorporated which is responsible for their payment. Connecticut General provides claim administration services to the plan, but Connecticut General does not insure the benefits described.

## **Special Copay Plan Provisions**

Participating Providers include Physicians, Hospitals and Other Health Care Professionals and Other Health Care Facilities. Consult your Physician Guide for a list of Participating Providers in your area. Participating Providers are committed to providing you and your Dependents appropriate care while lowering medical costs.

## **Services Available In Conjunction With Your Copay Plan Option**

The following several pages describe helpful services available in conjunction with your Copay Plan Option. You can access these services simply by calling the toll-free number shown on the back of your ID card.

## **CIGNA'S Toll-Free Care Line**

CIGNA's toll-free care line allows you to talk to a health care professional during normal business hours, Monday through Friday, simply by calling the toll-free number shown on your ID card.

CIGNA's toll-free care line personnel can provide you with the names of Participating Providers. If you or your Dependents need medical care, you may consult your Physician Guide which lists the Participating Providers in your area or call CIGNA's toll-free number for assistance. If you or your Dependents need medical care while away from home, you may have access to a national network of Participating Providers through CIGNA's Away-From-Home Care feature. Call CIGNA's toll-free care line for the names of Participating Providers in other network areas. Whether you obtain the name of a Participating Provider from your Physician Guide or through the care line, it is recommended that prior to

making an appointment you call the provider to confirm that he or she is a current participant in the Open Access Plus Program.

## **Case Management**

Case Management is a service provided through a Review Organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of Case Management is to ensure that patients receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a Hospital or specialized facility. Should the need for Case Management arise, a Case Management professional will work closely with the patient, his or her family and the attending Physician to determine appropriate treatment options which will best meet the patient's needs and keep costs manageable. The Case Manager will help coordinate the treatment program and arrange for necessary resources. Case Managers are also available to answer questions and provide ongoing support for the family in times of medical crisis.

Case Managers are Registered Nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A Case Manager trained in the appropriate clinical specialty area will be assigned to you or your Dependent. In addition, Case Managers are supported by a panel of Physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the Case Manager recommends alternate treatment programs and helps coordinate needed resources, the patient's attending Physician remains responsible for the actual medical care.

1. You, your dependent or an attending Physician can request Case Management services by calling the toll-free number shown on your ID card during normal business hours, Monday through Friday. In addition, a claim office or a utilization review program can refer you to Case Management (see the Prior Authorization/Pre-Authorized section of your benefits summary for the Copay Plan option regarding referral of an individual for Case Management).
2. The Review Organization assesses each case to determine whether Case Management is appropriate.
3. Following an initial assessment, the Case Manager works with you, your family and Physician to determine the needs of the patient and to identify what alternate treatment programs are available (for example, in-home medical

care in lieu of an extended Hospital convalescence). You are not penalized if the alternate treatment program is not followed.

4. The Case Manager arranges for alternate treatment services and supplies, as needed (for example, nursing services or a Hospital bed and other Durable Medical Equipment for the home).
5. The Case Manager also acts as a liaison between the insurer, the patient, his or her family and Physician as needed (for example, by helping you to understand a complex medical diagnosis or treatment plan).
6. Once the alternate treatment program is in place, the Case Manager continues to manage the case to ensure the treatment program remains appropriate to the patient's needs.

While participation in Case Management is strictly voluntary, Case Management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

### **Additional Programs**

CIGNA may, from time to time, offer or arrange for various entities to offer discounts, benefits, or other consideration to you for the purpose of promoting your general health and well being. CIGNA may also arrange for the reimbursement of all or a portion of the cost of services provided by other parties to you or your covered Dependents. Contact CIGNA for details regarding any such arrangements.

### **Important Information About Your Medical Plan**

Details of your medical benefits are described on the following pages.

### **Opportunity to Select a Primary Care Physician**

#### Choice of Primary Care Physician:

This medical plan does not require that you select a Primary Care Physician or obtain a referral from a Primary Care Physician in order to receive all benefits available to you under this medical plan. Notwithstanding, a Primary Care Physician may serve an important role in meeting your health care needs by providing or arranging for medical care for you and your Dependents. For this reason, we encourage the use of Primary Care Physicians and provide you with the opportunity to select a Primary Care Physician from a list provided by CIGNA for yourself and your Dependents. If you choose to select a Primary Care

Physician, the Primary Care Physician you select for yourself may be different from the Primary Care Physician you select for each of your Dependents.

#### Changing Primary Care Physicians:

You may request a transfer from one Primary Care Physician to another by contacting us at the member services number on your ID card. Any such transfer will be effective on the first day of the month following the month in which the processing of the change request is completed.

In addition, if at any time a Primary Care Physician ceases to be a Participating Provider, you or your Dependent will be notified for the purpose of selecting a new Primary Care Physician, if you choose.

#### **How To File Your Claim**

In most cases the provider will file claims directly to CIGNA on your behalf. If it is necessary to file a claim, remember the prompt filing of any required claim form will result in faster payment of your claim.

#### **CLAIM REMINDERS**

- BE SURE TO USE YOUR MEMBER ID AND ACCOUNT NUMBER WHEN YOU FILE CIGNA'S CLAIM FORMS, OR WHEN YOU CALL YOUR CIGNA CLAIM OFFICE.
- YOUR MEMBER ID IS THE ID SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- YOUR ACCOUNT NUMBER IS THE 7-DIGIT POLICY NUMBER SHOWN ON YOUR BENEFIT IDENTIFICATION CARD.
- PROMPT FILING OF ANY REQUIRED CLAIM FORMS RESULTS IN FASTER PAYMENT OF YOUR CLAIMS.
- PLEASE REMEMBER TO PRESENT YOUR BENEFIT ID CARD AT THE TIME OF SERVICE. THE CARD TELLS THE PROVIDER TO SEND ITS BILLS DIRECTLY TO CIGNA.
- IF NECESSARY TO FILE A CLAIM REMEMBER TO SUBMIT ITEMIZED COPIES OF YOUR BILLS WITH THE CLAIM FORM.

**WARNING:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinement in prison.

Any person who intentionally makes a misrepresentation of a material fact regarding eligibility, claims for benefits, or any matter related to the CIGNA Copay Plan option or who commits fraud on the CIGNA Copay Plan option shall be subject to having their coverage retroactively rescinded.

## **Accident and Health Provisions**

### **Notice of Claim**

Written notice of a claim must be given to CIGNA within 180 days after the commencement of any treatment by a contracted physician or receipt of any medical service or supply on which claim is based. If notice is not given in that time, the claim will not be invalidated or reduced if it is shown that written notice was given as soon as was reasonably possible.

### **Claim Forms**

When CIGNA receives the notice of claim, CIGNA will give you as the claimant, or TI for you, the claim forms which it uses for filing proof of loss. If you do not receive these claim forms within 15 days after CIGNA receives notice of claim, you will be considered to meet the proof of loss requirements if you submit written proof of loss within 180 days after the date of loss (or commencement of medical services). This proof must describe the occurrence, character and extent of the loss for which claim is made.

<b>Open Access Plus In-Network Medical Benefits The Schedule</b>
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<b>For You and Your Dependents</b>
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Open Access Plus In-Network Medical Benefits provide coverage for care In-Network. To receive Open Access Plus In-Network Medical Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for services and supplies. That portion is the Copayment, Deductible or Coinsurance.
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If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.
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**Open Access Plus In-Network Medical Benefits**  
**The Schedule**

**Coinsurance**

The term Coinsurance means the percentage of charges the Plan pays for Covered Expenses that a covered person incurs after satisfaction of any deductible and co-pay.

**Copayments**

Copayments are expenses to be paid by you or your Dependent for covered services. Copayments are in addition to any Coinsurance.

**Multiple Surgical Reduction**

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

**Assistant Surgeon and Co-Surgeon Charges**

**Assistant Surgeon**

The maximum amount payable will be limited to charges made by an assistant surgeon that do not exceed 20 percent of the surgeon's allowable charge. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts).

**Co-Surgeon**

The maximum amount payable will be limited to charges made by co-surgeons that do not exceed 20 percent of the surgeon's allowable charge plus 20 percent. (For purposes of this limitation, allowable charge means the amount payable to the surgeons prior to any reductions due to coinsurance or deductible amounts.)

BENEFIT HIGHLIGHTS	IN-NETWORK
<b>Lifetime Maximum</b>	Unlimited
<b>Coinsurance Level</b>	100%

BENEFIT HIGHLIGHTS	IN-NETWORK
<p><b>Physician's Services</b></p> <p>Primary Care Physician's Office visit</p> <p>Specialty Care Physician's Office Visits</p> <p>Consultant and Referral Physician's Services</p> <p><b>Note:</b> OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with CIGNA.</p> <p>Surgery Performed In the Physician's Office</p> <p>Second Opinion Consultations (provided on a voluntary basis)</p> <p>Allergy Treatment/Injections</p> <p>Allergy Serum (dispensed by the Physician in the office)</p>	<p>No charge after \$20 per office visit copay</p> <p>No charge after \$40 per office visit copay</p> <p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>No charge after either the \$20 PCP or \$40 Specialist per office visit copay or the actual charge, whichever is less</p> <p>No charge</p>
<p><b>Preventive Care</b></p> <p>Routine Preventive Care for children through age 2 (including immunizations)</p> <p>Immunizations</p>	<p>No charge</p> <p>No charge</p>
<p>Routine Preventive Care for ages 3 and above</p> <p><b>Note:</b> OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with CIGNA.</p> <p>Immunizations</p>	<p>No charge</p> <p>No charge</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
<b>Mammograms, PSA, PAP Smear</b>	
Preventive Care Related Services (i.e. "routine" services) Diagnostic Related Services (i.e. "non-routine" services)	No charge  Subject to the plan's x-ray & lab benefit; based on place of service  <b>Note:</b> The associated wellness exam will be covered at no charge.
<b>Inpatient Hospital - Facility Services</b> Semi-Private Room and Board Private Room Special Care Units (ICU/CCU)	\$250 per admission copay, then 100%  Limited to the semi-private negotiated rate Limited to the semi-private negotiated rate Limited to the negotiated rate
<b>Outpatient Facility Services</b> Operating Room, Recovery Room, Procedures Room, Treatment Room and Observation Room <b>Note:</b> Non-surgical treatment procedures are not subject to the facility copay/deductible.	\$125 per visit copay, then 100%
<b>Inpatient Hospital Physician's Visits/Consultations</b>	100%
<b>Inpatient Hospital Professional Services</b> Surgeon Radiologist Pathologist Anesthesiologist	100%
<b>Outpatient Professional Services</b> Surgeon Radiologist Pathologist Anesthesiologist	100%

BENEFIT HIGHLIGHTS	IN-NETWORK
<p><b>Emergency and Urgent Care Services</b></p> <p>Physician's Office Visit</p> <p>Hospital Emergency Room</p> <p>Outpatient Professional services (radiology, pathology and ER Physician)</p> <p>Urgent Care Facility</p> <p>X-ray and/or Lab performed at the Emergency Room/Urgent Care Facility (billed by the facility as part of the ER/UC visit)</p> <p>Independent x-ray and/or Lab Facility in conjunction with an ER visit</p> <p>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans, PET Scans etc.)</p> <p>Ambulance</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>No charge after \$100 per visit copay* *waived if admitted</p> <p>No charge</p> <p>No charge after \$50 per visit copay* *waived if admitted</p> <p>No charge</p> <p>No charge</p> <p>No charge</p> <p>100%</p>
<p><b>Inpatient Services at Other Health Care Facilities</b></p> <p>Includes Skilled Nursing Facility, Rehabilitation Hospital and Sub-Acute Facilities</p> <p>Calendar Year Maximum: Unlimited</p>	<p>100%</p>
<p><b>Laboratory and Radiology Services (includes pre-admission testing)</b></p> <p>Physician's Office Visit</p> <p>Outpatient Hospital Facility</p> <p>Independent X-ray and/or Lab Facility</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>100%</p> <p>100%</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
<p><b>Advanced Radiological Imaging (i.e. MRIs, MRAs, CAT Scans and PET Scans)</b></p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>\$250 per admission copay, then 100%</p> <p>100%</p>
<p><b>Outpatient Short-Term Rehabilitative Therapy</b></p> <p>Calendar Year Maximum: Unlimited</p> <p>Includes:            Cardiac Rehab            Physical Therapy            Speech Therapy            Occupational Therapy            Pulmonary Rehab            Cognitive Therapy</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p><b>Note:</b>            Outpatient Short Term Rehab copay applies, regardless of place of service, including the home.</p>
<p><b>Chiropractic Care</b></p> <p>Calendar Year Maximum: 20 days</p> <p>Physician's Office Visit</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p>
<p><b>Home Health Care</b></p> <p>Calendar Year Maximum: Unlimited (includes outpatient private nursing when approved as medically necessary)</p> <p>Note: The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day; with a visit defined as a period of 2 hours or less (e.g. maximum of 8 visits per day)</p>	<p>100%</p>
<p><b>Hospice</b></p> <p>Inpatient Services</p> <p>Outpatient Services (same coinsurance level as Home Health Care)</p>	<p>100%</p> <p>100%</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
<p><b>Bereavement Counseling</b>  Services Provided as part of Hospice Care</p> <p>Inpatient</p> <p>Outpatient</p> <p>Services Provided by Mental Health Professional</p>	<p>100%</p> <p>100%</p> <p>Covered under Mental Health benefit</p>
<p><b>Maternity Care Services</b></p> <p>Initial Visit to Confirm Pregnancy</p> <p><b>Note:</b>  OB/GYN providers will be considered either as a PCP or Specialist, depending on how the provider contracts with CIGNA.</p> <p>All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (i.e. global maternity fee)</p> <p>Physician's Office Visits in addition to the global maternity fee when performed by an OB/GYN or Specialist</p> <p>Delivery - Facility (Inpatient Hospital, Birthing Center)</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>100%</p> <p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>\$250 per admission copay, then 100%</p>
<p><b>Abortion</b></p> <p>Includes elective and non-elective procedures</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>\$250 per admission copay, then 100%</p> <p>\$125 per visit copay, then 100%</p> <p>100%</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
<p><b>Family Planning Services</b></p> <p>Office Visits, Lab and Radiology Tests and Counseling</p> <p><b>Note:</b> The standard benefit will include coverage for contraceptive devices (e.g. Depo-Provera and Intrauterine Devices (IUDs). Diaphragms will also be covered when services are provided in the physician's office.</p> <p>Surgical Sterilization Procedure for Vasectomy/ Tubal Ligation (excludes reversals)</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>\$250 per admission copay, then 100%</p> <p>\$125 per visit copay, then 100%</p> <p>100%</p>
<p><b>Infertility Treatment</b></p> <p>Coverage will be provided for the following services:</p> <ul style="list-style-type: none"> <li>• Testing and treatment services performed in connection with an underlying medical condition.</li> <li>• Testing performed specifically to determine the cause of infertility.</li> <li>• Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).</li> <li>• Artificial Insemination</li> </ul> <p>Surgical Treatment: Limited to procedures for the correction of infertility (excludes In-vitro, GIFT, ZIFT, etc.)</p>	
<p>Physician's Office Visit (Lab and Radiology Tests, Counseling)</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>\$250 per admission copay, then 100%</p> <p>\$125 per visit copay, then 100%</p> <p>100%</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
<p><b>Organ Transplants</b> Includes all medically appropriate, non-experimental transplants</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Physician's Services</p> <p>Lifetime Travel Maximum: \$10,000 per transplant</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>100% at Lifesource center after \$250 per admission copay, otherwise 100% after \$250 per admission copay</p> <p>100%</p> <p>No charge (only available when using Lifesource facility)</p>
<p><b>Durable Medical Equipment</b></p>	<p>100%</p>
<p><b>External Prosthetic Appliances</b></p>	<p>100%</p>
<p><b>Nutritional Evaluation</b> Calendar Year Maximum: 3 visits per person</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>\$250 per admission copay, then 100%</p> <p>\$125 per visit copay, then 100%</p> <p>100%</p>
<p><b>Dental Care</b> Limited to charges made for a continuous course of dental treatment started within six months of an injury to sound, natural teeth.</p> <p>Physician's Office Visit</p> <p>Inpatient Facility</p> <p>Outpatient Facility</p> <p>Physician's Services</p>	<p>No charge after the \$20 PCP or \$40 Specialist per office visit copay</p> <p>\$250 per admission copay, then 100%</p> <p>\$125 per visit copay, then 100%</p> <p>100%</p>

BENEFIT HIGHLIGHTS	IN-NETWORK
<b>Routine Foot Disorders</b>	Not covered except for services associated with foot care for diabetes and peripheral vascular disease.
<b>Mental Health</b> Inpatient Outpatient (Includes Individual, Group and Intensive Outpatient) Physician's Office Visit and Outpatient Facility	\$250 per admission copay, then 100%  No charge after the \$20 per office visit copay
<b>Substance Abuse</b> Inpatient Outpatient (Includes Individual and Intensive Outpatient) Physician's Office Visit and Outpatient Facility	\$250 per admission copay, then 100%  No charge after the \$20 per office visit copay

**Open Access Plus In-Network Medical Benefits**

**Prior Authorization/Pre-Authorized**

The term Prior Authorization means the approval that a Participating Provider must receive from the Review Organization, prior to services being rendered, in order for certain services and benefits to be covered under this policy.

