

2005 Retiree Health Benefits Frequently Asked Questions

Texas Instruments

Table of Contents

BLUE CROSS BLUE SHIELD (BCBS)	3
Claims Appeals Process	3
Coverage	3
Deductible	3
Definitions	3
Employee Assistance Program (EAP)	4
Enrollment.....	5
Filing Claims	5
ID Card.....	5
Lifetime Maximum	6
Network vs. Non-Network	6
Online Account Access	6
Out-of-Pocket Maximum	7
Pre-Existing.....	8
Primary vs. Secondary Coverage	8
Provider.....	8
Referrals	8
BLUE CROSS BLUE SHIELD (BCBS): MEDICARE-ELIGIBLE PARTICIPANTS	8
Build Your Own Options.....	8
Coverage	9
Filing Claims	9
Medicare Part B	9
Provider.....	9
PPO Plan	10
CARRIER CHANGE	10
Transition of Care	10
ELIGIBILITY	10
Coverage	10
GENERAL	11
Changing Contact Information	11
Customer Service	11
Death Certificate	11
Definition	12
Enrollment.....	12
Extended Health Benefits Billing	13
Generic Drugs.....	13
ID Card.....	14
Medigap	14
PPO vs. HMO	15
Provider Listing	15
Provider vs. Carrier	15
HMO	16
Coverage	16
Provider.....	16
TI RETIREE MEDICAL CAP	16

<i>Question</i>	<i>Answer</i>
-----------------	---------------

BLUE CROSS BLUE SHIELD (BCBS)

<i>Claims Appeals Process</i>	
<p>What can I do if the Blue Cross Blue Shield (BCBS) PPO doesn't pay a claim that I believe they should be paying?</p>	<p>There is a formal appeal process in place should Blue Cross Blue Shield (BCBS) deny payment on a claim. You must first submit a written appeal to BCBS. If the claim denial is upheld, you may then submit a written appeal to the Plan Administrator. See <i>Health and Insurance Benefits Guide</i> for additional information, including time requirements.</p>
<i>Coverage</i>	
<p>When I become Medicare eligible, do I need to notify Blue Cross Blue Shield (BCBS)?</p>	<p>Yes, you should call Blue Cross Blue Shield (BCBS) through TI SmartLink at (800) 890-2600 and tell the representative that you want to verify that Blue Cross Blue Shield has your Medicare information in its system. You will be asked for your Medicare number (which Medicare calls the Medicare Claim Number), located on your Medicare card. You will also need to provide your Medicare effective date. There is no paperwork required if you are the TI retiree. However, you must call BCBS. If you are calling for the TI retiree you may be asked to complete a form.</p>
<i>Deductible</i>	
<p>Does the cost of prescriptions apply to my deductible?</p>	<p>There are separate deductibles for medical, behavioral health and prescriptions under the Blue Cross Blue Shield (BCBS) PPO.</p> <p>For Medicare-eligible participants: there is not a deductible for prescriptions.</p> <p>For pre-Medicare participants: the deductible amounts for medical, behavioral health and prescriptions will vary depending on the choices you made through Build Your Own Options.</p>
<i>Definitions</i>	
<p>What is a copay/copayment?</p>	<p>A copayment is a flat dollar amount you pay, in addition to any applicable deductible, directly to the doctor or hospital when you receive certain covered services.</p>
<p>What is coinsurance?</p>	<p>Coinsurance is the percentage of medical expenses that you and the plan share after the deductible is met. For example, if the coinsurance amount is '80/20,' that means that the Blue Cross Blue Shield (BCBS) PPO Plan pays 80% and you pay 20% of the allowable amount for the eligible charges.</p>

