

# **2006 Retiree Health Benefits Frequently Asked Questions**

*Texas Instruments*

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<b>Question</b>	<b>Answer</b>
<b>BLUE CROSS BLUE SHIELD</b>	
<b>Claims Appeals Process</b>	
<p>What can I do if the Blue Cross Blue Shield 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 deny payment on a claim. You must first submit a written appeal to Blue Cross Blue Shield. If the claim denial is upheld, you may then submit a written appeal to the plan administrator. See <i>Retiree Health Benefits Guide</i> for additional information, including time requirements.</p>
<b>Coverage</b>	
<p>When I become Medicare-eligible, do I need to notify Blue Cross Blue Shield?</p>	<p>Yes, you should call Blue Cross Blue Shield through TI 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 Blue Cross Blue Shield. If you are calling for the TI retiree, you may be asked to complete a form. Once you are enrolled in Medicare, send all your medical claims to Medicare first. No claim under the Blue Cross Blue Shield PPO or an HMO will be accepted until your Medicare claim has been processed.</p>

<b>Coverage Changes</b>	
Are there any changes to plan design for the BCBS PPO plan?	The behavioral healthcare annual deductible will change to \$300 for an individual and \$600 for a family. The behavioral healthcare deductible is separate from your medical deductible.
<b>Deductible</b>	
Does the cost of prescriptions apply to my deductible?	<p>There are separate deductibles for medical, behavioral healthcare and prescriptions under the Blue Cross Blue Shield 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 and prescriptions will vary depending on the choices you made through “Build Your Own Options.”</p>
<b>Definitions</b>	
What is a copay/copayment?	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.
What is coinsurance?	Coinsurance is the percentage that TI contributes to your eligible medical expenses after you meet your medical deductible. For example, if the coinsurance amount is “70/30,” that means that the Blue Cross Blue Shield PPO Plan pays 70% and you pay 30% of the allowable amount for the eligible medical charges.

<p>What does “Build Your Own Options” mean and does it only apply to the Blue Cross Blue Shield PPO?</p>	<p>Yes, “Build Your Own Options” only applies to the Blue Cross Blue Shield 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 what 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, etc.) or you file a claim directly with a health plan. This statement is a summary of the action taken on your claim—how much of the bill was paid by the plan and how much is your responsibility to pay (you may already have paid that portion at the time of service). Most HMOs do not send or offer EOBs to their participants.</p>
<p>What is a deductible?</p>	<p>A deductible is the amount you must pay for eligible medical expenses each year before benefits begin. If you have covered dependents, all charges applied toward each individual's deductible will be applied toward the family deductible amount. When the family deductible amount is reached, no further individual deductibles will have to be satisfied for that calendar year. No individual will contribute more than the individual deductible amount towards the family deductible amount.</p>
<p>What is a lifetime maximum?</p>	<p>A lifetime maximum is the maximum amount the plan will pay for covered medical expenses for each covered participant during their lifetime.</p>

<p>What is reasonable and customary?</p>	<p>Some plans set reasonable and customary (R&amp;C) limits on fees that non-network providers charge. They are based on what providers typically charge for that procedure in your geographical area. This might be referred to on your explanation of benefits (EOB) as the "allowable amount" if you are enrolled in the Blue Cross Blue Shield PPO plan.</p>
<p>What is Blue Access?</p>	<p>This is the Blue Cross Blue Shield member access Web site containing information such as your membership and claims details.</p>
<p><b><i>Benefits While Traveling</i></b></p>	
<p>In the Blue Cross Blue Shield PPO, what happens if I get sick while traveling? Am I covered under the PPO?</p>	<p>Inside the United States: If you need another doctor, you can find an in-network doctor by using any of the following options: use the "Find a Doctor/Facility" option on YBR, call Blue Cross Blue Shield through TI SmartLink at (800) 890-2600 or contact the provider directly. Your benefits travel with you. For an emergency illness or injury requiring immediate care, you should be treated at the nearest hospital or doctor's office, regardless of whether that provider is in-network. In the case of services rendered as a result of an accident or medical emergency, benefits will be reimbursed at the in-network benefit level. If hospitalization is required, once you are stable, it might be necessary for you to transfer to a network hospital (if available) to receive the highest level of benefits coverage.</p>

***Dependents***

<p>I have an unmarried, dependent child who is a full-time student and will be turning 19 next year. Can he/she continue to be covered under my medical plan?</p>	<p>For Blue Cross Blue Shield participants, yes. Dependent, unmarried children who are dependent on you for more than 50 percent of their support and are full-time students can be covered under the Blue Cross Blue Shield PPO Plan until age 25. You must contact the TI Benefits Center through TI SmartLink at (800) 890-2600 within 90 days prior to your child's 19th birthday to continue coverage. Thereafter, you must certify full-time student status each year.</p> <p>If you are enrolled in an HMO, contact your HMO for information regarding full-time student certification.</p>
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***Employee Assistance Program (EAP)***