Services that require Prior Authorization include, but are not limited to:

- inpatient Hospital services;
- inpatient services at any participating Other Health Care Facility;
- residential treatment;
- non-emergency ambulance; or
- transplant services.

## Covered Expenses

The term Covered Expenses means the expenses incurred by or on behalf of a covered person for the charges listed below if they are incurred after he becomes covered for these benefits. Expenses incurred for such charges are considered Covered Expenses to the extent that the services or supplies provided are recommended by a Physician, and are Medically Necessary for the care and treatment of an Injury or a Sickness, as determined by CIGNA. **Any applicable Copayments, Deductibles or limits are shown in The Schedule.**

## Covered Expenses

- charges made by a Hospital, on its own behalf, for Bed and Board and other Necessary Services and Supplies; except that for any day of Hospital Confinement, Covered Expenses will not include that portion of charges for Bed and Board which is more than the Bed and Board Limit shown in The Schedule.
- charges for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided.
- charges made by a Hospital, on its own behalf, for medical care and treatment received as an outpatient.
- charges made by a Free-Standing Surgical Facility, on its own behalf for medical care and treatment.
- charges made on its own behalf, by an Other Health Care Facility, including a Skilled Nursing Facility, a Rehabilitation Hospital or a subacute facility for medical care and treatment; except that for any day of Other Health Care Facility confinement, Covered Expenses will not include that portion of charges which are in excess of the Other Health Care Facility Daily Limit shown in The Schedule.
- charges made for Emergency Services and Urgent Care.
- charges made by a Physician or a Psychologist for professional services.
- charges made by a Nurse, other than a member of your family or your Dependent's family, for professional nursing service.
- Charges made for anesthetics and their administration; diagnostic x-ray and laboratory examinations; x-ray, radium, and radioactive isotope treatment; chemotherapy; blood transfusions; oxygen and other gases and their administration.

- charges made for a mammogram for women ages 35 to 69, every year, or at any age for women at risk, when recommended by a Physician.
- charges made for an annual Papanicolaou laboratory screening test.
- charges made for an annual prostate-specific antigen test (PSA).
- charges for appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation.
- charges made for laboratory services, radiation therapy and other diagnostic and therapeutic radiological procedures.
- charges made for Family Planning, including medical history, physical exam, related laboratory tests, medical supervision in accordance with generally accepted medical practices, other medical services, information and counseling on contraception, implanted/injected contraceptives.
- office visits, tests and counseling for Family Planning services.
- charges made for Routine Preventive Care from age 3 including immunizations. Routine Preventive Care means health care assessments, wellness visits and any related services.
- charges made for visits for routine preventive care of a Dependent child during the first two years of that Dependent child's life, including immunizations.
- orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthodontics alone can not 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 performed prior to age 19 and 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.

### **Clinical Trials**

- charges made for routine patient services associated with cancer clinical trials approved and sponsored by the federal government. In addition the following criteria must be met:
- the cancer clinical trial is listed on the NIH web site [www.clinicaltrials.gov](http://www.clinicaltrials.gov) as being sponsored by the federal government;
- the trial investigates a treatment for terminal cancer and: (1) the person has failed standard therapies for the disease; (2) cannot tolerate standard therapies for the disease; or (3) no effective nonexperimental treatment for the disease exists;
- the person meets all inclusion criteria for the clinical trial and is not treated “off-protocol”;
- the trial is approved by the Institutional Review Board of the institution administering the treatment; and

Routine patient services do not include, and reimbursement will not be provided for:

- the investigational service or supply itself;
- services or supplies listed herein as Exclusions;
- services or supplies related to data collection for the clinical trial (i.e., protocol-induced costs);
- services or supplies which, in the absence of private health care coverage, are provided by a clinical trial sponsor or other party (e.g., device, drug, item or service supplied by manufacturer and not yet FDA approved) without charge to the trial participant.

### **Genetic Testing**

- charges made for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease. Genetic testing is covered only if:
  - a person has symptoms or signs of a genetically-linked inheritable disease;
  - it has been determined that a person is at risk for carrier status as supported

by existing peer-reviewed, evidence-based, scientific literature for the development of a genetically-linked inheritable disease when the results will impact clinical outcome; or

- the therapeutic purpose is to identify specific genetic mutation that has been demonstrated in the existing peer-reviewed, evidence-based, scientific literature to directly impact treatment options.

Pre-implantation genetic testing, genetic diagnosis prior to embryo transfer, is covered when either parent has an inherited disease or is a documented carrier of a genetically-linked inheritable disease.

Genetic counseling is covered if a person is undergoing approved genetic testing, or if a person has an inherited disease and is a potential candidate for genetic testing. Genetic counseling is limited to 3 visits per calendar year for both pre- and postgenetic testing.

### **Nutritional Evaluation**

- charges made for nutritional evaluation and counseling when diet is a part of the medical management of a documented organic disease.

### **Internal Prosthetic/Medical Appliances**

- charges made for internal prosthetic/medical appliances that provide permanent or temporary internal functional supports for nonfunctional body parts are covered. Medically Necessary repair, maintenance or replacement of a covered appliance is also covered.

### **Home Health Services**

- charges made for Home Health Services when you: (a) require skilled care; (b) are unable to obtain the required care as an ambulatory outpatient; and (c) do not require confinement in a Hospital or Other Health Care Facility.

Home Health Services are provided only if CIGNA has determined that the home is a medically appropriate setting. If you are a minor or an adult who is dependent upon others for nonskilled care and/or custodial services (e.g., bathing, eating, toileting), Home Health Services will be provided for you only during times when there is a family member or care giver present in the home to meet your nonskilled care and/or custodial services needs.

Home Health Services are those skilled health care services that can be provided during visits by Other Health Care Professionals. The services of a home health aide are covered when rendered in direct support of skilled health care services provided by Other Health Care Professionals. A visit is defined as

a period of 2 hours or less. Home Health Services are subject to a maximum of 16 hours in total per day. Necessary consumable medical supplies and home infusion therapy administered or used by Other Health Care Professionals in providing Home Health Services are covered. Home Health Services do not include services by a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house even if that person is an Other Health Care Professional. Skilled nursing services or private duty nursing services provided in the home are subject to the Home Health Services benefit terms, conditions and benefit limitations. Physical, occupational, and other Short-Term Rehabilitative Therapy services provided in the home are not subject to the Home Health Services benefit limitations in the Schedule, but are subject to the benefit limitations described under Short-term Rehabilitative Therapy Maximum shown in The Schedule.

### **Hospice Care Services**

- charges made for a person who has been diagnosed as having six months or fewer to live, due to Terminal Illness, for the following Hospice Care Services provided under a Hospice Care Program:
  - by a Hospice Facility for Bed and Board and Services and Supplies;
  - by a Hospice Facility for services provided on an outpatient basis;
  - by a Physician for professional services;
  - by a Psychologist, social worker, family counselor or ordained minister for individual and family counseling;
  - for pain relief treatment, including drugs, medicines and medical supplies;
  - by an Other Health Care Facility for:
    - part-time or intermittent nursing care by or under the supervision of a Nurse;
    - part-time or intermittent services of an Other Health Care Professional;
  - physical, occupational and speech therapy;
- medical supplies; drugs and medicines lawfully dispensed only on the written prescription of a Physician; and laboratory services; but only to the extent such charges would have been payable under the policy if the person had remained or been Confined in a Hospital or Hospice Facility.

The following charges for Hospice Care Services are not included as Covered Expenses:

- for the services of a person who is a member of your family or your Dependent's family or who normally resides in your house or your Dependent's house;
- for any period when you or your Dependent is not under the care of a Physician;
- for services or supplies not listed in the Hospice Care Program;
- for any curative or life-prolonging procedures;
- to the extent that any other benefits are payable for those expenses under the policy;
- for services or supplies that are primarily to aid you or your Dependent in daily living;

### **Mental Health and Substance Abuse Services**

**Mental Health Services** are services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

**Substance Abuse** is defined as the psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

### **Inpatient Mental Health Services**

Services that are provided by a Hospital while you or your Dependent is Confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization and Mental Health Residential Treatment Services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

Mental Health Residential Treatment Services are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions.

Mental Health Residential Treatment Center means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

### **Outpatient Mental Health Services**

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while you or your Dependent is not Confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program. Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; or acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment.

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine or more hours in a week.

### **Inpatient Substance Abuse Rehabilitation Services**

Services provided for rehabilitation, while you or your Dependent is Confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions and Residential Treatment services.

Partial Hospitalization sessions are services that are provided for not less than 4 hours and not more than 12 hours in any 24-hour period.

**Substance Abuse Residential Treatment Services** are services provided by a Hospital for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Substance Abuse conditions.

**Substance Abuse Residential Treatment Center** means an institution which (a) specializes in the treatment of psychological and social disturbances that are the result of Substance Abuse; (b) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (c) provides 24-hour care, in which a person lives in an open setting; and (d) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient in a Substance Abuse Residential Treatment Center upon the recommendation of a Physician.

### **Outpatient Substance Abuse Rehabilitation Services**

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while you or your Dependent is not Confined in a Hospital, including outpatient rehabilitation in an individual, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine, or more hours in a week.

### **Substance Abuse Detoxification Services**

Detoxification and related medical ancillary services are provided when required for the diagnosis and treatment of addiction to alcohol and/or drugs. CIGNA will decide, based on the Medical Necessity of each situation, whether such services will be provided in an inpatient or outpatient setting.

### **Exclusions**

The following are specifically excluded from Mental Health and Substance Abuse Services:

- Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under this policy or agreement

- Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain
- Developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders
- Counseling for activities of an educational nature
- Counseling for borderline intellectual functioning
- Counseling for occupational problems
- Counseling related to consciousness raising
- Vocational or religious counseling
- I.Q. testing
- Custodial care, including but not limited to geriatric day care
- Psychological testing on children requested by or for a school system
- Occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline

### **Durable Medical Equipment**

- charges made for purchase or rental of Durable Medical Equipment that is ordered or prescribed by a Physician and provided by a vendor approved by CIGNA for use outside a Hospital or Other Health Care Facility. Coverage for repair, replacement or duplicate equipment is provided only when required due to anatomical change and/or reasonable wear and tear. All maintenance and repairs that result from a person's misuse are the person's responsibility. Coverage for Durable Medical Equipment is limited to the lowest-cost alternative as determined by the utilization review Physician.

Durable Medical Equipment is defined as items which are designed for and able to withstand repeated use by more than one person; customarily serve a medical purpose; generally are not useful in the absence of Injury or Sickness; are appropriate for use in the home; and are not disposable. Such equipment includes, but is not limited to, crutches, hospital beds, respirators, wheel chairs, and dialysis machines.

**Durable Medical Equipment items that are not covered** include but are not limited to those that are listed below:

- **Bed Related Items:** bed trays, over the bed tables, bed wedges, pillows, custom bedroom equipment, mattresses, including nonpower mattresses, custom mattresses and posturepedic mattresses
- **Bath Related Items:** bath lifts, nonportable whirlpools, bathtub rails, toilet rails, raised toilet seats, bath benches, bath stools, hand held showers, paraffin baths, bath mats, and spas
- **Chairs, Lifts and Standing Devices:** computerized or gyroscopic mobility systems, roll about chairs, geriatric chairs, hip chairs, seat lifts (mechanical or motorized), patient lifts (mechanical or motorized – manual hydraulic lifts are covered if patient is two-person transfer), and auto tilt chairs
- **Fixtures to Real Property:** ceiling lifts and wheelchair ramps
- **Car/Van Modifications**
- **Air Quality Items:** room humidifiers, vaporizers, air purifiers and electrostatic machines
- **Blood/Injection Related Items:** blood pressure cuffs, centrifuges, nova pens and needleless injectors
- **Other Equipment:** heat lamps, heating pads, cryounits, cryotherapy machines, electronic-controlled therapy units, ultraviolet cabinets, sheepskin pads and boots, postural drainage board, AC/DC adaptors, enuresis alarms, magnetic equipment, scales (baby and adult), stair gliders, elevators, saunas, any exercise equipment and diathermy machines

### **External Prosthetic Appliances and Devices**

- charges made or ordered by a Physician for: the initial purchase and fitting of external prosthetic appliances and devices available only by prescription which are necessary for the alleviation or correction of Injury, Sickness or congenital defect. Coverage for External Prosthetic Appliances is limited to the most appropriate and cost effective alternative as determined by the utilization review Physician.

External prosthetic appliances and devices shall include prostheses/prosthetic appliances and devices, orthoses and orthotic devices; braces; and splints.

## **Prostheses/Prosthetic Appliances and Devices**

Prostheses/prosthetic appliances and devices are defined as fabricated replacements for missing body parts. Prostheses/prosthetic appliances and devices include, but are not limited to:

- basic limb prostheses;
- terminal devices such as hands or hooks; and
- speech prostheses.