<p>What does Build Your Own Options mean and does it only apply to the Blue Cross Blue Shield (BCBS) PPO?</p>	<p>Yes, Build Your Own Options only applies to the Blue Cross Blue Shield (BCBS) PPO plan and is only available for pre-Medicare participants. Build Your Own Options allows you to customize your medical plan coverage to meet the needs of you and your family. It gives you the ability to balance the price you pay for medical coverage and what you pay for covered services (such as your costs for an office visit).</p>
<p>What is an Explanation of Benefits (EOB)?</p>	<p>An Explanation of Benefits, or EOB, is a statement you receive after a claim has been filed on your behalf by the provider (doctor, hospital,...) or you file a claim with a health plan. This statement is a summary of the action taken on your claim—how much of the bill was paid by the plan and how much is your responsibility to pay (you may already have paid that portion at the time of service). Most HMOs do not send or offer EOBs to their participants.</p>
<p>What is a deductible?</p>	<p>A deductible is the amount that must be paid for most healthcare services by the covered person before the healthcare plan begins to pay. 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.</p>
<p>What is reasonable and customary?</p>	<p>Some plans set reasonable and customary (R&C) limits on fees that non-network providers charge. They are based on what providers typically charge for that procedure in your geographical area. This may be referred to on your EOB as the "allowable amount" if you are enrolled in the Blue Cross Blue Shield (BCBS) PPO plan.</p>
<p>What is Blue Access?</p>	<p>This is the Blue Cross Blue Shield (BCBS) member access Web site containing information such as your membership and claims details.</p>
<p><i>Employee Assistance Program (EAP)</i></p>	
<p>Do I need to call the Employee Assistance Program (EAP) prior to receiving care for behavioral health?</p>	<p>Yes. Services must be pre-certified through EAP before receiving behavioral health coverage under the Blue Cross Blue Shield (BCBS) PPO, otherwise benefits may be reduced. Contact the EAP via TI SmartLink at (800) 890-2600. Select "Wellness and Other Programs", then select "Employee Assistance Program".</p>

Enrollment	
Can I answer only 1 of the 4 questions and allow that coverage to be my new medical plan?	You must choose an answer in each of the 4 questions to complete your annual enrollment and Build Your Own Options. This is only available for pre-Medicare participants.
Filing Claims	
How do I obtain a Blue Cross Blue Shield (BCBS) claim form?	<p>There are several ways to obtain a Blue Cross Blue Shield (BCBS) claim form:</p> <ul style="list-style-type: none"> • Contact BCBS through TI SmartLink at (800) 890-2600 <ul style="list-style-type: none"> - Enter your Social Security number - First menu option, say "Healthcare" - Second menu option, say "Health Plans" - Third menu option, say "Medical" Your call will then be automatically routed to BCBS Customer Service and you can request a new ID card be sent to you. • Go online to the Your Benefits Resources (YBR) Web site at http://resources.hewitt.com/ti. Click on the "Request Materials" link located on the Health Insurance page. • You can also access the YBR Web site through the TI Alumni Association Web site at www.tialumni.org.
Where can I obtain forms to file my claims?	Claim forms can be accessed on the YBR Web site through the "Request Materials" link under Health Insurance.
ID Card	
I've lost my Blue Cross Blue Shield (BCBS) ID card. What do I do?	<p>Call Blue Cross Blue Shield (BCBS) via TI SmartLink at (800) 890-2600:</p> <ul style="list-style-type: none"> • Enter your Social Security number • First menu option, say "Health Care" • Second menu option, say "Health Plans" • Third menu option, say "Medical" <p>Your call will then be automatically routed to BCBS Customer Service and you can request a new ID card to be sent to you.</p>