<p>Do I need to call the Employee Assistance Program (EAP) prior to receiving behavioral healthcare?</p>	<p>Yes. In order to receive appropriate referral and treatment, retirees covered under the Blue Cross Blue Shield PPO Plan are advised to call the Employee Assistance Program (EAP) at (800) 888-CARE (2273) before receiving behavioral healthcare. Failure to use a behavioral healthcare network provider will result in a lower level of benefits.</p> <p>If you are hospitalized, you must call the Blue Cross Blue Shield Precertification Department at (800) 441-9188 within 72 hours to avoid paying a 10% penalty.</p>
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<b><i>“Build Your Own Options”</i></b>	
<p>When I’m making my “Build Your Own Options” selections, can I answer only one of the four questions and allow that to be my new coverage?</p>	<p>You must choose a level in each of the four questions to complete your annual enrollment. This is only available for pre-Medicare participants.</p>
<p>What pricing will I see when I enroll?</p>	<p>The pricing on the Blue Cross Blue Shield Build Your Own Options (BYO) worksheet reflects the plan prices that will be billed for 2006. Specifically, for retirees and/or their spouses who will be enrolling in the BYO plan design, prices will be based on the sum of responses to the components in the coverage category (e.g., “you + spouse” column) that a retiree elects. Please note: retirees will only be able to enroll in the coverage categories for which they are eligible. For example, the “spouse only” coverage category is available only to the eligible surviving spouse of a TI retiree or to a pre-Medicare spouse of a Medicare-eligible retiree (split coverage). It is not available to the spouse of a current pre-Medicare retiree.</p>
<b><i>Explanation of Benefits (EOB)</i></b>	
<p>If the Blue Cross Blue Shield explanation of benefits (EOB) is online, are retirees also sent a paper copy?</p>	<p>Yes. retirees may, however, elect to suppress obtaining hard copies of EOBs through the mail. This is done via Blue Access. You can get to Blue Access from the YBR Web site by clicking "BCBS".</p>

<b><i>Filing Claims</i></b>	
<p>Where can I obtain forms to file my claims?</p>	<p>There are several ways to obtain a Blue Cross Blue Shield (BCBS) claim form:</p> <ul style="list-style-type: none"> <li>• Contact BCBS through TI SmartLink at (800) 890-2600 <ul style="list-style-type: none"> <li>- Enter your Social Security number</li> <li>- First menu option, say "Healthcare"</li> <li>- Second menu option, say "Health Plans"</li> <li>- Third menu option, say "Medical"</li> </ul> <p>Your call will then be automatically routed to BCBS Customer Service and you can request a claim form be sent to you.</p> </li> <li>• You can also access claim forms on YBR through the “Request Materials” link under Health Insurance or just click <a href="#">here</a>.</li> <li>• You can also access YBR through the TI Alumni Association Web site at <a href="http://www.tialumni.org">www.tialumni.org</a>.</li> </ul>
<b><i>ID Card</i></b>	
<p>I've lost my Blue Cross Blue Shield (BCBS) ID card. What do I do?</p>	<p>Call Blue Cross Blue Shield (BCBS) via TI SmartLink at (800) 890-2600:</p> <ul style="list-style-type: none"> <li>• Enter your Social Security number</li> <li>• First menu option, say "Health Care"</li> <li>• Second menu option, say "Health Plans"</li> <li>• Third menu option, say "Medical"</li> </ul> <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>You can also go to the Blue Access Web site to request additional cards.</p>

<p>Will we get new health plan cards from Blue Cross Blue Shield for 2006?</p>	<p>No. You will only receive a new ID card if you are a new enrollee to the Blue Cross Blue Shield PPO for 2006. Please keep your previous Blue Cross Blue Shield card(s) to use for current and future coverage if you are continuing your Blue Cross Blue Shield PPO coverage.</p> <p>If you are a new enrollee and elect retiree-only coverage, you will receive one ID card. If you are a new enrollee and elect other coverage categories, you will receive two ID cards.</p> <p>To request additional ID cards, call Blue Cross Blue Shield customer service through TI SmartLink by selecting "healthcare," then "health plans," then "medical". There is no charge for additional ID cards. You can also request additional cards by going to the Blue Access Web site from YBR by clicking "BCBS".</p>
<p>Will my Social Security number be on my ID card?</p>	<p>Due to legislation in some states prohibiting the use of Social Security numbers on ID cards and explanations of benefits (EOBs), Blue Cross Blue Shield has changed member subscriber numbers (Social Security numbers) to unique identification numbers. This change was effective Jan. 1, 2005, on ID cards and EOBs.</p>
<p><b><i>Lifetime Maximum</i></b></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>