## **Orthoses and Orthotic Devices**

Orthoses and orthotic devices are defined as orthopedic appliances or apparatuses used to support, align, prevent or correct deformities. Coverage is provided for custom foot orthoses and other orthoses as follows:

- Nonfoot orthoses – only the following nonfoot orthoses are covered:
  - rigid and semirigid custom fabricated orthoses,
  - semirigid prefabricated and flexible orthoses; and
  - rigid prefabricated orthoses including preparation, fitting and basic additions, such as bars and joints.
- Custom foot orthoses – custom foot orthoses are only covered as follows:
  - for persons with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease);
  - when the foot orthosis is an integral part of a leg brace and is necessary for the proper functioning of the brace;
  - when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of Injury, Sickness or congenital defect; and
  - for persons with neurologic or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, malalignment, or pathological positioning of the foot and there is reasonable expectation of improvement.

The following are specifically excluded orthoses and orthotic devices:

- prefabricated foot orthoses;

- cranial banding and/or cranial orthoses. Other similar devices are excluded except when used postoperatively for synostotic plagiocephaly. When used for this indication, the cranial orthosis will be subject to the limitations and maximums of the External Prosthetic Appliances and Devices benefit;
- orthosis shoes, shoe additions, procedures for foot orthopedic shoes, shoe modifications and transfers;
- orthoses primarily used for cosmetic rather than functional reasons; and
- orthoses primarily for improved athletic performance or sports participation.

### **Braces**

A Brace is defined as an orthosis or orthopedic appliance that supports or holds in correct position any movable part of the body and that allows for motion of that part.

The following braces are specifically excluded: Copes scoliosis braces.

### **Splints**

A Splint is defined as an appliance for preventing movement of a joint or for the fixation of displaced or movable parts.

Coverage for replacement of external prosthetic appliances and devices is limited to the following:

- Replacement due to regular wear. Replacement for damage due to abuse or misuse by the person will not be covered.
- Replacement will be provided when anatomic change has rendered the external prosthetic appliance or device ineffective. Anatomic change includes significant weight gain or loss, atrophy and/or growth.
- Coverage for replacement is limited as follows:
  - No more than once every 24 months for persons 19 years of age and older and
  - No more than once every 12 months for persons 18 years of age and under.
  - Replacement due to a surgical alteration or revision of the site.

The following are specifically excluded external prosthetic appliances and devices:

- External and internal power enhancements or power controls for prosthetic limbs and terminal devices; and
- Myoelectric prostheses peripheral nerve stimulators.

### **Infertility Services**

- charges made for services related to diagnosis of infertility and treatment of infertility once a condition of infertility has been diagnosed. Services include, but are not limited to: approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; and diagnostic evaluations.

Infertility is defined as the inability of opposite sex partners to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility. The following are specifically excluded infertility services:

- Infertility drugs;
- In vitro fertilization (IVF); gamete intrafallopian transfer (GIFT); zygote intrafallopian transfer (ZIFT) and variations of these procedures;
- Reversal of male and female voluntary sterilization;
- Infertility services when the infertility is caused by or related to voluntary sterilization;
- Donor charges and services;
- Cryopreservation of donor sperm and eggs; and
- Any experimental, investigational or unproven infertility procedures or therapies.

### **Short-Term Rehabilitative Therapy**

Short-term Rehabilitative Therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, osteopathic manipulative, cardiac rehabilitation and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

The following limitation applies to Short-term Rehabilitative Therapy:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Short-term Rehabilitative Therapy services that are not covered include but are not limited to:

- Sensory integration therapy, group therapy; treatment of dyslexia; behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder;
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or swallowing dysfunction that is not based on an underlying diagnosed medical condition or Injury; and
- Maintenance or preventive treatment consisting of routine, long-term or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status;

A separate Copayment will apply to the services provided by each provider.

Services that are provided by a chiropractic Physician are not covered.

These services include the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to restore motion, reduce pain and improve function.

### **Chiropractic Care Services**

Charges made for diagnostic and treatment services utilized in an office setting by chiropractic Physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services you have direct access to qualified chiropractic Physicians.

The following limitation applies to Chiropractic Care Services:

- Occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness;

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, longterm or non-Medically Necessary care provided to prevent recurrence or to maintain the patient's current status; and
- vitamin therapy.

### **Transplant Services**

- charges made for human organ and tissue Transplant services which include solid organ and bone marrow/stem cell procedures at designated facilities throughout the United States or its territories. This coverage is subject to the following conditions and limitations.

Transplant services include the recipient's medical, surgical and Hospital services; inpatient immunosuppressive medications; and costs for organ or bone marrow/stem cell procurement. Transplant services are covered only if they are required to perform any of the following human to human organ or tissue transplants: allogeneic bone marrow/stem cell, autologous bone marrow/stem cell, cornea, heart, heart/lung, kidney, kidney/pancreas, liver, lung, pancreas or intestine which includes small bowel-liver or multi-visceral.

All Transplant services, other than cornea, are covered at 100% when received at CIGNA LIFESOURCE Transplant Network® facilities. Cornea transplants are not covered at CIGNA LIFESOURCE Transplant Network® facilities. Transplant services, including cornea, received at participating facilities specifically contracted with CIGNA for those Transplant services, other than CIGNA LIFESOURCE Transplant Network® facilities, are payable at the In-Network level. Transplant services received at any other facilities, including Non-Participating Providers and Participating Providers not specifically contracted with CIGNA for Transplant services, are not covered.

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant are also covered.

## **Transplant Travel Services**

Charges made for reasonable travel expenses incurred by you in connection with a preapproved organ/tissue transplant are covered subject to the following conditions and limitations. Transplant travel benefits are not available for cornea transplants. Benefits for transportation, lodging and food are available to you only if you are the recipient of a preapproved organ/tissue transplant from a designated CIGNA LIFESOURCE Transplant Network<sup>®</sup> facility. The term recipient is defined to include a person receiving authorized transplant related services during any of the following: (a) evaluation, (b) candidacy, (c) transplant event, or (d) post-transplant care. Travel expenses for the person receiving the transplant will include charges for: transportation to and from the transplant site (including charges for a rental car used during a period of care at the transplant facility); lodging while at, or traveling to and from the transplant site; and food while at, or traveling to and from the transplant site.

In addition to your coverage for the charges associated with the items above, such charges will also be considered covered travel expenses for one companion to accompany you. The term companion includes your spouse, a member of your family, your legal guardian, or any person not related to you, but actively involved as your caregiver. The following are specifically excluded travel expenses:

- travel costs incurred due to travel within 60 miles of your home; laundry bills; telephone bills; alcohol or tobacco products; and charges for transportation that exceed coach class rates.

These benefits are only available when the covered person is the recipient of an organ transplant. No benefits are available when the covered person is a donor.

## **Breast Reconstruction and Breast Prostheses**

- charges made for reconstructive surgery following a mastectomy; benefits include: (a) surgical services for reconstruction of the breast on which surgery was performed; (b) surgical services for reconstruction of the nondiseased breast to produce symmetrical appearance; (c) postoperative breast prostheses; and (d) mastectomy bras and external prosthetics, limited to the lowest cost alternative available that meets external prosthetic placement needs. During all stages of mastectomy, treatment of physical complications, including lymphedema therapy, are covered.

## **Reconstructive Surgery**

- charges made for reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit; (other than abnormalities of the jaw or conditions related to TMJ disorder) provided that: (a) the surgery or therapy restores or improves function; (b)

reconstruction is required as a result of Medically Necessary, noncosmetic surgery; or (c) the surgery or therapy is performed prior to age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part. Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review Physician.

<b>Prescription Drug Benefits The Schedule</b>
<b>For You and Your Dependents</b>
This option provides Prescription Drug benefits for Prescription Drugs and Related Supplies provided by Pharmacies as shown in this Schedule. To receive Prescription Drug Benefits, you and your Dependents may be required to pay a portion of the Covered Expenses for Prescription Drugs and Related Supplies for each 30-day supply at a retail pharmacy or each 90-day supply at a mail order pharmacy. That portion includes any applicable Copayment, Deductible and/or Coinsurance.
<b>Copayments</b>
Copayments are expenses to be paid by you or your Dependent for covered Prescription Drugs and Related Supplies. Copayments are in addition to any Coinsurance.

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
<b>Prescription Drugs – 30 –day supply</b>		
<b>Tier 1</b> Generic* drugs on the Prescription Drug List	No charge after \$15 per prescription order or refill	In-network coverage only
<b>Tier 2</b> Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after \$30 per prescription order or refill	In-network coverage only
<b>Tier 3</b> Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after \$50 per prescription order or refill	In-network coverage only

BENEFIT HIGHLIGHTS	PARTICIPATING PHARMACY	Non-PARTICIPATING PHARMACY
* Designated as per generally-accepted industry sources and adopted by CIGNA		
<b>Mail-Order Drugs – 90 day supply</b>		
<b>Tier 1</b> Generic* drugs on the Prescription Drug List	No charge after \$40 per prescription order or refill	In-network coverage only
<b>Tier 2</b> Brand-Name* drugs designated as preferred on the Prescription Drug List with no Generic equivalent	No charge after \$85 per prescription order or refill	In-network coverage only
<b>Tier 3</b> Brand-Name* drugs with a Generic equivalent and drugs designated as non-preferred on the Prescription Drug List	No charge after \$145 per prescription order or refill	In-network coverage only
* Designated as per generally-accepted industry sources and adopted by CIGNA		

## Prescription Drug Benefits

### For You and Your Dependents

#### Covered Expenses

If you or any one of your Dependents, while covered under the Copay Plan option for Prescription Drug Benefits, incurs expenses for charges made by a Pharmacy, for Medically Necessary Prescription Drugs or Related Supplies ordered by a Physician, CIGNA will provide coverage for those expenses as shown in the Schedule. Coverage also includes Medically Necessary Prescription Drugs and Related Supplies dispensed for a prescription issued to you or your Dependents by a licensed dentist for the prevention of infection or pain in conjunction with a dental procedure.

When you or a Dependent is issued a prescription for Medically Necessary Prescription Drugs or Related Supplies as part of the rendering of Emergency Services and that prescription cannot reasonably be filled by a Participating

Pharmacy, the prescription will be covered by CIGNA, as if filled by a Participating Pharmacy.

## **Limitations**

Each Prescription Order or refill shall be limited as follows:

- up to a consecutive 30-day supply, at a retail Pharmacy, unless limited by the drug manufacturer's packaging; or
- up to a consecutive 90-day supply at a mail-order Participating Pharmacy, unless limited by the drug manufacturer's packaging; or
- to a dosage and/or dispensing limit as determined by the P&T Committee.

Coverage for certain Prescription Drugs and Related Supplies requires your Physician to obtain authorization prior to prescribing. Prior authorization may include, for example, a step therapy determination. Step therapy determines the specific usage progression of therapeutically equivalent drug products or supplies appropriate for treatment of a specific condition. If your Physician wishes to request coverage for Prescription Drugs or Related Supplies for which prior authorization is required, your Physician may call or complete the appropriate prior authorization form and fax it to CIGNA to request prior authorization for coverage of the Prescription Drugs or Related Supplies. Your Physician should make this request before writing the prescription.

If the request is approved, your Physician will receive confirmation. The authorization will be processed in our claim system to allow you to have coverage for those Prescription Drugs or Related Supplies. The length of the authorization will depend on the diagnosis and Prescription Drugs or Related Supplies. When your Physician advises you that coverage for the Prescription Drugs or Related Supplies has been approved, you should contact the Pharmacy to fill the prescription(s).

If the request is denied, your Physician and you will be notified that coverage for the Prescription Drugs or Related Supplies is not authorized.

If you disagree with a coverage decision, you may appeal that decision in accordance with the provisions of the Policy, by submitting a written request stating why the Prescription Drugs or Related Supplies should be covered.

If you have questions about a specific prior authorization request, you should call Member Services at the toll-free number on the ID card.

All drugs newly approved by the Food and Drug Administration (FDA) are designated as either non-Preferred or non-Prescription Drug List drugs until the

P & T Committee clinically evaluates the Prescription Drug for a different designation.

Prescription Drugs that represent an advance over available therapy according to the FDA will be reviewed by the P&T Committee within six months after FDA approval. Prescription Drugs that appear to have therapeutic qualities similar to those of an already marketed drug according to the FDA, will not be reviewed by the P&T Committee for at least six months after FDA approval. In the case of compelling clinical data, an ad hoc group will be formed to make an interim decision on the merits of a Prescription Drug.

## **Your Payments**

Coverage for Prescription Drugs and Related Supplies purchased at a Pharmacy is subject to the Copayment or Coinsurance shown in the Schedule. Please refer to the Schedule for any required Copayments, Coinsurance, or Maximums if applicable.

When a treatment regimen contains more than one type of Prescription Drugs which are packaged together for your, or your Dependent's convenience, a Copayment will apply to each Prescription Drug.

## **Exclusions**

No payment will be made for the following expenses:

- drugs available over the counter that do not require a prescription by federal or state law;
- any drug that is a pharmaceutical alternative to an over-the-counter drug other than insulin;
- a drug class in which at least one of the drugs is available over the counter and the drugs in the class are deemed to be therapeutically equivalent as determined by the P&T Committee;
- injectable infertility drugs and any injectable drugs that require Physician supervision and are not typically considered self-administered drugs. The following are examples of Physician supervised drugs: Injectables used to treat hemophilia and RSV (respiratory syncytial virus), chemotherapy injectables and endocrine and metabolic agents.
- any drugs that are experimental or investigational as described under the Medical "Exclusions" section of your certificate;

- Food and Drug Administration (FDA) approved drugs used for purposes other than those approved by the FDA unless the drug is recognized for the treatment of the particular indication in one of the standard reference compendia (The United States Pharmacopeia Drug Information, The American Medical Association Drug Evaluations; or The American Hospital Formulary Service Drug Information) or in medical literature. Medical literature means scientific studies published in a peer-reviewed national professional medical journal;
- prescription and nonprescription supplies (such as ostomy supplies), devices, and appliances other than Related Supplies;
- implantable contraceptive products;
- any fertility drug;
- drugs used for the treatment of sexual dysfunction, including, but not limited to erectile dysfunction, delayed ejaculation, anorgasm, and decreased libido;
- prescription vitamins (other than prenatal vitamins), dietary supplements, and fluoride products;
- drugs used for cosmetic purposes such as drugs used to reduce wrinkles, drugs to promote hair growth as well as drugs used to control perspiration and fade cream products;
- diet pills or appetite suppressants (anorectics);
- prescription smoking cessation products;
- immunization agents, biological products for allergy immunization, biological sera, blood, blood plasma and other blood products or fractions and medications used for travel prophylaxis;
- replacement of Prescription Drugs and Related Supplies due to loss or theft;
- drugs used to enhance athletic performance;
- drugs which are to be taken by or administered to you while you are a patient in a licensed Hospital, Skilled Nursing Facility, rest home or similar institution which operates on its premises or allows to be operated on its premises a facility for dispensing pharmaceuticals;
- prescriptions more than one year from the original date of issue.

Other limitations are shown in the Medical “Exclusions” section.

## **Reimbursement/Filing a Claim**

When you or your Dependents purchase your Prescription Drugs or Related Supplies through a retail Participating Pharmacy, you pay any applicable Copayment, Coinsurance or Deductible shown in the Schedule at the time of purchase. You do not need to file a claim form.

To purchase Prescription Drugs or Related Supplies from a mail-order Participating Pharmacy, see your mail-order drug introductory kit for details, or contact member services for assistance.

See your Employer's Benefit Plan Administrator to obtain the appropriate claim form.