<p>Will we get new health plan cards for 2005?</p>	<p>Yes. If you select the Blue Cross Blue Shield (BCBS) PPO or an HMO, ID cards will be mailed to your home before January. If you elect you-only coverage, you will receive one ID card. If you elect other coverage categories, you will receive two ID cards. You can call the BCBS Customer Service through TI SmartLink by selecting the options, "Healthcare," "Health Plans," and then "Medical" to request additional cards once the initial cards are received. There is no charge for additional ID cards.</p>
<p>My Social Security number is on my ID card, and I'm worried about identity theft. Is there anything I can do to change that?</p>	<p>Due to recent legislation in some states prohibiting the use of Social Security numbers on ID cards and EOBs, Blue Cross Blue Shield (BCBS) will be changing member subscriber numbers (Social Security numbers) to unique identification numbers effective 01/01/05, on ID cards and EOBs.</p>
<p><i>Lifetime Maximum</i></p>	
<p>Does the lifetime maximum include claims incurred while I was an active employee?</p>	<p>Yes. The lifetime maximum includes all claims on which the plan has made payments, both as an active employee and as a retiree.</p>
<p><i>Network vs. Non-Network</i></p>	
<p>What's the difference between in-network and non-network?</p>	<p>Blue Cross Blue Shield (BCBS) has a network of doctors and hospitals with which they have negotiated rates. You are free to choose any doctor or hospital. However, when using network providers for your medical care, you will receive the network (highest) level of benefits and you will not have to file your own claims – the network provider will file the claims for you. A non-network provider is not subject to billing you a negotiated rate and the coinsurance that the plan pays is based on reasonable and customary charges.</p>
<p><i>Online Account Access</i></p>	
<p>Do retirees have online access to their Blue Cross Blue Shield (BCBS) account?</p>	<p>Yes. Once enrolled in the Blue Cross Blue Shield (BCBS) PPO Plan, retirees may access claims and membership information via Blue Access. In addition, members may obtain duplicate copies of their EOBs as well as temporary health ID cards.</p>
<p>How do I get to Blue Access to view my claims?</p>	<p>If you are currently enrolled in the Blue Cross Blue Shield (BCBS) PPO plan, you can access Blue Access from the YBR Web site by clicking on "Health Insurance" and then under the "Take Action" heading, select the "BCBS" Link.</p>

<p>How do I view my online claims history for AdvancePCS?</p>	<p>To view your AdvancePCS claims history online, log on to the AdvancePCS Web site (www.advancerx.com). Click on “Manage Your Prescription”. Then, click the “Go Now” button. You will be asked to authenticate with your e-mail and password. Next, click on “Detail History”. You are required to enter a prescription number upon your first time in Prescription Manager.</p>
<p>How do I view my online claims history for MetLife?</p>	<p>To view your MetLife claims history online, log on to the MetLife My Benefits Web site (www.metlife.com/mybenefits). First-time users will need to register with MyBenefits. This will require a user to select a unique User Name and Password and answer an identity verification question. A user will be able to reset a forgotten password and/or User name online by correctly answering the required question.</p>
<p><i>Out-of-Pocket Maximum</i></p>	
<p>How does an annual out-of-pocket maximum work?</p>	<p>The out-of-Pocket Maximum is the annual limit you would pay for most eligible plan expenses in a calendar year, after the deductible is met. After the Out-of-pocket maximum is reached, the Blue Cross Blue Shield (BCBS) PPO Plan pays 100% of most covered charges for the rest of the plan year. The out-of-pocket maximum does not include deductibles, hospital copays, any behavioral health expenses, custodial care, charges not covered by the plan or that exceed plan limits, pharmacy expenses, and non-network expenses that exceed reasonable and customary or other plan limits.</p>
<p>What is the annual out-of-pocket maximum for pharmacy in the Blue Cross Blue Shield (BCBS) PPO?</p>	<p><u>For Medicare-eligible participants:</u> the annual out-of-pocket maximum for pharmacy is \$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 generic 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.</p> <p><u>For pre-Medicare participants:</u> the annual out-of-pocket maximum for pharmacy is either \$5,000 individual / \$10,000 family or \$10,000 individual / \$20,000 family, depending on the pharmacy option you chose through Build Your Own Options. If a generic is available and a brand-name drug is purchased instead, you pay the appropriate coinsurance for the generic drug cost plus the cost difference between the brand-name and generic drug. The cost difference does not apply towards the pharmacy out-of-pocket maximum — you must still pay the difference, even if your out-of-pocket pharmacy maximum has been met. The out-of-pocket pharmacy maximum does not include deductibles.</p>