<b>Network vs. Non-Network</b>	
What's the difference between in-network and non-network?	Blue Cross Blue Shield has a network of doctors and hospitals with which they have negotiated rates. You are free to choose any doctor or hospital. However, when using network providers for your medical care, you will receive the network (highest) level of benefits and you will not have to file your own claims – the network provider will file the claims for you.
<b>Online Account Access</b>	
Do retirees have online access to their Blue Cross Blue Shield accounts?	Yes. Once enrolled in the Blue Cross Blue Shield PPO Plan, retirees may access claims and membership information via Blue Access. In addition, members may obtain duplicate copies of their explanations of benefits (EOBs) as well as temporary health ID cards.
How do I get to Blue Access?	If you are currently enrolled in the Blue Cross Blue Shield PPO plan, you can access Blue Access from YBR by clicking "BCBS".
How do I view my online claims history for Caremark, formerly Advance PCS?	To view your Caremark claims history online, log on to the Caremark Web site ( <a href="http://www.caremark.com">www.caremark.com</a> ). Click on "Manage Your Prescription". Then, click the "Go Now" button. You will be asked to verify your identity 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.

### ***Out-of-Pocket Maximum***

How does an annual out-of-pocket maximum work?

The out-of-pocket maximum is the annual limit you would pay for most eligible plan expenses in a calendar year, after the deductible is met. After the out-of-pocket maximum is reached, the Blue Cross Blue Shield PPO Plan pays 100 percent of most covered charges for the rest of the plan year. The out-of-pocket maximum for medical expenses does not include deductibles, hospital copays, any behavioral healthcare expenses, custodial care, charges not covered by the plan or that exceed plan limits, pharmacy expenses, or non-network expenses that exceed reasonable and customary or other plan limits. There is a separate out-of-pocket maximum for pharmacy expenses. The out-of-pocket maximum for pharmacy expenses does not include deductibles or the cost difference you pay if a brand-name drug is received when a generic is available.

<p>What is the annual out-of-pocket maximum for pharmacy in the Blue Cross Blue Shield PPO?</p>	<p>For Medicare-eligible participants: the annual out-of-pocket maximum for pharmacy is \$5,000 individual / \$10,000 family.</p> <p>If a generic 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>For pre-Medicare participants: 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.”</p> <p>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>
<p><b><i>Pre-Existing</i></b></p>	
<p>Does the Blue Cross Blue Shield PPO plan have a pre-existing clause?</p>	<p>The plan does not impose any limitations on pre-existing conditions.</p>

<b>Preventive Services</b>	
Where can I find details about what preventive benefits are covered under the Blue Cross Blue Shield PPO?	This information can be viewed in the <i>Retiree Health Benefits Guide</i> under “Preventive Healthcare.”
<b>Primary vs. Secondary Coverage</b>	
How does the Blue Cross Blue Shield 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 private plan such as those available through the American Association of Retired Persons (AARP), other than Medicare or another group plan provided by an employer (i.e. HMO), the Blue Cross Blue Shield PPO Plan will not coordinate benefits as secondary payer and will ignore the private plan.
<b>Provider</b>	
How can I determine if my doctor is on the Blue Cross Blue Shield PPO Plan?	Visit YBR and select the “Find a Doctor” option. You can also call Blue Cross Blue Shield through TI SmartLink at (800) 890-2600.
How often are the lists of Blue Cross Blue Shield providers updated on YBR?	The Blue Cross Blue Shield provider listing on YBR is updated monthly. We recommend that you also confirm a provider’s status with Blue Cross Blue Shield customer service or contact the provider directly.
Can I nominate a doctor for the Blue Cross Blue Shield PPO plan? How?	Yes. You can fill out a provider nomination form and mail it to Blue Cross Blue Shield. You can find the form on YBR by clicking on “Request Materials.” Nominating a provider does not guarantee that he or she will join the network.

<b>Same-Gender Domestic Partner</b>	
Is my same-gender domestic partner eligible for benefits?	Retirees can enroll their eligible same-gender domestic partners in medical and dental. However, the retiree must be enrolled in the medical and/or dental plan for the same-gender domestic partner coverage to be effective. Certain criteria must be met; see the “Eligibility” section in the <i>Retiree Health Benefits Guide</i> for details.
<b>Referrals</b>	
Are doctor referrals required on the Blue Cross Blue Shield 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.  For behavioral healthcare, see the <a href="#">earlier question</a> regarding Employee Assistance Plan (EAP) referral and Blue Cross Blue Shield Precertification requirements.
<b>BLUE CROSS BLUE SHIELD (BCBS): MEDICARE-ELIGIBLE PARTICIPANTS</b>	
<b>Build Your Own Options</b>	
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 BCBS PPO plan is secondary to Medicare, 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.

<b>Coverage</b>	
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.
<b>Filing Claims</b>	
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.
<b>Medicare Part B</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) PPO will estimate what Medicare Part B would have paid and will continue to pay as secondary insurance. You must enroll in Medicare Part B if you want to realize the full benefit under the BCBS PPO Plan.