## **Exclusions, Expenses Not Covered and General Limitations on Medical/Behavioral Health Benefits**

Additional coverage limitations determined by plan or provider type are shown in the Schedule. Payment for the following is specifically excluded from this plan:

- expenses for supplies, care, treatment, or surgery that are not Medically Necessary.
- to the extent that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid.
- to the extent that payment is unlawful where the person resides when the expenses are incurred.
- charges made by a Hospital owned or operated by or which provides care or performs services for, the United States Government, if such charges are directly related to a military-service-connected Injury or Sickness.
- for or in connection with an Injury or Sickness which is due to war, declared or undeclared.
- charges which you are not obligated to pay or for which you are not billed or for which you would not have been billed except that they were covered under this plan.
- assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other Custodial Services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.

- for or in connection with experimental, investigational or unproven services.

Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by the utilization review Physician to be:

- not demonstrated, through existing peer-reviewed, evidence-based, scientific literature to be safe and effective for treating or diagnosing the condition or sickness for which its use is proposed;
  - not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use;
  - the subject of review or approval by an Institutional Review Board for the proposed use except as provided in the “Clinical Trials” section of this plan; or
  - the subject of an ongoing phase I, II or III clinical trial, except as provided in the “Clinical Trials” section of this plan.
- cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one’s appearance.
  - regardless of clinical indication for macromastia or gynecomastia surgeries; abdominoplasty/panniculectomy; rhinoplasty; blepharoplasty; redundant skin surgery; removal of skin tags; acupressure; craniosacral/cranial therapy; dance therapy; movement therapy; applied kinesiology; rolfing; prolotherapy; and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions.
  - surgical or nonsurgical treatment of TMJ dysfunction.
  - for or in connection with treatment of the teeth or periodontium unless such expenses are incurred for: (a) charges made for a continuous course of dental treatment started within six months of an Injury to sound natural teeth (unless treatment was not medically advisable within such time period); (b) charges made by a Hospital for Bed and Board or Necessary Services and Supplies; (c) charges made by a Free-Standing Surgical Facility or the outpatient department of a Hospital in connection with surgery.
  - for medical and surgical services, initial and repeat, intended for the treatment or control of obesity including clinically severe (morbid) obesity, including: medical and surgical services to alter appearance or physical changes that are

the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a Physician or under medical supervision.

- unless otherwise covered in this plan, for reports, evaluations, physical examinations, or hospitalization not required for health reasons including, but not limited to, employment, insurance or government licenses, and court-ordered, forensic or custodial evaluations.
- court-ordered treatment or hospitalization, unless such treatment is prescribed by a Physician and listed as covered in this plan.
- transsexual surgery including medical or psychological counseling and hormonal therapy in preparation for, or subsequent to, any such surgery.
- any medications, drugs, services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation.
- medical and Hospital care and costs for the infant child of a Dependent, unless this infant child is otherwise eligible under this plan.
- nonmedical counseling or ancillary services, including but not limited to Custodial Services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return to work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, developmental delays, autism or mental retardation.
- therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including but not limited to routine, long term, or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Home Health Services" or "Breast Reconstruction and Breast Prostheses" sections of this plan.
- private Hospital rooms and/or private duty nursing except as provided under the **Home Health Services** provision.

- personal or comfort items such as personal care kits provided on admission to a Hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements, and other articles which are not for the specific treatment of an Injury or Sickness.
- artificial aids including, but not limited to, corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- hearing aids, including but not limited to semi-implantable hearing devices, audiant bone conductors and Bone Anchored Hearing Aids (BAHAs). A hearing aid is any device that amplifies sound.
- aids or devices that assist with nonverbal communications, including but not limited to communication boards, prerecorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- medical benefits for eyeglasses, contact lenses or examinations for prescription or fitting thereof, except that Covered Expenses will include the purchase of the first pair of eyeglasses, lenses, frames or contact lenses that follows keratoconus or cataract surgery.
- charges made for or in connection with routine refractions, eye exercises and for surgical treatment for the correction of a refractive error, including radial keratotomy, when eyeglasses or contact lenses may be worn.
- treatment by acupuncture.
- all noninjectable prescription drugs, injectable prescription drugs that do not require Physician supervision and are typically considered self-administered drugs, nonprescription drugs, and investigational and experimental drugs, except as provided in this plan.
- routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.
- membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- genetic screening or pre-implantations genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

- dental implants for any condition.
- fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in the utilization review Physician's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- blood administration for the purpose of general improvement in physical condition.
- cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
- cosmetics, dietary supplements and health and beauty aids.
- nutritional supplements and formulae except for infant formula needed for the treatment of inborn errors of metabolism.
- for or in connection with an Injury or Sickness arising out of, or in the course of, any employment for wage or profit.
- telephone, e-mail, and Internet consultations, and telemedicine.
- massage therapy.
- for charges which would not have been made if the person had no insurance.
- for medical plans to the extent that they are more than the Maximum Reimbursable Charges applicable to care, if any received out of network (for example, emergency care).
- expenses incurred outside the United States or Canada, unless you or your Dependent is a U.S. or Canadian resident and the charges are incurred while traveling on business or for pleasure.
- charges made by any covered provider who is a member of your family or your Dependent's family.
- to the extent of the exclusions imposed by any certification requirement shown in this plan.

### **Coordination of Benefits**

This section applies if you or any one of your Dependents is covered under more than one Plan and determines how benefits payable from all such Plans will be coordinated. You should file all claims with each Plan.

## **Definitions**

For the purposes of this section, the following terms have the meanings set forth below:

### **Plan**

Any of the following that provides benefits or services for medical care or treatment:

- (1) Group insurance and/or group-type coverage, whether insured or self-insured which neither can be purchased by the general public, nor is individually underwritten, including closed panel coverage.
- (2) Coverage under Medicare and other governmental benefits as permitted by law, excepting Medicaid and Medicare supplement policies.
- (3) Medical benefits coverage of group, group-type, and individual automobile contracts.

Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

### **Closed Panel Plan**

A Plan that provides medical or dental benefits primarily in the form of services through a panel of employed or contracted providers, and that limits or excludes benefits provided by providers outside of the panel, except in the case of emergency or if referred by a provider within the panel.

### **Primary Plan**

The Plan that determines and provides or pays benefits without taking into consideration the existence of any other Plan.

### **Secondary Plan**

A Plan that determines, and may reduce its benefits after taking into consideration, the benefits provided or paid by the Primary Plan. A Secondary Plan may also recover from the Primary Plan the Reasonable Cash Value of any services it provided to you.

### **Allowable Expense**

A necessary, reasonable and customary service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any Plan covering you. When a Plan provides benefits in the form of services, the

Reasonable Cash Value of each service is the Allowable Expense and is a paid benefit.

Examples of expenses or services that are not Allowable Expenses include, but are not limited to the following:

- (1) An expense or service or a portion of an expense or service that is not covered by any of the Plans is not an Allowable Expense.
- (2) If you are confined to a private Hospital room and no Plan provides coverage for more than a semiprivate room, the difference in cost between a private and semiprivate room is not an Allowable Expense.
- (3) If you are covered by two or more Plans that provide services or supplies on the basis of reasonable and customary fees, any amount in excess of the highest reasonable and customary fee is not an Allowable Expense.
- (4) If you are covered by one Plan that provides services or supplies on the basis of reasonable and customary fees and one Plan that provides services and supplies on the basis of negotiated fees, the Primary Plan's fee arrangement shall be the Allowable Expense.
- (5) If your benefits are reduced under the Primary Plan (through the imposition of a higher copayment amount, higher coinsurance percentage, a deductible and/or a penalty) because you did not comply with Plan provisions or because you did not use a preferred provider, the amount of the reduction is not an Allowable Expense. Such Plan provisions include second surgical opinions and precertification of admissions or services.

### **Claim Determination Period**

A calendar year, but does not include any part of a year during which you are not covered under this policy or any date before this section or any similar provision takes effect.

### **Reasonable Cash Value**

An amount which a duly licensed provider of health care services usually charges patients and which is within the range of fees usually charged for the same service by other health care providers located within the immediate geographic area where the health care service is rendered under similar or comparable circumstances.

### **Order of Benefit Determination Rules**

A Plan that does not have a coordination of benefits rule consistent with this section shall always be the Primary Plan. If the Plan does have a coordination of

benefits rule consistent with this section, the first of the following rules that applies to the situation is the one to use:

- (1) The Plan that covers you as an enrollee or an employee shall be the Primary Plan and the Plan that covers you as a Dependent shall be the Secondary Plan;
- (2) If you are a Dependent child whose parents are not divorced or legally separated, the Primary Plan shall be the Plan which covers the parent whose birthday falls first in the calendar year as an enrollee or employee;
- (3) If you are the Dependent of divorced or separated parents, benefits for the Dependent shall be determined in the following order:
  - (a) first, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the Plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - (b) then, the Plan of the parent with custody of the child;
  - (c) then, the Plan of the spouse of the parent with custody of the child;
  - (d) then, the Plan of the parent not having custody of the child, and
  - (e) finally, the Plan of the spouse of the parent not having custody of the child.
- (4) The Plan that covers you as an active employee (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (5) The Plan that covers you under a right of continuation which is provided by federal or state law shall be the Secondary Plan and the Plan that covers you as an active employee or retiree (or as that employee's Dependent) shall be the Primary Plan. If the other Plan does not have a similar provision and, as a result, the Plans cannot agree on the order of benefit determination, this paragraph shall not apply.
- (6) If one of the Plans that covers you is issued out of the state whose laws govern this Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.

If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.

When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended except for anyone who is Disabled or diagnosed with End Stage Renal Disease for 30 months or less, in which case this Plan will be the Primary Plan. However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

### **Effect on the Benefits of This Plan**

If this Plan is the Secondary Plan, this Plan may reduce benefits so that the total benefits paid by all Plans during a Claim Determination Period are not more than 100% of the total of all Allowable Expenses.

The difference between the amount that this Copay Plan option would have paid if it had been the Primary Plan, and the benefit payments that this Copay Plan option had actually paid as the Secondary Plan, will be recorded as a benefit reserve for you. Thus, the benefit reserve results from benefit savings determined from the Copay Plan's original liability minus the Copay Plan's actual payment after coordinating benefits. CIGNA will use this benefit reserve to pay any Allowable Expense (e.g., your future covered out-of-pocket expenses) not otherwise paid during the Claim Determination Period.

As each claim is submitted, CIGNA will determine the following:

- (1) CIGNA's obligation to provide services and supplies under this Copay plan option;
- (2) whether a benefit reserve has been recorded for you; and
- (3) whether there are any unpaid Allowable Expenses during the Claims Determination Period.

If there is a benefit reserve, CIGNA will use the benefit reserve recorded for you to pay up to 100% of the total of all Allowable Expenses. At the end of the Claim Determination Period, your benefit reserve will return to zero and a new benefit reserve will be calculated for each new Claim Determination Period.

### **Recovery of Excess Benefits**

If CIGNA pays charges for benefits that should have been paid by the Primary Plan, or if CIGNA pays charges in excess of those for which the Plan is obligated

to provide under the Policy, CIGNA will have the right to recover the actual payment made or the Reasonable Cash Value of any services.

CIGNA will have sole discretion to seek such recovery from any person to, or for whom, or with respect to whom, such services were provided or such payments made by any insurance company, healthcare plan or other organization. If the Plan request, you must execute and deliver to us such instruments and documents as the Plan determines are necessary to secure the right of recovery.

### **Right to Receive and Release Information**

CIGNA, without consent or notice to you, may obtain information from and release information to any other Plan with respect to you in order to coordinate your benefits pursuant to this section. You must provide us with any information we request in order to coordinate your benefits pursuant to this section. This request may occur in connection with a submitted claim; if so, you will be advised that the "other coverage" information, (including an Explanation of Benefits paid under the Primary Plan) is required before the claim will be processed for payment. If no response is received within 90 days of the request, the claim will be denied. If the requested information is subsequently received, the claim will be processed.

### **Medicare Eligibles**

CIGNA will pay as the Secondary Plan as permitted by the Social Security Act of 1965 as amended for the following:

- (a) a former Employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this Copay plan option;
- (b) a former Employee's Dependent, or a former Dependent Spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this Copay plan option;
- (c) an Employee, retired Employee, Employee's Dependent or retired Employee's Dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

CIGNA will assume the amount payable under:

- Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
- Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.

- Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.

A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.

This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (c) above.

### **Domestic Partners**

Under federal law, the Medicare Secondary Payer Rules do not apply to Domestic Partners covered under a group health plan. Therefore, Medicare is always the Primary Plan for a person covered as a Domestic Partner, and CIGNA is the Secondary Plan.

### **Expenses For Which A Third Party May Be Responsible**

The Copay Plan option does not cover:

1. Expenses incurred by you or your Dependent (hereinafter individually and collectively referred to as a "Participant,") for which another party may be responsible as a result of having caused or contributed to an Injury or Sickness.
2. Expenses incurred by a Participant to the extent any payment is received for them either directly or indirectly from a third party tortfeasor or as a result of a settlement, judgment or arbitration award in connection with any automobile medical, automobile no-fault, uninsured or underinsured motorist, homeowners, workers' compensation, government insurance (other than Medicaid), or similar type of insurance or coverage.

### **Subrogation/Right of Reimbursement**

If a Participant incurs a Covered Expense for which, in the opinion of the plan or its claim administrator, another party may be responsible or for which the Participant may receive payment as described above:

1. Subrogation: The plan shall, to the extent permitted by law, be subrogated to all rights, claims or interests that a Participant may have against such party and shall automatically have an equitable lien upon the proceeds of any recovery by a Participant from such party to the extent of any benefits paid under the plan and such lien shall have first priority over such proceeds. Any proceeds received by a Participant from such third party shall be held by the Participant in a segregated account in a constructive trust for the benefit of the TI Employee

Health Benefit Plan. A Participant or his/her representative shall execute such documents as may be required to secure the plan's subrogation rights.

2. Right of Reimbursement: The plan is also granted a right of reimbursement from the proceeds of any recovery whether by settlement, judgment, or otherwise. This right of reimbursement is cumulative with and not exclusive of the subrogation right granted in paragraph 1, but only to the extent of the benefits provided by the plan.

### **Lien of the Plan**

By accepting benefits under this plan, a Participant:

- grants a lien and assigns to the plan an amount equal to the benefits paid under the plan against any recovery made by or on behalf of the Participant which is binding on any attorney or other party who represents the Participant whether or not an agent of the Participant or of any insurance company or other financially responsible party against whom a Participant may have a claim provided said attorney, insurance carrier or other party has been notified by the plan or its agents;
- agrees that this lien shall constitute a charge against the proceeds of any recovery and the plan shall be entitled to assert a security interest thereon;
- agrees to hold the proceeds of any recovery in trust for the benefit of the plan to the extent of any payment made by the plan.