<i>Pre-Existing</i>	
Does the Blue Cross Blue Shield (BCBS) PPO Plan have a pre-existing clause?	The Blue Cross Blue Shield (BCBS) PPO Plan does not impose any limitations on pre-existing conditions.
<i>Primary vs. Secondary Coverage</i>	
How does the Blue Cross Blue Shield (BCBS) PPO Plan coordinate benefits with a plan, other than Medicare or another group plan provided by an employer (i.e. HMO)?	If you have a plan, other than Medicare or another group plan provided by an employer (i.e. HMO), the Blue Cross Blue Shield (BCBS) PPO Plan will not coordinate benefits as secondary payer and will ignore the private plan.
<i>Provider</i>	
How often are the lists of Blue Cross Blue Shield (BCBS) providers updated on YBR?	The Blue Cross Blue Shield (BCBS) provider listing on YBR is updated on a monthly basis. We recommend that you also confirm a provider's status with BCBS Customer Service or contact the provider directly.
Can I nominate a doctor for the Blue Cross Blue Shield (BCBS) PPO plan? How?	Yes. You can contact Blue Cross Blue Shield (BCBS) via TI SmartLink (800) 890-2600 and speak to a customer service representative to request a form.
<i>Referrals</i>	
Are doctor referrals required on the Blue Cross Blue Shield (BCBS) PPO?	No. You do not need a referral to a specialist. You can visit any doctor or hospital, but you will receive the highest level of benefits coverage when using in-network providers.

BLUE CROSS BLUE SHIELD (BCBS): MEDICARE-ELIGIBLE PARTICIPANTS

<i>Build Your Own Options</i>	
Why aren't the Build Your Own Options available to Medicare eligible retirees?	Build Your Own Options are not available for Medicare-eligible retirees because the contributions reflect the fact that Medicare is the primary payer of benefits when you become Medicare-eligible, and pays the majority of your healthcare costs. Since the TI plan is secondary, giving you a choice of deductible levels and coinsurance percentages under a Build Your Own Options arrangement would have little or no effect on your contribution amount.

Coverage	
What happens if a service is not covered by Medicare, but is covered by Blue Cross Blue Shield (BCBS)?	Once Blue Cross Blue Shield (BCBS) receives the Medicare denial of that service, BCBS will process the claim as if BCBS is primary.
If I am 65 and Medicare is Primary, do I have to carry TI coverage to have my spouse covered who is under 65?	Yes, the retiree has to be insured by TI for any coverage to be available to their spouse and/or eligible dependents.
Filing Claims	
Do I need to file my own claims?	Ask your provider if they will be filing your claim for you. If the provider is filing your claim, there is no further action required on your part. If the provider is not filing the claim for you, you must file the claim. You must first file the claim with Medicare. Upon receiving your EOB from Medicare, you should then file a claim with Blue Cross Blue Shield (BCBS) and attach the EOB from Medicare to it.
Medicare Part B	
What if I do not enroll in Medicare Part B?	If you do not enroll in Medicare Part B, Blue Cross Blue Shield (BCBS) will estimate what Medicare Part B would have paid and will continue to pay as secondary insurance. You must enroll in Medicare Part B if you want to realize the full benefit under the BCBS PPO Plan.
Provider	
What if my doctor does not accept assignment?	You may have to pay the doctor in full. If so, you will have to file the claim with Medicare. Once Medicare has processed the claim, you will receive a Medicare Explanation of Benefits (EOB). You will then need to file the claim with Blue Cross Blue Shield (BCBS) and include the Medicare EOB with it.
What if my provider accepts Medicare, but is not a Blue Cross Blue Shield (BCBS) PPO provider?	Your Blue Cross Blue Shield (BCBS) coverage will be reduced to reflect out-of-network benefits.

PPO Plan	
<p>Why should I want to have the Blue Cross Blue Shield (BCBS) PPO Plan when I'm retired and am Medicare eligible?</p>	<p>The Blue Cross Blue Shield (BCBS) PPO plan offers the following benefits:</p> <ul style="list-style-type: none"> • Prescription drug coverage • Coverage when you travel outside of the United States. • Annual out-of-pocket maximums apply.