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

## CARRIER CHANGE

### *Transition of Care*

I want to keep my doctor and he is not participating in my newly available HMO option. How do I get transition of care information when I change my medical plan?

If any of the following conditions apply to you, you might be eligible to remain with your current doctor for a transition period of up to three months:

- Pregnancy, with expected delivery in the first quarter of 2006
- Extensive therapy such as chemotherapy
- A terminal illness
- Waiting for a transplant
- Behavioral health issues (beyond EAP)
- Surgery scheduled for the first quarter of 2006

If you have other ongoing medical conditions and your current doctor is not in the new network, you may be eligible for other assistance. Your new medical plan administrator will be able to help you find an appropriate 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 medical plan administrators by contacting them directly. Return the forms to your new medical plan administrator in early December. If you are hospitalized at the end of the year and your hospital stay continues into 2006, you should contact your 2005 medical plan administrator and your 2006 medical plan administrator to understand what procedures need to be followed.

<b>DENTAL</b>	
<i>Dental</i>	
Can I elect dental only through TI Extended Health Benefits Coverage?	Yes, you can elect dental only.
If I do not elect dental coverage at the time of retirement, will I be able to elect it at a later date?	<p>If you terminated employment on or after Jan. 1, 1998, and you don't enroll in dental coverage through TI Extended Health Benefits Coverage prior to or within 30 days from the date you terminated, you'll be eligible to enroll for coverage later (during annual enrollment or in the event of an appropriate qualified status change) as long as you're enrolled in medical coverage through TI Extended Health Benefits Coverage.</p> <p>If you terminated employment prior to Jan. 1, 1998, and you do not elect dental coverage at the time of retirement, you can elect dental coverage at later date.</p> <p>Regardless of your termination date, if you elect coverage, you may also enroll your eligible dependents, unless they are eligible for coverage under another health plan. In this case, you may not cover your dependents under this plan. If a dependent loses eligibility for coverage at a later date, it will be considered a qualified status change, and you may enroll the dependent at that time, as long as you remain enrolled in TI Extended Health Benefits Coverage. You may also add a dependent during any annual enrollment period.</p>

<p>I was told that if I'm on MetLife Dental Plus and then sign up for MetLife Dental Basic, I can't sign back up for Dental Plus again. Is that true?</p>	<p>This is not true. MetLife Dental Basic and MetLife Dental Plus should both be displayed as available options for 2006. During annual enrollment you can change the dental coverage between the available choices.</p> <p>Please be aware that switching from MetLife Dental Basic to MetLife Dental Plus does not allow increased orthodontia benefits. In addition, please note there are cost differences between the two plans.</p>
<p>What is the annual maximum for the MetLife Dental Plan?</p>	<p>The annual maximum for Dental Basic is \$1,000 and the annual maximum for Dental Plus is \$1,500.</p> <p>Orthodontia services are covered at 50% up to the lifetime maximum of \$1,000 for Dental Basic and 50% up to the lifetime maximum of \$1,500 for Dental Plus.</p>
<p>What is the advantage of using a network provider in the MetLife dental plans?</p>	<p>Dentists in the MetLife network must negotiate their rates, resulting in lower fees for you and TI. Reasonable and customary limits do not apply if you use network providers.</p> <p>There is not a penalty or coinsurance difference if you do not use a MetLife dentist, but reasonable and customary limits do apply.</p>
<p>What is Reasonable and Customary?</p>	<p>Reasonable and Customary charge is the usual cost for comparable treatment in a local geographic area.</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 MyBenefits Web site (<a href="http://www.metlife.com/mybenefits">www.metlife.com/mybenefits</a>). 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><b><i>DeltaCare Dental HMO</i></b></p>	
<p>Why is DeltaCare Dental HMO no longer offered?</p>	<p>The DeltaCare Dental HMO will not be offered in 2006 due to rate increases.</p>
<p>What if I have not completed a dental procedure with DeltaCare by the end of the year?</p>	<p>The network dentist will complete treatment in progress for dental procedures such as teeth prepared for crowns, root canals in progress and the completion of a partial or full denture for which the impression has been taken.</p> <p>If you or your covered dependents are receiving any orthodontic treatment, you will be solely responsible for payment of any balance due for treatment provided after December 31, 2005. In this event, your payment shall be based on a maximum of \$1,950 for dependent children up to age 19 and \$2,150 for covered full-time students and adults. The amount will be prorated over the number of months to completion of the treatment and will be payable on such terms and conditions as are arranged between the enrolled and the network orthodontist. Start-up fees are included in these amounts.</p>