### **Additional Terms**

- No adult Participant hereunder may assign any rights that it may have to recover medical expenses from any third party or other person or entity to any minor Dependent of said adult Participant without the prior express written consent of the plan. The plan's right to recover shall apply to decedents', minors', and incompetent or disabled persons' settlements or recoveries.
- No Participant shall make any settlement, which specifically reduces or excludes, or attempts to reduce or exclude, the benefits provided by the plan.
- The plan's right of recovery shall be a prior lien against any proceeds recovered by the Participant. This right of recovery shall not be defeated nor reduced by the application of any so-called "Made-Whole Doctrine", "Rimes Doctrine", or any other such doctrine purporting to defeat the plan's recovery rights by allocating the proceeds exclusively to non-medical expense damages.
- No Participant hereunder shall incur any expenses on behalf of the plan in pursuit of the plan's rights hereunder, specifically; no court costs, attorneys'

fees or other representatives' fees may be deducted from the plan's recovery without the prior express written consent of the plan. This right shall not be defeated by any so-called "Fund Doctrine", "Common Fund Doctrine", or "Attorney's Fund Doctrine".

- The plan shall recover the full amount of benefits provided hereunder without regard to any claim of fault on the part of any Participant, whether under comparative negligence or otherwise.
- In the event that a Participant shall fail or refuse to honor its obligations hereunder, then the plan shall be entitled to recover any costs incurred in enforcing the terms hereof including, but not limited to, attorney's fees, litigation, court costs, and other expenses. The plan shall also be entitled to offset the reimbursement obligation against any entitlement to future medical benefits hereunder until the Participant has fully complied with his reimbursement obligations hereunder, regardless of how those future medical benefits are incurred.
- Any reference to state law in any other provision of this plan shall not be applicable to this provision, if the plan is governed by ERISA. By acceptance of benefits under the plan, the Participant agrees that a breach hereof would cause irreparable and substantial harm and that no adequate remedy at law would exist. Further, the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien and/or constructive trust, as well as injunctive relief.

## **Payment of Benefits**

### **To Whom Payable**

All Medical Benefits are payable to you. However, at the option of CIGNA, all or any part of them may be paid directly to the person or institution on whose charge claim is based.

Medical Benefits are not assignable unless agreed to by CIGNA. CIGNA may, at its option, make payment to you for the cost of any Covered Expenses received by you or your Dependent from a Non-Participating Provider even if benefits have been assigned. When benefits are paid to you or your Dependent, you or your Dependent is responsible for reimbursing the Provider. If any person to whom benefits are payable is a minor or, in the opinion of CIGNA, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. If no request for payment has been made by his legal guardian, CIGNA may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

If you die while any of these benefits remain unpaid, CIGNA may choose to make direct payment to any of your following living relatives: spouse, mother, father, child or children, brothers or sisters; or to the executors or administrators of your estate.

Payment as described above will release CIGNA from all liability to the extent of any payment made.

### **Time of Payment**

Benefits will be paid by CIGNA when it receives due proof of loss.

### **Recovery of Overpayment**

When an overpayment has been made by CIGNA, CIGNA will have the right at any time to: (a) recover that overpayment from the person to whom or on whose behalf it was made; or (b) offset the amount of that overpayment from a future claim payment.

### **Calculation of Covered Expenses**

CIGNA, in its discretion, will calculate Covered Expenses following evaluation and validation of all provider billings in accordance with:

- the methodologies in the most recent edition of the Current Procedural terminology.
- the methodologies as reported by generally recognized professionals or publications.

### **Termination of Coverage**

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

- Date you die
- Date the plan is discontinued or amended to eliminate TI Extended Health Benefits Coverage
- 30 days following the due date of a required cost, if any, if it remains unpaid. See important note in Cost – Who Pays section.

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

- Date a dependent becomes covered as a Tler
- Date the dependent does not meet the definition of an eligible dependent

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

## **Death**

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

**Death on or after January 1, 1998** -- TI Extended Health Benefits Coverage must be elected within 30 days of your death, by at least one survivor. If your survivors do not enroll in dental coverage through TI Extended Health Benefits Coverage within 30 days of your death, they will only be eligible to enroll for dental coverage in the event of an appropriate qualified status change or during annual enrollment as long as they are enrolled in medical coverage through TI Extended Health Benefits Coverage. If none of your survivors enroll in medical coverage through TI Extended Health Benefits Coverage, or if they all opt out at a later date, none of the survivors will be eligible to enroll for medical or dental coverage through TI Extended Health Benefits Coverage in the future.

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

## **Federal Requirements**

The following pages explain your rights and responsibilities under federal laws and regulations. Some states may have similar requirements. If a similar provision appears elsewhere in this booklet, the provision which provides the better benefit will apply.

## **Notice Regarding Provider/Pharmacy Directories and Provider/Pharmacy Networks**

You may access a list of Providers who participate in the network by visiting [www.cigna.com](http://www.cigna.com); [mycigna.com](http://mycigna.com) or by calling the toll-free telephone number on your ID card.

Your Participating Provider/Pharmacy networks consist of a group of local medical practitioners, and Hospitals, of varied specialties as well as general practice or a group of local Pharmacies who are employed by or contracted with CIGNA HealthCare.

### **Coverage for Maternity Hospital Stay**

Group health plans and health insurance issuers offering group health insurance coverage generally may not, under a federal law known as the “Newborns’ and Mothers’ Health Protection Act”: restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section; or require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay not in excess of the above periods. The law generally does not prohibit an attending provider of the mother or newborn, in consultation with the mother, from discharging the mother or newborn earlier than 48 or 96 hours, as applicable.

Please review this Plan for further details on the specific coverage available to you and your Dependents.

### **Women’s Health and Cancer Rights Act (WHCRA)**

Do you know that your plan, as required by the Women’s Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedema? Call Member Services at the toll free number listed on your ID card for more information.

### **Group Plan Coverage Instead of Medicaid**

If your income and liquid resources do not exceed certain limits established by law, the state may decide to pay premiums for this coverage instead of for Medicaid, if it is cost effective. This includes premiums for continuation coverage required by federal law.

### **Claim Determination Procedures Under ERISA**

#### **Procedures Regarding Medical Necessity Determinations**

In general, health services and benefits must be Medically Necessary to be covered under the plan. The procedures for determining Medical Necessity vary, according to the type of service or benefit requested, and the type of health plan.

Medical Necessity determinations are made on either a preservice, concurrent, or postservice basis, as described below:

Certain services require prior authorization in order to be covered. This prior authorization is called a "preservice medical necessity determination." The Certificate describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request Medical Necessity determinations according to the procedures described below, in the Certificate, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not Medically Necessary, you or your representative will receive a written description of the adverse determination, and may appeal the determination. Appeal procedures are described in the Certificate, in your provider's network participation documents, and in the determination notices.

### **Preservice Medical Necessity Determinations**

When you or your representative request a required Medical Necessity determination prior to care, CIGNA will notify you or your representative of the determination within 15 days after receiving the request. However, if more time is needed due to matters beyond CIGNA's control, CIGNA will notify you or your representative within 15 days after receiving your request. This notice will include the date a determination can be expected, which will be no more than 30 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to CIGNA within 45 days after receiving the notice. The determination period will be suspended on the date CIGNA sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

If the determination periods above would (a) seriously jeopardize your life or health, your ability to regain maximum function, or (b) in the opinion of a Physician with knowledge of your health condition, cause you severe pain which cannot be managed without the requested services, CIGNA will make the preservice determination on an expedited basis. CIGNA's Physician reviewer, in consultation with the treating Physician, will decide if an expedited determination is necessary. CIGNA will notify you or your representative of an expedited determination within 72 hours after receiving the request.

However, if necessary information is missing from the request, CIGNA will notify you or your representative within 24 hours after receiving the request to specify

what information is needed. You or your representative must provide the specified information to CIGNA within 48 hours after receiving the notice. CIGNA will notify you or your representative of the expedited benefit determination within 48 hours after you or your representative responds to the notice. Expedited determinations may be provided orally, followed within 3 days by written or electronic notification.

If you or your representative fails to follow CIGNA's procedures for requesting a required preservice medical necessity determination, CIGNA will notify you or your representative of the failure and describe the proper procedures for filing within 5 days (or 24 hours, if an expedited determination is required, as described above) after receiving the request. This notice may be provided orally, unless you or your representative requests written notification.

### **Concurrent Medical Necessity Determinations**

When an ongoing course of treatment has been approved for you and you wish to extend the approval, you or your representative must request a required concurrent Medical Necessity determination at least 24 hours prior to the expiration of the approved period of time or number of treatments. When you or your representative requests such a determination, CIGNA will notify you or your representative of the determination within 24 hours after receiving the request.

### **Postservice Medical Necessity Determinations**

When you or your representative requests a Medical Necessity determination after services have been rendered, CIGNA will notify you or your representative of the determination within 30 days after receiving the request. However, if more time is needed to make a determination due to matters beyond CIGNA's control CIGNA will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request.

If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information to CIGNA within 45 days after receiving the notice. The determination period will be suspended on the date CIGNA sends such a notice of missing information, and the determination period will resume on the date you or your representative responds to the notice.

### **Postservice Claim Determinations**

When you or your representative requests payment for services which have been rendered, CIGNA will notify you of the claim payment determination within 30 days after receiving the request. However, if more time is needed to make a

determination due to matters beyond CIGNA's control, CIGNA will notify you or your representative within 30 days after receiving the request. This notice will include the date a determination can be expected, which will be no more than 45 days after receipt of the request. If more time is needed because necessary information is missing from the request, the notice will also specify what information is needed, and you or your representative must provide the specified information within 45 days after receiving the notice. The determination period will be suspended on the date CIGNA sends such a notice of missing information, and resume on the date you or your representative responds to the notice.

### **Notice of Adverse Determination**

Every notice of an adverse benefit determination will be provided in writing or electronically, and will include all of the following that pertain to the determination: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; (4) a description of the plan's review procedures and the time limits applicable, including a statement of a claimant's rights to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal; (5) 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 claim, and 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; and (6) in the case of a claim involving urgent care, a description of the expedited review process applicable to such claim.

### **When You Have a Complaint or an Appeal**

For the purposes of this section, any reference to "you," "your," or "Member" also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

"Physician Reviewers" are licensed Physicians depending on the care, service or treatment under review.

We want you to be completely satisfied with the care you receive. That is why we have established a process for addressing your concerns and solving your problems.

## **Start With Member Services**

We are here to listen and help. If you have a concern regarding a person, a service, the quality of care, or contractual benefits, you may call the toll-free number on your Benefit Identification card, explanation of benefits, or claim form and explain your concern to one of our Member Services representatives. You may also express that concern in writing.

We will do our best to resolve the matter on your initial contact. If we need more time to review or investigate your concern, we will get back to you as soon as possible, but in any case within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals procedure.

## **Appeals Procedure**

CIGNA has a two-step appeals procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal in writing to CIGNA within 365 days of receipt of a denial notice. If you are unable or choose not to write, you may ask CIGNA to register your appeal by telephone. Call or write us at the toll-free number on your Benefit Identification card, explanation of benefits, or claim form.

You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. You may submit additional evidence and testimony in support of your appeal and if any new evidence is provided by the Plan or any new rationale is considered by the Plan Administrator in making the decision, you must receive notice of such new evidence and new rationale and have an opportunity to respond. You must respond within the time period during which the Plan Administrator is considering 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.

## **Level-One Appeal**

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

For level-one appeals, we will respond in writing with a decision within 15 calendar days after we receive an appeal for a required preservice or concurrent care coverage determination, and within 30 calendar days after we received an appeal for a postservice coverage determination. If more time or information is needed to make the determination, we 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.

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 functionality 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 nonauthorization of an admission or continuing inpatient Hospital stay. CIGNA's Physician reviewer, in consultation with the treating Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

### **Level-Two Appeal**

If you are dissatisfied with our level-one appeal decision, you may request a second review. To initiate a level-two appeal, follow the same process required for a level-one appeal.

Most requests for a second review will be conducted by the Committee, which consists of a minimum of three people. Anyone involved in the prior decision may not vote on the Committee. For appeals involving Medical Necessity or clinical appropriateness the Committee will consult with at least one Physician in the same or similar specialty as the care under consideration, as determined by CIGNA's Physician reviewer. You may present your situation to the Committee in person or by conference call.

For level-two appeals we will acknowledge in writing that we have received your request and schedule a Committee review. For required preservice and concurrent care coverage determinations the Committee review will be completed within 15 calendar days and for post service claims, the Committee review will be completed within 30 calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to 15 calendar days and to specify any additional information needed by the Committee to complete the review. You will be notified in writing of the Committee's decision within 5 business days after the Committee meeting, and within the Committee review time frames above if the Committee does not approve the requested coverage.

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 functionality 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 nonauthorization of an admission or continuing inpatient Hospital stay. CIGNA's Physician reviewer, in consultation with the treating

Physician, will decide if an expedited appeal is necessary. When an appeal is expedited, CIGNA will respond orally with a decision within 72 hours, followed up in writing.

### **Notice of Benefit Determination on Appeal**

Every notice of a determination on appeal will be provided in writing or electronically and, if an adverse determination, will include: (1) the specific reason or reasons for the adverse determination; (2) reference to the specific plan provisions on which the determination is based; (3) 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; (4) 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); (5) 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, and 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 and (6) the information necessary to identify the claim, including the date of service, healthcare provider, claim amount and diagnosis code and its meaning and the treatment code and its corresponding meaning and a description of the Plan's standard used in denying the claim and a description of available internal appeals and external appeal procedures, including information regarding how to initiate an appeal, and contact information for the office of health insurance consumer assistance or the ombudsman.

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 and your State insurance regulatory agency. You may also contact the Plan Administrator.

### **Relevant Information**

Relevant information is any document, record or other information which: (a) was 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 federal law 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 for the claimant's

diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

### **Legal Action**

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 CIGNA until you have completed the Level-One and Level-Two appeal processes. If your appeal is expedited, there is no need to complete the Level-Two process prior to bringing legal action.

### **Discretionary Authority**

The Plan Administrator delegates to CIGNA the discretionary authority to interpret and apply plan terms and to make factual determinations in connection with its review of claims under the plan. Such discretionary authority is intended to include, but not limited to, the determination of the eligibility of persons desiring to enroll in or claim benefits under the plan, the determination of whether a person is entitled to benefits under the plan, and the computation of any and all benefit payments. The Plan Administrator also delegates to CIGNA the discretionary authority to perform a full and fair review, as required by ERISA, of each claim denial which has been appealed by the claimant or his duly authorized representative.

### **Plan Modification, Amendment and Termination**

The Employer as Plan Sponsor reserves the right to, at any time, change or terminate benefits under the Plan, to change or terminate the eligibility of classes of employees to be covered by the Plan, to amend or eliminate any other plan term or condition, and to terminate the whole plan or any part of it. The procedure by which benefits may be changed or terminated, by which the eligibility of classes of employees may be changed or terminated, or by which part or all of the Plan may be terminated, is contained in the Employer's Plan Document, which is available for inspection and copying from the Plan Administrator designated by the Employer. No consent of any participant is required to terminate, modify, amend or change the Plan.

Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any covered medical expenses incurred prior to the date that Plan terminates. Likewise, any extension of benefits under the policy(s) due to you or your Dependent's total disability which began prior to and has continued beyond the date the Plan terminates will not be affected by the Plan termination. A subsequent Plan termination will not affect the extension of benefits and rights under the policy(s).

Your coverage under the Plan's insurance policy(s) will end on the earliest of the following dates:

- the date you leave Active Service;
- the date you are no longer in an eligible class;
- if the Plan is contributory, the date you cease to contribute;
- the date the policy(s) terminates.

See your Plan Administrator to determine if any extension of benefits or rights are available to you or your Dependents under this policy(s). No extension of benefits or rights will be available solely because the Plan terminates.