CARRIER CHANGE

Transition of Care	
<p>I want to keep my doctor and he is not participating in my newly available HMO option. How do I get transition of care information when I change my medical plan?</p>	<p>If any of the following conditions apply to you, you might be eligible to remain with your current doctor for a transition period of up to 3 months:</p> <ul style="list-style-type: none"> - Pregnancy, with expected delivery in the first quarter of 2005 - Extensive therapy such as chemotherapy - A terminal illness - Waiting for a transplant - Behavioral health issues (beyond EAP) - Surgery scheduled for the first quarter of 2005 <p>If you have other ongoing medical conditions and your current doctor is not in the new network, your new health plan administrator will be able to help you find an appropriate doctor in the network so that your care can be continued without disruption. You can get the transition of care form(s) for your new health plan administrators by contacting them directly. Return the forms to your new plan administrator in early December. If you are hospitalized at the end of the year and your hospital stay continues into 2005, you should contact your 2004 medical carrier and your 2005 medical carrier to understand what procedures need to be followed. Transition of care forms are also available on the TI Alumni Association Web site at http://tialumni.org.</p>

ELIGIBILITY

Coverage	
<p>Do I have to carry medical insurance to be covered by dental?</p>	<p>Yes. As a retiree, you have to carry medical insurance to be covered by dental.</p>

GENERAL

<i>Changing Contact Information</i>	
<p>What is the process to change my personal information, including phone number and address? Does this also affect the information that TI retains?</p>	<p>Through YBR:</p> <ul style="list-style-type: none"> - Go to the Your Benefits Resources (YBR) Web Site at http://resources.hewitt.com/ti/ - Input your Social Security number and Hewitt password - Click the Log On box - Click on the "Your Profile" link, this is located in the Topics box on the left side of the page - From the "Your Profile" page, click the tab labeled "Mailing Addresses". The Web site will show the permanent address on file for you. Retirees can change this address by clicking the "Change" link next to the Permanent Address. <p>The TI Benefits Center can also change your address. You can reach them by calling (800) 890-2600 and saying "TI Benefits Center" from the main menu. You will be prompted to give your Hewitt password.</p> <p>Your updated address will be shared with TI. One consideration is that the medical and dental plans you are enrolled in may be impacted based on an address change. You will need to contact the TI Benefits Center directly to understand how a change of address may change your benefits.</p>
<i>Customer Service</i>	
<p>When I call the TI Benefits Center through TI Smartlink, will I be talking to a TI employee?</p>	<p>No, but TI Benefits Center representatives are trained to answer questions regarding the TI healthcare plans, as well as the defined pension plans and the defined contributions plans. TI Benefits Center representatives are available Monday through Friday, 8:30am to 4:30 pm Central Standard Time.</p>
<i>Death Certificate</i>	
<p>Why do you need a copy of a death certificate to cancel the insurance coverage on my deceased spouse?</p>	<p>A death certificate is not required to cancel health insurance coverage on a deceased spouse. Please contact TI Benefits Center via TI SmartLink at (800) 890-2600 to report the death and update your coverage.</p>

Definition	
<p>What is Medicare Part A and Part B?</p>	<p>Medical Part A is hospital insurance that pays for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.</p> <p>Medical Part B is the part of Medicare that covers doctors' services and outpatient hospital care. It also covers other medical services that Part A does not cover, such as physical and occupational therapy.</p>
Enrollment	
<p>If my spouse and I are both enrolled in an HMO, when I become Medicare eligible does my spouse have to change to the PPO?</p>	<p><u>Split-Family Coverage</u></p> <p>Medical options available vary based on eligibility for Medicare, as follows:</p> <ul style="list-style-type: none"> • If you or an eligible family member is eligible for Medicare, but at least one family member is not eligible for Medicare, special split-family rules may apply depending on which plan you are enrolled in. Some HMOs do not allow split-family enrollments. • When a family member becomes eligible for Medicare, that member must enroll in a Medicare-Eligible Extended Medical Plan. All family members who are not eligible for Medicare can continue to be enrolled in their current medical plan if it allows split-family enrollments. You must choose two medical plan options: one for those who are eligible for Medicare and one for those who are not. • When a family member becomes eligible for Medicare and you are enrolled in an HMO that does not allow split-family enrollments, all family members must move to another plan.