How do I find out whether my dentist is in one of the other dental plan offerings in 2006?	Visit YBR and select the “Find a Doctor” option. You can also call MetLife or Aetna Dental HMO (DMO) by contacting the TI Benefits Center through TI SmartLink at (800) 890-2600.
If I do not make a dental election during annual enrollment what type of coverage will I have?	<p>If you're enrolled in the Delta Dental HMO plan for 2005 and don't make another choice for 2006, you will automatically be enrolled in either:</p> <ul style="list-style-type: none"> <li>• Aetna Dental HMO (DMO),if available in your area, or</li> <li>• MetLife Basic Dental, if Aetna DMO is not available in your area.</li> </ul> <p><b>Note:</b> Your 2005 category of coverage (for example, you + family) will automatically be carried forward for 2006.</p>
Will there be a change in the plan price?	Yes. Please refer to the health plan prices in your annual enrollment materials.
How can I nominate a dentist in Aetna Dental HMO (DMO) plan	If you would like to nominate dental providers for the Aetna Dental HMO (DMO) plan, visit <a href="http://www.aetna.com">www.aetna.com</a> . Select “Doctors and Hospitals,” then “Provider Application Request,” then “Dental.” Or just click <a href="#">here</a> .

## ELIGIBILITY

### *Coverage*

Do I have to carry medical insurance to be covered by dental?	No. As a retiree, you do not have to carry medical insurance to be covered by dental.
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## GENERAL

### ***Changing Contact Information***

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

Through YBR:

- Go to the Your Benefits Resources (YBR) Web site at <http://resources.hewitt.com/ti/>
- Check the “Log On” box
- Input your Social Security number and Hewitt password
- If you have never created a Hewitt password, click the “Register as a New User” box. You will be prompted to enter your birth date and old zip code. Once that information is verified, you will create your password to be used with the YBR Web site and the TI Benefits Center. Once the process is completed, you will be logged on to the YBR Web site and gain access to all its tools and features.
- From the main page, click "Your Profile", which is located in the “Topics” box on the left side of the page.
- On the "Your Profile" page, click the tab labeled "Mailing Addresses". The Web site will display the permanent address on file for you.
- Retirees can change this address by clicking the "Change" link next to the permanent address.

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<p>What is the process to change my personal information, including phone number and address? Does this also affect the information that TI retains? <i>(continued)</i></p>	<p>The TI Benefits Center can also change your address. You can reach them by calling (800) 890-2600, enter or say your Social Security number; the system will state the main menu items. Please say "TI Benefits Center". You will be prompted to give your Hewitt password. If you don't have one, do nothing. The system will repeat the request for your password four times. After the fourth request, you will be transferred to a TI Benefits Center representative who will assist you with setting up a password for the TI Benefits Center and the YBR Web site. Be prepared to provide the representative with your birth date and your "old" zip code (the zip code currently in the YBR system).</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. <b>If you move, you must contact the TI Benefits Center within 30 days of your move.</b> You will need to contact the TI Benefits Center directly to understand how a change of address may change your benefits. Additionally, if you have a temporary address during part of the year, don't forget to notify the U.S. Postal Service so that correspondence from TI and the TI Benefits Center is forwarded to you.</p>
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<b>Customer Service</b>	
When I call the TI Benefits Center through TI SmartLink, will I be talking to a TI employee?	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 contribution plans. TI Benefits Center representatives are available Monday through Friday, 8:30 am to 4:30 pm Central Time.
<b>Death Certificate</b>	
Why do you need a copy of a death certificate to cancel the insurance coverage on my deceased spouse?	A death certificate is not required to cancel health insurance coverage on a deceased spouse. Please contact the TI Benefits Center via TI SmartLink at (800) 890-2600 to report the death and update your coverage.
<b>Definitions</b>	
What is Medicare Part A and Part B?	<p>Medicare Part A is hospital insurance that helps pay for inpatient hospital stays, care in a skilled nursing facility, hospice care and some home health care.</p> <p>Medicare Part B is the part of Medicare that covers doctors' services and outpatient hospital care. It also covers other medical services that Part A does not cover, such as physical and occupational therapy.</p>
What is split-family coverage?	If you and your spouse are both pre-Medicare, you must enroll in the same pre-Medicare plan option. If you and your spouse are both Medicare-eligible, you must enroll in the same Medicare-eligible plan option. Split-family coverage is available only if you and your spouse have different Medicare eligibility statuses.

## ***Enrollment***

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?

### **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 is not eligible for Medicare, special split-family rules may apply depending on which plan you are enrolled in. Some HMOs do not allow split-family enrollments.
  