## **Definitions**

### **Active Service**

You will be considered in Active Service:

- on any of your Employer's scheduled work days if you are performing the regular duties of your work on a full-time basis on that day either at your Employer's place of business or at some location to which you are required to travel for your Employer's business.
- on a day which is not one of your Employer's scheduled work days if you were in Active Service on the preceding scheduled work day.

### **Bed and Board**

The term Bed and Board includes all charges made by a Hospital on its own behalf for room and meals and for all general services and activities needed for the care of registered bed patients.

### **Charges**

The term "charges" means the actual billed charges; except when the provider has contracted directly or indirectly with CIGNA for a different amount.

### **Chiropractic Care**

The term Chiropractic Care means the conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function.

## **Custodial Services**

Any services that are of a sheltering, protective, or safeguarding nature. Such services may include a stay in an institutional setting, at-home care, or nursing services to care for someone because of age or mental or physical condition. This service primarily helps the person in daily living. Custodial care also can provide medical services, given mainly to maintain the person's current state of health. These services cannot be intended to greatly improve a medical condition; they are intended to provide care while the patient cannot care for himself or herself. Custodial Services include but are not limited to:

- Services related to watching or protecting a person;
- Services related to performing or assisting a person in performing any activities of daily living, such as: (a) walking, (b) grooming, (c) bathing, (d) dressing, (e) getting in or out of bed, (f) toileting, (g) eating, (h) preparing foods, or (i) taking medications that can be self administered, and
- Services not required to be performed by trained or skilled medical or paramedical personnel.

## **Emergency Services**

Emergency services are medical, psychiatric, surgical, Hospital and related health care services and testing, including ambulance service, which are required to treat a sudden, unexpected onset of a bodily Injury or serious Sickness which could reasonably be expected by a prudent layperson to result in serious medical complications, loss of life or permanent impairment to bodily functions in the absence of immediate medical attention. Examples of emergency situations include uncontrolled bleeding, seizures or loss of consciousness, shortness of breath, chest pains or severe squeezing sensations in the chest, suspected overdose of medication or poisoning, sudden paralysis or slurred speech, burns, cuts and broken bones. The symptoms that led you to believe you needed emergency care, as coded by the provider and recorded by the Hospital on the UB92 claim form, or its successor, or the final diagnosis, whichever reasonably indicated an emergency medical condition, will be the basis for the determination of coverage, provided such symptoms reasonably indicate an emergency. Emergency services shall with respect to an emergency condition include medical screening examinations that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate emergency medical conditions, and such further medical examinations and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital , as are required to stabilize the patient in compliance with 42 USC 1395dd.

## **Employee**

The term Employee means a full-time employee of the Employer who is currently in Active Service. The term does not include employees who are part-time or temporary or who normally work less than 20 hours a week for the Employer.

## **Employer**

The term Employer means Texas Instruments Incorporated, the plan sponsor self-insuring the benefits described in this booklet, on whose behalf CIGNA is providing claim administration services.

## **Expense Incurred**

An expense is incurred when the service or the supply for which it is incurred is provided.

## **Free-Standing Surgical Facility**

The term Free-standing Surgical Facility means an institution which meets all of the following requirements:

- it has a medical staff of Physicians, Nurses and licensed anesthesiologists;
- it maintains at least two operating rooms and one recovery room;
- it maintains diagnostic laboratory and x-ray facilities;
- it has equipment for emergency care;
- it has a blood supply;
- it maintains medical records;
- it has agreements with Hospitals for immediate acceptance of patients who need Hospital Confinement on an inpatient basis; and
- it is licensed in accordance with the laws of the appropriate legally authorized agency.

## **Hospice Care Program**

The term Hospice Care Program means:

- a coordinated, interdisciplinary program to meet the physical, psychological, spiritual and social needs of dying persons and their families;

- a program that provides palliative and supportive medical, nursing and other health services through home or inpatient care during the illness;
- a program for persons who have a Terminal Illness and for the families of those persons.

### **Hospice Care Services**

The term Hospice Care Services means any services provided by: (a) a Hospital, (b) a Skilled Nursing Facility or a similar institution, (c) a Home Health Care Agency, (d) a Hospice Facility, or (e) any other licensed facility or agency under a Hospice Care Program.

### **Hospice Facility**

The term Hospice Facility means an institution or part of it which:

- primarily provides care for Terminally Ill patients;
- is accredited by the National Hospice Organization;
- meets standards established by CIGNA; and
- fulfills any licensing requirements of the state or locality in which it operates.

### **Hospital**

The term Hospital means:

- an institution licensed as a hospital, which: (a) maintains, on the premises, all facilities necessary for medical and surgical treatment; (b) provides such treatment on an inpatient basis, for compensation, under the supervision of Physicians; and (c) provides 24-hour service by Registered Graduate Nurses;
- an institution which qualifies as a hospital, a psychiatric hospital or a tuberculosis hospital, and a provider of services under Medicare, if such institution is accredited as a hospital by the Joint Commission on the Accreditation of Healthcare Organizations; or
- an institution which: (a) specializes in treatment of Mental Health and Substance Abuse or other related illness; (b) provides residential treatment programs; and (c) is licensed in accordance with the laws of the appropriate legally authorized agency.

The term Hospital will not include an institution which is primarily a place for rest, a place for the aged, or a nursing home.

### **Hospital Confinement or Confined in a Hospital**

A person will be considered Confined in a Hospital if he is:

- a registered bed patient in a Hospital upon the recommendation of a Physician;
- receiving treatment for Mental Health and Substance Abuse Services in a Partial Hospitalization program;
- receiving treatment for Mental Health and Substance Abuse Services in a Mental Health or Substance Abuse Residential Treatment Center.

### **Injury**

The term Injury means an accidental bodily injury.

### **Maintenance Treatment**

The term Maintenance Treatment means:

- treatment rendered to keep or maintain the patient's current status.

### **Maximum Reimbursable Charge - Medical**

The Maximum Reimbursable Charge for covered services is determined based on the lesser of:

- the provider's normal charge for a similar service or supply; or
- a policyholder-selected percentile of charges made by providers of such service or supply in the geographic area where it is received as compiled in a database selected by CIGNA.

The percentile used to determine the Maximum Reimbursable Charge can be obtained by contacting Member Services/Customer Service.

The Maximum Reimbursable Charge is subject to all other benefit limitations and applicable coding and payment methodologies determined by CIGNA. Additional information about how CIGNA determines the Maximum Reimbursable Charge is available upon request.

## **Medicaid**

The term Medicaid means a state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965 as amended.

## **Medically Necessary/Medical Necessity**

Medically Necessary Covered Services and Supplies are those determined by the Medical Director to be:

- required to diagnose or treat an illness, injury, disease or its symptoms;
- in accordance with generally accepted standards of medical practice;
- clinically appropriate in terms of type, frequency, extent, site and duration;
- not primarily for the convenience of the patient, Physician or other health care provider; and
- rendered in the least intensive setting that is appropriate for the delivery of the services and supplies. Where applicable, the Medical Director may compare the cost-effectiveness of alternative services, settings or supplies when determining least intensive setting.

## **Medicare**

The term Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as amended.

## **Necessary Services and Supplies**

The term Necessary Services and Supplies includes:

- any charges, except charges for Bed and Board, made by a Hospital on its own behalf for medical services and supplies actually used during Hospital Confinement;
- any charges, by whomever made, for licensed ambulance service to or from the nearest Hospital where the needed medical care and treatment can be provided; and
- any charges, by whomever made, for the administration of anesthetics during Hospital Confinement.

The term Necessary Services and Supplies will not include any charges for special nursing fees, dental fees or medical fees.

## **Nurse**

The term Nurse means a Registered Graduate Nurse, a Licensed Practical Nurse or a Licensed Vocational Nurse who has the right to use the abbreviation "R.N.," "L.P.N." or "L.V.N."

## **Other Health Care Facility**

The term Other Health Care Facility means a facility other than a Hospital or hospice facility. Examples of Other Health Care Facilities include, but are not limited to, licensed skilled nursing facilities, rehabilitation Hospitals and subacute facilities.

## **Other Health Professional**

The term Other Health Professional means an individual other than a Physician who is licensed or otherwise authorized under the applicable state law to deliver medical services and supplies. Other Health Professionals include, but are not limited to physical therapists, registered nurses and licensed practical nurses.

## **Participating Pharmacy**

The term Participating Pharmacy means a retail pharmacy with which Connecticut General Life Insurance Company has contracted to provide prescription services to insureds; or a designated mail-order pharmacy with which CIGNA has contracted to provide mail-order prescription services to insureds.

## **Participating Provider**

The term Participating Provider means a hospital, a Physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with CIGNA to provide covered services with regard to a particular plan under which the participant is covered.

## **Pharmacy**

The term Pharmacy means a retail pharmacy, or a mail-order pharmacy.

## **Pharmacy & Therapeutics (P & T) Committee**

A committee of CIGNA Participating Providers, Medical Directors and Pharmacy Directors which regularly reviews Prescription Drugs and Related Supplies for safety and efficacy. The P&T Committee evaluates Prescription Drugs and Related Supplies for potential addition to or deletion from the Prescription Drug

List and may also set dosage and/or dispensing limits on Prescription Drugs and Related Supplies.

### **Physician**

The term Physician means a licensed medical practitioner who is practicing within the scope of his license and who is licensed to prescribe and administer drugs or to perform surgery. It will also include any other licensed medical practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Physician.

### **Prescription Drug**

Prescription Drug means; (a) a drug which has been approved by the Food and Drug Administration for safety and efficacy; (b) certain drugs approved under the Drug Efficacy Study Implementation review; or (c) drugs marketed prior to 1938 and not subject to review, and which can, under federal or state law, be dispensed only pursuant to a Prescription Order.

### **Prescription Drug List**

Prescription Drug List means a listing of approved Prescription Drugs and Related Supplies. The Prescription Drugs and Related Supplies included in the Prescription Drug List have been approved in accordance with parameters established by the P&T Committee. The Prescription Drug List is regularly reviewed and updated.

### **Prescription Order**

Prescription Order means the lawful authorization for a Prescription Drug or Related Supply by a Physician who is duly licensed to make such authorization within the course of such Physician's professional practice or each authorized refill thereof.

### **Preventive Treatment**

The term Preventive Treatment means:

- treatment rendered to prevent disease or its recurrence.

## **Primary Care Physician**

The term Primary Care Physician means a Physician: (a) who qualifies as a Participating Provider in general practice, internal medicine, family practice or pediatrics; and (b) who has been selected by you, as authorized by the Provider Organization, to provide or arrange for medical care for you or any of your insured Dependents.

## **Psychologist**

The term Psychologist means a person who is licensed or certified as a clinical psychologist. Where no licensure or certification exists, the term Psychologist means a person who is considered qualified as a clinical psychologist by a recognized psychological association. It will also include any other licensed counseling practitioner whose services are required to be covered by law in the locality where the policy is issued if he is:

- operating within the scope of his license; and
- performing a service for which benefits are provided under this plan when performed by a Psychologist.

## **Related Supplies**

Related Supplies means diabetic supplies (insulin needles and syringes, lancets and glucose test strips), needles and syringes for injectables covered under the pharmacy plan, and spacers for use with oral inhalers.

## **Review Organization**

The term Review Organization refers to an affiliate of CIGNA or another entity to which CIGNA has delegated responsibility for performing utilization review services. The Review Organization is an organization with a staff of clinicians which may include Physicians, Registered Graduate Nurses, licensed mental health and substance abuse professionals, and other trained staff members who perform utilization review services.

## **Sickness – For Medical Insurance**

The term Sickness means a physical or mental illness. It also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

## **Skilled Nursing Facility**

The term Skilled Nursing Facility means a licensed institution (other than a Hospital, as defined) which specializes in:

- physical rehabilitation on an inpatient basis; or
- skilled nursing and medical care on an inpatient basis;

but only if that institution: (a) maintains on the premises all facilities necessary for medical treatment; (b) provides such treatment, for compensation, under the supervision of Physicians; and (c) provides Nurses' services.

## **Terminal Illness**

A Terminal Illness will be considered to exist if a person becomes terminally ill with a prognosis of six months or less to live, as diagnosed by a Physician.

## **Urgent Care**

Urgent Care is medical, surgical, Hospital or related health care services and testing which are not Emergency Services, but which are determined by CIGNA, in accordance with generally accepted medical standards, to have been necessary to treat a condition requiring prompt medical attention. This does not include care that could have been foreseen before leaving the immediate area where you ordinarily receive and/or were scheduled to receive services. Such care includes, but is not limited to, dialysis, scheduled medical treatments or therapy, or care received after a Physician's recommendation that the insured should not travel due to any medical condition.

## REGIONAL HEALTH MAINTENANCE ORGANIZATIONS (HMOs)

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Most retirees can choose a Health Maintenance Organization (HMO) as an alternative to the Blue Cross Blue Shield PPOs or the CIGNA Copay Plan. Because TI offers different HMOs to retirees across the U.S., this section offers an overview of the services that HMOs generally provide. Details about each HMO can be obtained on the Fidelity NetBenefits® Web site on the Plan's "Detail" link or directly from the HMO.

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

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

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

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

Enrolling in an HMO may not be advisable if:

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

Before choosing a medical plan, you should carefully weigh the quality of the health care options available to you, the accessibility of that care and the cost.

**You cannot change your enrollment from a Blue Cross Blue Shield PPO, the CIGNA Copay Plan, or a regional HMO except during annual enrollment, or in the event of an appropriate qualified status change.**

## **Adding Newborn or Adopted Children**

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

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

## **Overview of Medicare**

Medicare is a federal medical coverage program that helps Americans age 65 and older, and some disabled people younger than 65, to pay for health care. Medicare has different types of benefits.

- Hospital coverage (Part A) helps pay for inpatient care and for certain follow-up care after you leave the hospital. This coverage is generally automatic when you attain age 65 if you have meet the working requirements.
- Medical coverage (Part B) helps pay for physicians' fees, outpatient services and many other medical items and services not covered under hospital coverage. You must elect and pay for this coverage.
- Hospital, medical and prescription drug coverage (Part C), which is referred to as an optional Medicare HMO, helps pay for Part A, Part B, and often Part D coverage. You must elect and pay for this coverage.
- Prescription drug coverage (Part D) may be added to your Part A and/or Part B coverage. You must elect and pay for this coverage.

Generally, everyone age 65 and older is eligible for Medicare. To enroll and ensure that you receive full protection, check with your Social Security office at least three months before you or your dependent spouse reaches age 65.

If you or your spouse applies for or is receiving Social Security retirement benefits, you will be enrolled automatically for Medicare hospital coverage (Part A). At the same time, you are eligible for Medicare medical coverage (Part B) and Medicare prescription drug coverage (Part D). You must elect and pay the required monthly premium (or have it deducted from your Social Security check) for such coverage.

When you or your spouse reaches age 65, your benefits will be paid as if you have Medicare Parts A and B for your primary coverage. However, you can continue having the Blue Cross Blue Shield PPO provide supplementary coverage. If you cannot receive supplementary coverage from your HMO after you retire, you may transfer to the Blue Cross Blue Shield PPO without a pre-existing condition limitation.