<p>If I do not make any changes for annual enrollment, what will happen to my coverage?</p>	<p>If you do not make an election, you will automatically be enrolled in the coverage you had in 2004. If you have no coverage in 2004, you will be assigned no coverage in 2005.</p> <p>If your 2004 medical plan is no longer available, you will automatically be enrolled in the Blue Cross Blue Shield (BCBS) PPO (current design) for 2005 at the level of coverage you had in 2004 (for example, you + family).</p> <p>You cannot change the election until the next annual enrollment period or unless you have a qualified status change. Changes in coverage must be consistent with the change in status.</p> <p>You must make changes within 30 days of a qualifying event. Please see the Retiree Health Benefits Guide for additional information about qualified status changes.</p> <p>If you want to drop coverage, you must contact the TI Benefits Center. IMPORTANT NOTE: If you terminated your employment with TI on or after January 1, 1998, you may not opt in and out of Extended Health Benefits Coverage; if you elect to drop coverage you will not be eligible to re-enroll in a TI-sponsored plan at any time.</p>
---------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Extended Health Benefits Billing

<p>When will I be billed for my extended health benefits?</p>	<p>Billing notices will be generated on the 10th of the month, mailed on the 15th of the month for premiums due the first of the month. For example: The billing notices will be generated on 12/10/04 and mailed 12/15/04 for premiums due on 1/1/2005.</p>
---------------------------------------------------------------	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

Generic Drugs

<p>My doctor prescribed a brand-name drug and I can't take the generic drug in its place. Do I still need to pay the higher coinsurance or copay?</p>	<p>For Blue Cross Blue Shield (BCBS) PPO, you will pay the total cost plus the difference between the generic and brand name based on the prescription drug coinsurance that you selected. If you are an HMO participant, please contact your current carrier for details on their process.</p>
-------------------------------------------------------------------------------------------------------------------------------------------------------	-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

ID Card	
<p>What do I do if I have to go to the doctor and I have not received my ID cards yet?</p>	<p>Annual Enrollment Time--Medical ID cards will be mailed to your home prior to January 1st. If you don't receive your card in that time period, verify your address information on the Your Benefits Resources Web Site at http://resources.hewitt.com/ti/.</p> <p>If your address information is correct, please contact your carrier through TI SmartLink at 1-800-890-2600 to request ID cards.</p> <p>Your provider should still be able to verify their eligibility and benefits by contacting your carrier /health plan directly, even if they don't have ID card yet.</p>
Medigap	
<p>What is Medigap insurance?</p>	<p>There are ten standardized Medigap plans called by letters A through J. Each plan has a different set of benefits. Plan A covers only the basic (core) benefits. These basic benefits are included in all the plans. Each plan after A adds benefits to the basic plan.</p> <p>Different types of standardized Medigap plans are sold in Massachusetts, Minnesota, or Wisconsin.</p> <p>You buy a Medigap policy from an insurance company and pay them the premium for the plan you select. This premium is in addition to the Medicare Part B premium you pay to Medicare.</p> <p>If you buy a Medigap policy, it only covers your individual healthcare costs. It doesn't cover any healthcare costs for your spouse. They would have to buy their own policy.</p> <p>Medigap policies only help pay healthcare costs if you have the Original Medicare Plan. You don't need to buy a Medigap policy if you're enrolled in a Medicare + Choice Plan.</p>
<p>I am over 65, is the Blue Cross Blue Shield (BCBS) PPO equivalent to a Medigap policy?</p>	<p>No. A Medigap policy is a health insurance policy sold by private insurance companies to fill the "gaps" in Original Medicare Plan coverage. To buy a Medigap policy, you must be enrolled in Medicare Part A and Part B.</p>