- When a family member becomes eligible for Medicare, that member must enroll in a Medicare-eligible medical plan through the TI Extended Health Benefits Coverage. All family members who are not eligible for Medicare can continue to be enrolled in their current medical plan, if it allows split-family enrollments. You must choose two (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 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 for health benefits by the enrollment deadline, you will be automatically enrolled in the coverage you had in 2005. If you have no coverage in 2005, you will be assigned no coverage in 2006.</p> <p>If your 2005 medical plan is no longer available, you will be enrolled in the Blue Cross Blue Shield PPO Plan (default design) for 2006 at the coverage category you had in 2005 (for example, you + family).</p> <p>The DeltaCare Dental HMO plan won't be offered in 2006. If you're enrolled in this plan for 2005 and don't make another choice for 2006, you'll automatically be enrolled in either:</p> <ul style="list-style-type: none"><li>• Aetna Dental HMO (DMO), if available in your area, or</li><li>• MetLife Dental Basic, if Aetna DMO isn't available in your area.</li></ul> <p><b>Note:</b> Your 2005 category of coverage (for example, you + family) will automatically be carried forward for 2006.</p> <p>Once annual enrollment is over, you will not be able to change your coverage until the next annual enrollment period, unless you have an appropriate qualified status change. Changes in coverage must be consistent with the change in status. You must make changes within 30 days of a qualifying event.</p> <p><i>Continued on next page</i></p>
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If I do not make any changes for annual enrollment, what will happen to my coverage?  
*(continued)*

If you want to drop coverage, you must contact the TI Benefits Center. **IMPORTANT NOTE:** If you terminated employment on or after Jan. 1, 1998, you may not opt in and out of medical coverage through TI Extended Health Benefits Coverage. If you elect to drop coverage, **you will not be eligible** to re-enroll in a TI-sponsored medical plan at any time.

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How do I report a life event (for example, birth, adoption, death, marriage, divorce, etc.) and change my benefits elections?

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

- Within 30 days of your first day as a TI retiree
- Each year during annual enrollment
- Within 30 days of a qualified status change, which includes changes in:
  - Legal marital status
  - Number of dependents
  - Dependent eligibility (when a dependent meets or fails to meet eligibility requirements)
  - Death of a spouse or same-gender domestic partner/dependent
  - Spouse or same-gender domestic partner/dependent annual enrollment

A full list of qualified status changes can be found in the *2006 Retiree Health Benefits Guide*.

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

You must make your election changes within 30 days of the qualifying event by either processing the “Change Your Current Coverage” online request, found under the “Health, Insurance...” section on the Your Benefits Resources™ (YBR) Web site or by contacting the TI Benefits Center.

If you move, you must contact the TI Benefits Center. If you are covered by an HMO and move out of that HMO’s service area, you may enroll in the Blue Cross Blue Shield PPO or another HMO, if available in your area. In such cases, you must contact the TI Benefits Center within 30 days of your move.

***TI Extended Health Benefits Coverage Billing***

<p>When will I be billed for my TI Extended Health Benefits Coverage?</p>	<p>Billing notices will be generated on the 10th of the month and mailed on the 15th of the month for plan prices due the first of the month. For example: The January billing notices will be generated on Dec. 10, 2005 and mailed Dec. 15, 2005 for January plan prices due on Jan. 1, 2006.</p> <p>Regardless of when you terminated from TI, if you fail to submit monthly payments within 30 days of the due date, your coverage will end retroactive to the last day of the month for which payment was received. If your coverage is dropped because of non-payment, you <b>WILL NOT BE ELIGIBLE</b> to re-enroll in a TI-sponsored health plan at any time.</p>
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***Generic Drugs***

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?

Retirees/dependents enrolled in the Blue Cross Blue Shield PPO, will pay the appropriate coinsurance (based on your “Build Your Own Options” prescription selection for pre-Medicare participants) for the generic drug, plus the cost difference between the brand-name and generic drug.

For Medicare-eligible participants - Retirees/dependents enrolled in the Blue Cross Blue Shield PPO, will pay the appropriate coinsurance for the generic drug, plus the cost difference between the brand-name and generic drug.

If you are an HMO participant, please contact your current carrier for details on their process.

How can I get my Caremark prescriptions through the mail-order program?

To participate in the Caremark mail-order program you must complete the mail service order form. The form can be accessed on the Caremark Web site ([www.caremark.com](http://www.caremark.com)). Click “Online Forms,” then “Mail Service Order Form.” Or you can contact Caremark directly through TI SmartLink.

### ***ID Card***

What do I do if I have to go to the doctor and I have not received my medical ID cards?

If you remain in your current plan for 2006, you will not receive a new plan card.

Following annual enrollment, medical ID cards will be mailed to your home prior to Jan. 1, 2006. If you don't receive your card by Jan. 1, 2006, verify your address information on the Your Benefits Resources (YBR) Web site at <http://resources.hewitt.com/ti/> or call the TI Benefits Center through TI SmartLink.

If your address information is correct, contact your health plan through TI SmartLink at (800) 890-2600 to request replacement cards be mailed to you.

## **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 Advantage (formerly known as 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>

<b>Plan Prices</b>	
Why did some prices increase?	Like most employers, Texas Instruments is facing steep increases in the cost of healthcare for its employees and retirees. As a result, TI had to look for ways to manage costs while trying to maintain affordable benefits for employees and retirees.