Automatic enrollment for Medicare (Parts A) may not be available to people who are age 65 and have not worked long enough to be eligible for Social Security retirement benefits on their own work record. They may, however, be eligible under their spouses' work record, provided their spouse is at least age 62 and eligible for Social Security benefits.

### **Medicare Prescription Drug Coverage (Medicare Part D) Information**

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

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

- **If you terminated employment on or after January 1, 1998:**

- If **you** choose to enroll in Medicare Prescription Drug Coverage, you and any covered family members will lose coverage under the TI Plan, and WILL NOT be eligible to re-enroll at any time. *This means medical and prescription drug coverage under the TI Plan ends for you and any covered family members. Once coverage ends, it cannot be reinstated.* Please plan carefully, because if you enroll for Medicare Prescription Drug Coverage, your family members will be left without medical and prescription drug coverage if they don't have coverage elsewhere.
- If **any of your covered family members** choose to enroll in Medicare Prescription Drug Coverage, they will lose their coverage under the TI Plan. *This means their medical and prescription drug coverage under the TI Plan ends.* If they drop their Medicare Prescription Drug Coverage, you will be able to re-enroll them for prescription drug coverage through the TI Plan during any annual

enrollment period or within 30 days of an appropriate qualified status change (provided that you notify TI through the Fidelity NetBenefits® Web site or the TI Benefits Center within the same thirty day period of the status change), as long as you remain enrolled in the TI Plan. If you drop coverage under the TI Plan, neither you nor your dependents can re-enroll in the TI Plan.

• **If you terminated employment prior to January 1, 1998:**

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

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

## Creditable Prescription Drug Coverage Notices

Below is a sample of the Creditable Prescription Drug Coverage Notice. You should have received a copy of this notice. If you didn't receive a copy of this notice, you can contact the TI Benefits Center at 888-660-1411 to request one.

### **Important Notice from Texas Instruments Incorporated About Your Prescription Drug Coverage and Medicare**

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Texas Instruments Incorporated (TI) and new prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

- 1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**
- 2. TI has determined that the prescription drug coverage offered by the TI Retiree Health Benefits Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage.**

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

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

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

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

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

TI has determined that the option(s) listed below is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is therefore considered Creditable Coverage:

- BCBS PPO A & B
- CIGNA Copay Plan
- Medex III
- Medex Standard
- SecureHorizon HMO – Rhode Island
- SecureHorizon HMO – Texas
- Regional HMOs

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

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

on or after January 1, 1998, in which case **once TI coverage ends, it cannot be reinstated.**

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

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

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

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

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

**For more information about your options under Medicare prescription drug coverage...**

More detailed information about Medicare plans that offer prescription drug coverage is in the **Medicare & You** handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. You can also get more information about Medicare prescription drug plans from the following:

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

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

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

## **HFC LivingFree - A Smoking Cessation Program- Internet Delivery**

The LivingFree program is a comprehensive internet training program available for smoking cessation. This program assists smokers and smokeless tobacco users to become tobacco-free.

“LivingFree – A Program for Smokers” is delivered in an engaging interactive format via the internet. The approach is both positive and motivational.

This three-week course includes the following:

- Animated audio presentations
- 20 to 30 minute daily sessions presenting four to five minute segments, each followed by an interactive exercise
- An interactive workbook enabling participants to practice applying program concepts to their lives
- Personalized feedback via audio messages, on-screen advice and emails to provide guidance throughout the course
- Community center with live call-in radio talk shows, on-line bulletin boards, and mentoring programs for personal support and motivation

When you sign up, you are a member of the site for 12 months. Members may take and retake the program up to 4 times during their membership. Members also have full access to the many site support and news features.

For more information and to enroll in the program online, go to [www.tialumni.org](http://www.tialumni.org). You can also call the Support Line at 877-719-9860 for technical assistance.

### **Continuation of Benefits (COBRA)**

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

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

ERISA PLAN, offered through the TI Retiree Health Benefit Plan

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### **A Quick Look at MetLife Dental (Basic and Plus) and DHMOs**

#### **MetLife Dental**

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

- Dental Basic
- Dental Plus

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

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

#### **DHMO**

Key features of the DHMO, available in your area, can be viewed on the Fidelity NetBenefits<sup>®</sup> Web site on the Plan's "Detail" link. The list of available DHMOs and contact information can be found in the beginning of this guide.

#### **Enrollment**

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

**If you terminate employment on or after January 1, 1998**, to have dental coverage offered through the TI Retiree Health Benefit Plan, you must elect TI Extended Health Benefits Coverage prior to or within 30 days from the date you

terminate employment or forego eligibility in the future. You may not opt in and out of TI Extended Health Benefits Coverage; once you elect it, you must continue paying costs without lapse in order to maintain coverage. If you don't enroll in dental coverage through TI Extended Health Benefits Coverage prior to or within 30 days from the date you terminated, you'll be eligible to enroll for coverage later (during annual enrollment or in the event of an appropriate qualified status change) as long as you're enrolled in medical coverage through TI Extended Health Benefits Coverage.

**If you terminated employment prior to January 1, 1998**, you remain under the enrollment rules in effect when you terminated. You may defer election of TI Extended Health Benefits Coverage at the time of your termination and remain eligible to re-enroll in the plan at any time in the future.

Regardless of your termination date, if you elect coverage, you may also enroll your eligible dependents, unless they are eligible for coverage under another health plan. In this case, you may not cover your dependents under this plan. If a dependent loses eligibility for coverage at a later date, it will be considered a qualified status change, and you may enroll the dependent at that time, as long as you remain enrolled in TI Extended Health Benefits Coverage. You may also add a dependent during any annual enrollment period.

### **When You Can Change 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.

### **Changes in Coverage**

During the annual enrollment period or within 30 days of an appropriate qualified status change, you may make changes in dental coverage by participating in annual enrollment, or by processing the Life Event change on the Fidelity NetBenefits<sup>®</sup> Web site (click on the "What To Do When" link on the "Health & Insurance" tab) or by contacting the TI Benefits Center. You must print your "Confirmation of Benefit Election" page; this will serve as your confirmation.

### **Effective Date of Coverage**

Coverage for you and your dependents will begin retroactive to your retirement date provided you enroll prior to or within the first 30 days of your retirement. Changes made during annual enrollment are effective on the first day of the year following annual enrollment. If you add coverage due to a qualified status change within 30 days, coverage takes effect retroactive to the date of the qualified status change.

## Newborn or Adopted Children

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

## Cost — Who Pays

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

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

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

## Your Benefits (Dental Basic and Dental Plus)

### Pre-Existing Condition Limitations

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

### What is Covered

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

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

**Network Providers** You can choose any dentist to obtain dental services. There is not a penalty if you do not use a MetLife dentist, but reasonable and customary

limits apply. Dentists in the MetLife network must negotiate their rates, resulting in lower fees. By having network prices, you and TI pay less for dental care. Reasonable and customary limits do not apply if you use network providers.

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

## How the Plan Pays

The following chart shows the amount of reimbursement available.

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

\* Annual deductible applies to Basic and Major services only

\*\* This is the maximum amount the plan will pay

\*\*\* The plan provides the alternate benefit of an amalgam filling for composite fillings performed on molar teeth.

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

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

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

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

### **How Reasonable and Customary is Determined**

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

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

### **Limitations and Exclusions (Dental Basic/Dental Plus)**

**The following are limitations:**

- Preventive/diagnostic exams – two per calendar year
- Cleanings – two per calendar year
- Periodontal cleanings – combined limit of four per calendar year, including two routine cleanings
- Periodontal scaling and root planing – once per quadrant in 24 consecutive months
- Periodontal surgery – once per quadrant in 36 consecutive months
- Bitewing x-rays one (1) set per calendar year for adults
- Bitewing x-rays one (1) set in six months per calendar year for child(ren)

- Topical application of fluoride – for children through age 17; limited to two per calendar year
- Sealants – for children through age 13, applies only to permanent premolars/molars, replacement limit of once every 60 consecutive months
- Complete intraoral x-ray series (including bitewings) OR panoramic film (without bitewings) – once during a period of 60 consecutive months
- Denture relining – covered if more than six months after installation; one per denture during any period of 36 consecutive months
- Denture adjustments – covered if more than six months after installation
- Temporomandibular joint dysfunction (TMJ) – maximum benefit per person is \$750. Surgical expenses associated with TMJ are not paid under the dental plan; however, they may be covered under your medical plan.

**The following are exclusions:**

- Treatment or service not performed by a licensed dentist, licensed physician or licensed dental hygienist acting under the direction of a licensed dentist
- Treatment or service performed primarily for cosmetic purposes, including facings and personalization of teeth
- Procedures, services or supplies that are not necessary or do not meet accepted standards of dental practice, including charges for experimental or investigational procedures
  - Experimental or investigational treatment includes procedures, treatments, care, services and supplies which do not represent a commonly accepted form of treatment; are not generally accepted by the dental community in the United States as effective, appropriate and essential for the treatment of a diagnosed condition; or are not proven effective in the treatment of an illness
- Covered procedures that are performed more frequently than the plan allows
- Replacing a lost or stolen prosthetic device
- Any duplicate prosthetic device or any other duplicate appliance
- A permanent prosthetic device received more than 12 months after receipt of the temporary device
- Oral hygiene, dietary instructions or plaque control program
- Expenses that would not have been charged if the Dental Plan did not exist, or expenses that you are not required to pay
- Treatment or service covered under Workers' Compensation or a similar program
- Replacement of an existing denture or fixed bridgework that was installed less than five years ago

- Replacement of an existing crown/inlay/onlay that was installed less than five years ago
- Dental expenses that are covered under the Blue Cross Blue Shield PPO (or HMO)
- The initial installation of any prosthesis including a denture, bridge or implant to replace one or more natural teeth lost before coverage began under a TI Dental Plan or as a replacement for congenitally missing natural teeth
- Services or supplies received by a covered person before the Dental Plan benefits start for that person
- Replacement of a lost, missing or stolen crown, bridge or denture
- Services or supplies received as a result of dental disease, defect or injury due to an act of war, or a warlike act in time of peace, which occurs while the Dental Plan benefits for the covered person are in effect
- Use of material or home health aids to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride for children through age 17
- Periodontal splinting
- Temporary or provisional restorations
- Temporary or provisional appliances
- Services or supplies furnished by a family member
- Accidents to sound, natural teeth

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

### **Alternate Benefits (Dental Basic/Dental Plus)**

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

## Pretreatment Estimate (Dental Basic/Dental Plus)

### When You Should Ask for an Estimate

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

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

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

- |                     |   |
|---------------------|---|
| <b>You</b>          | 1. Fill out the standard dental claim form, available from the Fidelity NetBenefits <sup>®</sup> Web site or MetLife, and take it to your dentist.                        |
| <b>Your Dentist</b> | 2. Fills in the description of the proposed treatment and its cost. (Be sure the dentist does not sign the section that certifies that the treatment has been completed.) |
|                     | 3. Submits the form to MetLife for review.  |
| <b>MetLife</b>      | 4. Reviews the proposed treatment and costs.<br>5. Tells you and your dentist approximately how much the plan will cover.   |

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

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

## Claiming Benefits

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

MetLife claim forms can be found on the Fidelity NetBenefits<sup>®</sup> Web site. From the “Home Page” tab, select the “Health & Insurance” tab. You can click on the

“Forms” link in the View column or select “All Health & Insurance Forms” at the bottom of the benefit summary. You can also obtain a claim form by contacting MetLife through TI HR Connect at 888-660-1411 or you can go to the [www.metlife.com/dental](http://www.metlife.com/dental) Web site. Fill in the patient information section on the claim form. Be sure to include your Social Security number and sign the form. Your dentist should complete the dentist's section of the form or provide an itemized bill for you to submit.

Claims should be sent to:

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

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

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

## **Claim Denial and Appeal Information**

### **If a Claim is Denied**

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

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

If MetLife determines that you are not entitled to receive all or part of the benefits you claim in a post-service claim for benefits (other than a claim involving concurrent care), a notice will be provided to you within a reasonable period of time, but no later than 30 days from the day your claim was received by MetLife. This notice (which will be provided to you in writing by mail, or hand delivery, or through e-mail) will describe (i) the Claims Administrator's determination, (ii) the

basis for the determination (along with appropriate references to pertinent Plan provisions on which the denial is based), and (iii) the procedure you must follow to obtain a review of the determination, including a description of the appeals procedure, and your right to bring a cause of action for benefits under section 502(a) of ERISA. This notice will also, if appropriate, explain how you may properly complete your claim and why the submission of additional information may be necessary.

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

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

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

### **MetLife Dental Basic and Dental Plus Plan Claim Appeals**

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

MetLife  
PO Box 14589  
Lexington, KY 40512

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

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

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

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

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

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

The notice describing MetLife's or the Plan Administrator's decision will describe (i) the specific reason or reasons for its 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, (iv) a description of any voluntary appeals procedures, if any, and your right to obtain information about such procedures, and (v) your right to bring a cause of action for benefits under section 502(a) of ERISA. If you do not agree with any of the Claims or Plan Administrators' decisions you must exhaust all levels of appeals provided by the Plan before you can proceed to court.

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

## **Coordination of Benefits**

If you have coverage under another group dental plan, MetLife Dental, like most dental plans, has a Coordination of Benefits (COB) provision. Under this provision, one of your plans is considered primary and the other secondary. The primary plan pays your expenses first.

For all retirees, the MetLife Dental annual and maximum benefit amounts will be reduced each time a secondary claim is submitted, regardless of whether the TI plan pays toward the claim.

How COB is determined depends on your age and retirement date:

- **If you retired on or after January 1, 1988, or you became either age 65 or eligible for Medicare after this date**, Maintenance of Benefits provisions are in effect. In this case, when MetLife Dental is secondary, the plan will pay the difference between what it would have paid as the primary plan and the amount paid by another group dental plan. MetLife Dental will use the lowest eligible amount due the provider in this calculation. **If the primary plan has paid the same or more than the MetLife Plan, the MetLife Plan will not pay on the claim.**
- **If you were either age 65 or eligible for Medicare and retired before January 1, 1988**, MetLife Dental will pay covered dental expenses up to 100 percent of the charges incurred, subject to plan limits. This means that MetLife Dental will pay the remainder of covered expenses incurred by you or your dependent and not paid by another group dental plan.

### **If You Have Other Private Dental Insurance**

MetLife Dental will not coordinate with other private health insurance plans such as those available through the American Association of Retired Persons (AARP). If you carry insurance, other than Medicare or another group plan provided by an employer, MetLife Dental will ignore the private plan.

### **Birthday Rule**

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

### **Termination of Coverage**

Your dental coverage will end the earlier of the following:

- Date you die
- Date the plan is discontinued or amended to eliminate TI Extended Health Benefits Coverage
- 30 days following the due date of a required cost, if any, if it remains unpaid. See important note in the Cost – Who Pays section.

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

- Date a dependent becomes covered as a Tler
- Date the dependent does not meet the definition of an eligible dependent

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

## **Death**

If you die, coverage for your eligible dependents may be elected under TI Extended Health Benefits Coverage, as long as they continue to be eligible for dependent coverage. TI will bill the dependents for the cost of their coverage. If your surviving spouse remarries, coverage will end and the surviving spouse and/or eligible dependents are no longer eligible to continue coverage under COBRA.