<i>PPO vs. HMO</i>	
<p>What is the difference between a PPO and an HMO?</p>	<p>Under a PPO, you have the freedom to choose any provider when you need care as long as you are willing to pay more for a non-network provider. There is also no need for physician referrals under a PPO plan. You can make an appointment directly with a specialist.</p> <p>Under an HMO, you must use HMO network providers to receive benefits, and your medical care must typically be provided by a primary care physician (PCP) who will arrange for referrals to specialists and coordinate any hospital services.</p>
<i>Provider Listing</i>	
<p>Can you mail a provider listing to me?</p>	<p>You can obtain a provider listing by accessing the Your Benefits Resources (YBR) Web site. Click on 'Find a Doctor' or you can contact your medical carrier. You can reach your medical carrier by calling TI SmartLink at (800) 890-2600.</p> <ul style="list-style-type: none"> • Enter your Social Security number • First menu option, say "Healthcare" • Second menu option, say "Health Plans" • Third menu option, say "Medical" <p>Your call will then be automatically routed to your carrier.</p>
<i>Provider vs. Carrier</i>	
<p>What is the difference between a provider and a carrier?</p>	<p>In general, a provider is considered to be your doctor, hospital, pharmacist (a person or place that treat your illness) while a carrier is your health plan or insurance carrier such as Blue Cross Blue Shield (BCBS), CIGNA, MetLife, or Aetna (a group that administers or pays the claims based on the design of the plan).</p>

HMO

Coverage	
<p>I am under 65 and thinking of changing to a participating HMO. I am concerned if my medication will be covered.</p>	<p>Check on your medication by going to the HMO's Web site to determine if your medications are covered. You can also call the HMO directly. The HMO Web site can be accessed by going to the YBR Web site and selecting the link showing your HMO plan options. In addition, if you are not currently enrolled in an HMO, you can call the HMO directly by using the YBR Plan Comparison Charts which provide the HMO contact information. If already enrolled in the HMO plan, you will be able to call TI SmartLink at (800) 890-2600 and follow the directions below to speak with the HMO service representative.</p> <ul style="list-style-type: none"> • Enter your Social Security number • First menu option, say "Health Care" • Second menu option, say "Health Plans" • Third menu option, say "Medical" <p>Your call will then be automatically routed to the HMO's Customer Service so you can make your medication inquiry.</p>
Provider	
<p>If I change to an HMO, what if my current doctors are not in their plan?</p>	<p>Check the HMO Web site to determine if your primary care and other doctors are covered by their plan. You might also confirm with the physician's office if they will accept your HMO coverage. If your doctors are not in the HMO, you will need to select new physicians if you change to the HMO.</p>

TI RETIREE MEDICAL CAP

<p>Why does TI have a cap?</p>	<p>The rising cost of medical benefits for TI retirees caused TI to change its cost-sharing policy back in 1992. Costs for retiree medical benefits have continued to rise over the years. In order to remain competitive and still offer a comprehensive health plan for retirees, TI has to share some of the cost with its retirees.</p>
--------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

<p>How did TI come up with the amount of its retiree medical cap?</p>	<p>Based on TI Health Plan costs in 1992, TI calculated the maximum it would contribute toward premiums for post-1992 retirees with at least 30 years of service at \$6,000 for pre-Medicare retirees and \$1,800 for Medicare-eligible retirees.</p> <p>After reviewing TI Health Plan costs again in 2004, TI made the decision to raise the caps to \$11,000 for pre-Medicare retirees and \$4,000 for Medicare-eligible retirees with at least 30 years of service. TI's maximum contribution is prorated for retirees with service between 15 and 30 years. TI does not contribute to spouse and dependent premiums for post-1992 retirees.</p>
<p>Will the amount of the cap change in the future?</p>	<p>No, TI will not make further increases in the cap.</p>
<p>What can I do to help TI control healthcare costs?</p>	<p>Many things, and remember, controlling healthcare costs is a win-win for both you and TI. Some ways you can help:</p> <ul style="list-style-type: none"> - Take care of yourself. Exercise regularly, eat healthy, and get regular check-ups. - Ask about generics when filling a prescription. - Do not smoke. - Adhere to treatment plans for chronic conditions. - Prepare and ask questions at doctor visits.
<p>Does the retiree medical cap have anything to do with all of the Medicare changes I've heard about?</p>	<p>No. The retiree medical cap increase is a separate issue.</p>
<p>When will I hear more about TI's plans for working with Medicare?</p>	<p>TI intends to continue offering prescription drug benefits for Medicare-eligible retirees as part of the medical plan.</p> <p>In early 2005, we will be ready to talk in detail about the choices that retirees will need to make later in 2005 to be effective January 1, 2006. Additional retiree meetings will be held and detailed communication will be distributed.</p>

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