<b><i>PPO vs. HMO</i></b>	
What is the difference between a PPO and an HMO?	<p>Under a PPO (preferred provider organization), you have the freedom to choose any provider when you need care as long as you are willing to pay more for a non-network provider. There is also no need for physician referrals under a PPO plan. You can make an appointment directly with a specialist.</p> <p>Under an HMO (health maintenance organization), you must use HMO network providers to receive benefits, and your medical care must typically be provided by a primary care physician (PCP) who will arrange for referrals to specialists and coordinate any hospital services.</p>

<b><i>Find a Doctor</i></b>	
How can I obtain a provider listing?	You can obtain a provider listing by accessing the Your Benefits Resources (YBR) Web site. Click “Find a Doctor” or contact your medical carrier. You can reach your medical carrier by calling TI SmartLink at (800) 890-2600.

<b><i>Provider vs. Carrier</i></b>	
What is the difference between a provider and a carrier/supplier?	In general a provider is considered to be your doctor, hospital or pharmacist (a person or place that treats your illness) while a carrier/supplier is your health plan or insurance carrier, such as Blue Cross Blue Shield, CIGNA, MetLife or Aetna (a group that administers or pays the claims based on the design of the plan).
<b>HMO</b>	
<b><i>Coverage</i></b>	
I am under 65 and thinking of changing to a participating HMO. I am concerned if my medication will be covered.	<p>To determine whether your medication is covered under the HMO, go to the HMO's Web site or contact 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 view HMO contact information on the YBR Health Plan Comparison Charts. 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 customer service representative.</p> <ul style="list-style-type: none"> <li>• Enter your Social Security number</li> <li>• First menu option, say "Health Care"</li> <li>• Second menu option, say "Health Plans"</li> <li>• Third menu option, say "Medical"</li> </ul> <p>Your call will then be automatically routed to the HMO's Customer Service.</p>

<b><i>Provider</i></b>	
If I change to an HMO, what if my current doctors are not in their plan?	Check the HMO Web site to determine if your primary care and other doctors are covered by their plan. You should also confirm with the physician's office if they will accept your HMO coverage. If your doctors are not in the HMO, you will need to select new physicians if you change to the HMO.
<b>MEDICARE PRESCRIPTION DRUG COVERAGE</b>	
<b><i>Eligibility</i></b>	
What is Medicare Prescription Drug Coverage?	Medicare Prescription Drug Coverage is the new voluntary outpatient prescription drug benefit (available Jan. 1, 2006) administered by private health insurance companies.
Can I choose to keep my medical coverage through TI Extended Health Benefits Coverage in 2006?	Yes. You may elect to keep your medical coverage through TI Extended Health Benefits Coverage in 2006. However, Medicare-eligible TI retirees and/or Medicare-eligible dependents will not be able to participate in both medical coverage through TI Extended Health Benefits Coverage and Medicare Prescription Drug Coverage.
Can I be in medical coverage through TI Extended Health Benefits Coverage and have Medicare Prescription Drug Coverage?	No. You will not be allowed to be enrolled in medical coverage through TI Extended Health Benefits Coverage <u>and</u> Medicare Prescription Drug Coverage.

<p>If I choose Medicare Prescription Drug Coverage, can my spouse or dependent that is not Medicare-eligible remain in medical coverage through TI Extended Health Benefits Coverage?</p>	<p>No. To maintain coverage of your spouse or dependent in medical coverage through TI Extended Health Benefits Coverage, you must also remain in medical coverage through TI Extended Health Benefits Coverage.</p>
<p>What will happen if I accidentally enroll in medical coverage through TI Extended Health Benefits Coverage and Medicare Prescription Drug Coverage?</p>	<p>If you enroll in medical coverage through TI Extended Health Benefits Coverage and Medicare Prescription Drug Coverage the following will happen:</p> <p><b>Prior to May 15, 2006</b>  You will be notified by the TI Benefits Center and given notice that if you do not drop Medicare Prescription Drug Coverage you will be dropped from the plan in a specified period of time.</p> <p><b>After May 15, 2006</b>  If no action is taken prior to May 15, 2006, you will be dropped from the TI Extended Health Benefits Coverage. If you terminated prior to January 1, 1998, you will lose medical benefits for the remainder of the year and will be eligible to re-enroll in a TI sponsored health plan during any annual enrollment or within 30 days of an appropriate qualified status change. If you terminated on or after January 1, 1998 you will not be able to re-enroll in a TI sponsored health plan at any time.</p>