**If you terminated employment on or after January 1, 1998** -- TI Extended Health Benefits Coverage must be elected within 30 days of your death, by at least one survivor. If your survivors do not enroll in dental coverage through TI Extended Health Benefits Coverage within 30 days of your death, they will only be eligible to enroll for coverage in the event of an appropriate qualified status change or during annual enrollment as long as they are enrolled in medical coverage through TI Extended Health Benefits Coverage. If none of your survivors enroll in medical coverage through TI Extended Health Benefits Coverage, or if they all opt out at a later date, none of the survivors will be eligible to enroll for medical or dental coverage through TI Extended Health Benefits Coverage in the future.

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

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

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

termination will apply to your subsequent termination. You may qualify for additional years of service.

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 at the end of this section.

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

## **When Benefits Change**

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

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

## **Dental Health Maintenance Organization (DHMO)**

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

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

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

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

Enrolling in a DHMO may not be advisable if:

- You and your family already have a relationship with a personal dentist who is not affiliated with the DHMO in your service area

- DHMO services are not located within easy access of your home
- Your eligible dependents do not live in the DHMO service area

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

**You cannot change DHMO coverage or enroll in Dental Basic / Dental Plus except during annual enrollment, or in the event of an appropriate qualified status change.**

### **Adding Newborn or Adopted Children**

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

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

### **Continuation of Benefits (COBRA)**

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

## **EMPLOYEE ASSISTANCE PROGRAM (EAP)**

Offered through the TI Retiree Health Benefit Plan

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

### **Eligibility and Cost**

If you are a retiree, you and your spouse or same-gender domestic partner and your household members are automatically eligible to participate in the EAP. Your coverage and coverage of your eligible household members is automatic; you do not need to take any steps to enroll.

Eligible household members include your:

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

### **How to Obtain EAP Services**

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

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

Spanish-speaking representatives and counselors are available.

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

You can also access information, self-help tools, and other resources through Magellan’s Web site. You can reach this Web site directly at [www.magellanhealth.com](http://www.magellanhealth.com), or you can reach the site by hyperlink through [www.tialumni.org](http://www.tialumni.org).

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

## **Covered Services**

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

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

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

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

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

## **Payment of Counselors**

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

## **Coordination with Blue Cross Blue Shield PPO or Your HMO**

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

## **EAP Exclusions and Limitations**

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

- Treatment by someone other than an EAP counselor to whom (i) a Magellan representative opened a case or (ii) you completed an electronic referral request through Magellan's online EAP self-referral process,
- Charge for failure to keep a scheduled visit,
- Charges for completing claim forms,
- Services or supplies not needed for treatment or not approved by your EAP counselor,
- Services or supplies required or paid for under any government law, including workers' compensation or other federal, state or local law,
- Services or supplies for which there is no charge,
- Services rendered before coverage became effective,
- Services rendered by a family member,
- Treatments, procedures or devices considered experimental or investigational in nature as determined by the EAP administrator,
- Treatment for any problem or condition that cannot be resolved in short-term counseling (for example, a psychosis or any other condition that requires inpatient treatment or more than fifteen (15) sessions),
- Psychiatric services or other medical care,
- Inpatient treatment,
- Treatment for any physical illness,
- Direct treatment for mental retardation, learning disabilities, or autism,
- More than fifteen (15) in-person EAP sessions per problem per calendar year,
- Psychological, psychiatric, neurological, educational, or IQ testing,

- Remedial education services, such as evaluation or treatment of learning disabilities, developmental and learning disorders, behavioral training, and cognitive rehabilitation,
- Medication, medication management, or treatment of any condition for which medication is required, unless you are seeing a doctor who prescribes medication for that condition and oversees your use of the medication,
- Examinations and diagnostic services in connection with obtaining employment or a particular employment assignment, admission to or continuing in school, securing any kind of license (including professional licenses), obtaining any kind of insurance coverage,
- Court-mandated counseling, evaluations required by a state or federal judicial officer or other governmental agency or to be used in legal actions of any kind (for example, child custody proceedings),
- Testimony in legal proceedings or preparation for legal proceedings,
- Acupuncture,
- Aversion therapy,
- Biofeedback and hypnotherapy, and
- Sleep therapy.

### **Continuation of Benefits (COBRA)**

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

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

### **Termination of Coverage**

The benefit ceases when any of the following occurs:

- On discovery of fraud or deception on the part of the retiree
- TI discontinues the program

## **Complaint Review**

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

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

## EYE-CARE DISCOUNT PROGRAM

You and your family members may use the EyeMed Eye-Care Discount Program (“Discount Program”) to receive discounts on glasses and contacts. This program is administered by EyeMed Vision Care. You must show your retiree badge or a TI Medical ID card to receive discounts at the time of purchase. There is no membership cost. Vision care expenses are not reimbursable under the Blue Cross Blue Shield PPO, the CIGNA Copay Plan or regional HMOs.

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

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

The Discount Program includes the following savings:

### Summary of Discounts

Vision Care Services	Retiree Cost
<b>Exam with Dilation as Necessary:</b>	\$5 off routine exam \$10 off contact lens exam
<b><i>Complete Pair of Glasses Purchase*: frame, lenses and lens options must be purchased in the same transaction to receive full discount.</i></b>	
<b>Standard Plastic Lenses:</b>	
Single Vision	\$50
Bifocal	\$70
Trifocal	\$105
<b>Frames:</b>	
Any frame available at provider location	40% off retail price
<b>Lens Options:</b>	
UV Coating	\$15
Tint (Solid and Gradient)	\$15
Standard Scratch-Resistance	\$15
Standard Polycarbonate	\$40
Standard Progressive(Add-on to Bifocal)	\$65

<b>Vision Care Services</b>	<b>Retiree Cost</b>
Standard Anti-Reflective Coating Other Add-Ons and Services	\$45 20% discount
<b>Contact Lens Materials (Discount applied to materials only)</b> Disposable Conventional	0% off retail price 15% off retail price
<b>Laser Vision Correction**:</b> Lasik or PRK	15% off retail price - or - 5% off promotional price
<b>Frequency:</b> Examination Frame Lenses Contact Lenses	Unlimited Unlimited Unlimited Unlimited

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

\*\*Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a participating provider near you and the discount authorization, please call 1-877-5LASER6.

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

***Prices are subject to change without notice.***

**Limitations/ Exclusions:**

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

## Pricing

Prices are subject to change.

### Example of Program Savings

	REGULAR RETAIL	DISCOUNTED COST
Frame	\$100	\$ 60
Single vision lenses	\$ 56	\$ 50
Lens options		
• Ultraviolet coating	\$ 20	\$ 15
• Scratch resistant coating	\$ 20	\$ 15
Total	<u>\$196</u>	<u>\$140</u>
		<b>You Save \$56</b>

# **CONTINUATION OF MEDICAL AND/OR DENTAL BENEFITS (COBRA Benefits)**

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## **COBRA Continuation Coverage**

TI, in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, allows you, your spouse or same-gender domestic partner and your eligible dependent children (or children of your domestic partner) to elect to continue medical and/or dental benefits offered under the TI Retiree Health Benefit Plan beyond the date coverage is otherwise scheduled to end because of the occurrence of certain events known as “qualifying events.” Specific qualifying events are described later in this notice. When a qualifying event occurs, COBRA continuation coverage must be offered to each person who is a “qualified individual.” You, your spouse or same-gender domestic partner, and your dependent children could become qualified individuals if coverage under one of the plans described above is lost because of the qualifying event. Qualified individuals who elect COBRA continuation coverage must pay for COBRA continuation coverage.

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

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

### **Qualifying Events**

If you are a retiree, you will not become a qualified individual.

If you are the spouse or same-gender domestic partner of a retiree, you will become a qualified individual if you lose your coverage because any of the following qualifying events happens:

- Your spouse/same-gender domestic partner dies;

- Your spouse/same-gender domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse/same-gender domestic partner.

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

- The parent-employee dies;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a "dependent child."

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

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

### **Notice Requirements for COBRA Continuation Coverage**

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

Medicare benefits (under Part A, Part B, or both), TI will make sure that the TI Benefits Center is notified of the qualifying event.

### **You Must Give Notice of Some Qualifying Events**

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

TI Benefits Center  
100 Half Day Road  
P.O. Box 770003  
Cincinnati, OH 45277

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

### **Electing COBRA Coverage**

Once the TI Benefits Center has been notified of the occurrence of a qualifying event, you will be provided with instructions on how to elect COBRA continuation coverage. You must elect COBRA continuation coverage by the date specified in the enrollment notice. If you decline COBRA continuation coverage, but then decide to elect COBRA continuation coverage before the date specified in the enrollment notice, you may do so. However, in no event can you elect COBRA continuation coverage after the date specified in the enrollment notice.

### **Maximum Periods of Coverage**

The maximum length of COBRA continuation coverage available for loss of medical and/or dental benefits will vary depending on which qualifying event occurs. COBRA continuation coverage for loss of medical and/or dental benefits is available for 36 months as outlined below.

#### **36-Month COBRA Continuation Coverage Period**

Upon the occurrence of one of the following qualifying events, COBRA continuation coverage for medical and/or dental benefits will be available to your spouse or same-gender domestic partner and your eligible children (or children of your domestic partner):

- Loss of coverage for your eligible dependent(s) under the medical and/or dental plans because of your death, or your divorce or legal separation from your lawful spouse/same-gender domestic partner
- A dependent child ceasing to be a dependent child under the terms of the plan
- Loss of coverage under the plan because of your entitlement to Medicare.

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

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

### **Early Termination of COBRA Continuation Coverage**

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

- Texas Instruments no longer provides group health coverage to any of its employees
- The premium for continuation coverage is not paid in a timely manner
- The employee, spouse/same-gender domestic partner or dependent(s) first becomes covered after electing COBRA continuation coverage under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition
- The employee or spouse/same-gender domestic partner first becomes entitled to Medicare

- The employee, spouse/same-gender domestic partner or dependent(s) notifies the TI Benefits Center that they wish to cancel continuation coverage

## Premiums

An employee, spouse, same-gender domestic partner or dependent(s) does not have to show they are insurable in order to choose continuation coverage. But an employee, spouse, same-gender domestic partner or dependent(s) must have been actually covered under the medical and/or dental benefits offered under the TI Retiree Health Benefit Plan the day before the qualifying event in order to qualify for COBRA coverage.

An employee, spouse, same-gender domestic partner or dependent(s) may have to pay all of the applicable premiums, which generally cannot exceed 102% of the plan costs for a 12-month period. 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 and/or dental benefits offered under the TI Retiree Health Benefit Plan increase.

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

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

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

## Coverage for Eligible Employees in California Enrolled in an HMO

There are two types of coverage extensions available to persons living in California who are enrolled in a California HMO, one is for certain seniors and the

other applies to individuals who are otherwise on federal COBRA continuation coverage after July 1, 2003.

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

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

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

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

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

### **Extensions for Eligible Employees in California**

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

- End of the period for which you have paid premiums
- Date you attain age 65
- Date you begin coverage under a health plan not sponsored by TI
- Date you become entitled to Medicare
- Date TI terminates the plan or terminates the California HMO as a benefit option under the plan
- (For your spouse) five years after the date on which his or her COBRA coverage was scheduled to end.

- The date on which you commit fraud or deception in the use of the HMOs services
- The date on which you move outside of the California HMO's service area

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

## **California's COBRA Extension for Persons in Insured Plans or HMO's in California**

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

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

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

### **Extensions for Eligible Employees in California**

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

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

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

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

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

## **Conversion Information for the Blue Cross Blue Shield PPO**

### **Conversion to an Individual Policy**

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

### **If You Have Questions**

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

### **Keep the TI Benefits Center Informed of Address Changes**

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

## **Plan Contact Information**

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

# ERISA

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## ERISA GUIDELINES

The Employee Retirement Income Security Act of 1974 (ERISA) protects your rights under the TI Retiree Health Benefit Plan and ensures you receive appropriate information.

## TEXAS INSTRUMENTS BENEFIT PLANS UNDER ERISA

### Texas Instruments Incorporated Retiree Health Benefit Plan

*Type of Plan*

Hospitalization and Medical-Care Benefits  
Dental Benefits

*Employer Identification Number: 75-0289970*

*Plan Number: 502*

*Plan Trustee*

The Northern Trust Company  
Master Trust  
Corporate Financial Services  
South LaSalle Street  
Chicago, Illinois 60675

*Plan Year*

January 1 through December 31

*Sponsoring Employer*

Texas Instruments Incorporated  
12500 TI Boulevard  
Dallas, Texas 75243

*Agent for Service of Legal Process*

Joseph F. Hubach, Secretary  
Texas Instruments Incorporated  
12500 TI Boulevard  
Dallas, Texas 75243

*Plan Administrator:*

Texas Instruments Incorporated Retiree Health Benefit Plan  
Attn: Plan Administrator  
P.O. Box 650311  
Dallas, Texas 75265

*Claims Administrators/Insurance Companies:*

**PPO:** Blue Cross Blue Shield PPO benefits are administered by Blue Cross Blue Shield. This option is self-insured by TI, and TI is responsible for payment of such claims.

**Blue Cross Blue Shield PPO**

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

**CIGNA:** CIGNA Copay Plan (Open Access Plus In Network) benefits are administered by CIGNA. This option is self-insured by TI, and TI is responsible for payment of such claims.

CIGNA  
900 Cottage Grove Road  
Hartford, CT 06152

**HMOs:** HMO benefits are fully insured and claims are administered by the respective HMOs.

HMO Blue New England Landmark Center, 401 Park Drive Boston, MA 22153
HMO Illinois 300 E. Randolph Street Chicago, IL 60601
Kaiser Northern California 1305 Tommydon Street Stockton, CA 95210

<p>Kaiser Southern California  PO Box 1840  Corona, CA 91718</p>
<p>Optimum Choice (MAMSI)  UnitedHealthcare of the Mid-Atlantic  4 Taft Court  Rockville, MD 20850</p>
<p>PacifiCare California  5701 Katella Avenue  Cypress, CA 90630</p>
<p>Secure Horizons HMO – Texas  6200 Northwest Parkway  San Antonio, TX 78249</p>
<p>Secure Horizons HMO – Rhode Island  475 Kilvert Street, #310  Warwick, RI 28861</p>

**Dental:** The Dental benefit is self-insured and claims are administered by MetLife Dental.

**Dental**  
MetLife Dental  
PO Box 14093  
Lexington, KY 40512

**DHMO:** The DHMO benefit is fully insured and claims are administered by Aetna.

Aetna  
2777 Stemmons Freeway, #300  
Dallas, TX 75207

## **Your Rights Under ERISA**

As a participant in any or all of the plans described in the preceding summary plan descriptions, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

## **Receive Information About Your Plan(s) and Benefits**

You may examine, without charge, at the Plan Administrator's office or at other specified locations, all documents governing the plan(s), including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan(s) with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Administrator(s), copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

You may receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

## **Prudent Action by Plan Fiduciaries**

In addition to creating rights for plan participants, ERISA imposes duties on the people that are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

## **Continue Group Health Plan Coverage**

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

There may be a reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided with a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

## **Enforce Your Rights**

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain timeframes.

### **Additional Rights Under ERISA**

Under ERISA, there are steps you can take to enforce the above listed rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or part and you have exhausted your administrative appeals, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order and you have exhausted your administrative appeals, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or you are discriminated against for asserting your rights, 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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