<p>What will Medicare Prescription Drug Coverage cost?</p>	<p>Currently, according to Medicare, you will pay approximately between \$33 and \$37 per month per person during 2006 and your annual Medicare Prescription Drug Coverage deductible will be up to \$250. Medicare also indicates that you will be required to pay a copay or coinsurance that will vary depending on which drug plan you choose.</p>
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<p>I am currently enrolled in medical coverage through TI Extended Health Benefits Coverage. How will I know whether to sign up for the new Medicare Prescription Drug Coverage benefit in November?</p>	<p>TI will continue to provide medical coverage through TI Extended Health Benefits Coverage which is considered to be at least as good as Medicare’s Prescription Drug Coverage.</p> <p>If you can afford medical coverage through TI Extended Health Benefits Coverage you can keep it and not enroll Medicare Prescription Drug Coverage. In this case, if you later lose your retiree coverage, you can enroll in the Medicare Prescription Drug Coverage benefit without a penalty (as long as you are not without drug coverage for more than 63 days).</p> <p>If medical coverage through TI Extended Health Benefits Coverage is too expensive for you, you can drop medical coverage and enroll in a Medicare Prescription Drug Coverage plan. If you decide to drop medical coverage through TI Extended Health Benefits Coverage you will receive a Creditable Prescription Drug Coverage notice to prove that your prior coverage is considered to be at least as good as Medicare’s Prescription Drug Coverage. If you terminated employment on or after Jan. 1, 1998, you will <b>not be eligible</b> to re-enroll in medical coverage through TI Extended Health Benefits Coverage at any time.</p> <p>If you elect Medicare Prescription Drug Coverage you and your dependents will be dropped from medical coverage through TI Extended Health Benefits Coverage. This means that you and your covered family members will lose both your TI medical and prescription coverage. If you terminated employment on or after Jan. 1, 1998, you <b>will not be eligible</b> to re-enroll in medical coverage through TI Extended Health Benefits Coverage at any time.</p>
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<p>Why might I want to choose Medicare Prescription Drug Coverage instead of a medical coverage through TI Extended Health Benefits Coverage?</p>	<p>For some individuals, Medicare Prescription Drug Coverage may be a better option than the TI prescription drug portion of the medical coverage through TI Extended Health Benefits Coverage. Depending on your prescription drug needs and your cost, each plan has its own advantages.</p>
<p>Do I need to enroll in Medicare Prescription Drug Coverage if I have medical coverage through TI Extended Health Benefits Coverage?</p>	<p>NO. You CANNOT enroll in Medicare Prescription Drug Coverage if you want to maintain your medical coverage through TI Extended Health Benefits Coverage.</p>
<p>Can TI tell me which Plan is better for me?</p>	<p>No. Under the Medicare Modernization Act, companies are not allowed to provide guidance to participants that would persuade them to take one plan over another. Thus, TI can only provide information and each retiree must make his or her own decision about which option best meets his or her needs.</p>

<p>What if I cover a dependent?</p>	<p>It is important to consider how much you are spending to cover your dependent with medical coverage through TI Extended Health Benefits Coverage and compare that to the expected cost of a replacement plan under Medicare's Prescription Drug Coverage.</p> <p>Retirees covering dependents who are not Medicare-eligible may want to maintain medical coverage through TI Extended Health Benefits Coverage in order to maintain medical coverage for these dependents. If a Medicare-eligible TI retiree chooses Medicare Prescription Drug Coverage, his or her dependents will no longer be able to receive medical coverage through TI Extended Health Benefits Coverage.</p> <p>Please plan carefully because this change may leave your family members without medical and prescription drug coverage if they don't have coverage elsewhere.</p>
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<p>How do I know if my prescription drug coverage is, on average, “as good as” Medicare’s Prescription Drug Coverage?</p>	<p>Health plans are required to provide a Creditable Prescription Drug Coverage notice to all Medicare-eligible participants stating whether the plan is, on average, proven to be at least as good as Medicare Prescription Drug Plans.</p> <p>TI has determined that the prescription drug portions of all medical coverage through TI Extended Health Benefits Coverage <u>are</u> creditable, or on average, at least as good as Medicare Prescription Drug Plans.</p> <p>You will receive a Creditable Prescription Drug Coverage notice with your TI Extended Health Benefits Coverage annual enrollment materials. It is important that you keep a copy of the notice so you can prove to Medicare that you had continuous coverage, if you ever choose to enroll in Medicare Prescription Drug Coverage.</p>
<p>Why is Creditable Prescription Drug Coverage important?</p>	<p>If you have creditable prescription drug coverage, you will not be penalized if you choose to enroll in Medicare Prescription Drug Coverage after the initial enrollment period.</p> <p>If you do not have creditable prescription drug coverage, your Medicare Prescription Drug Coverage premium will go up 1% for every month you delay enrolling.</p> <p>If you have creditable coverage and lose it, you will have 63 days to enroll in Medicare Prescription Drug Coverage without penalty.</p>

<p>If I meet TI eligibility requirements, when and how do I enroll in TI's Extended Health Benefits Coverage?</p>	<p>Between <b>Oct. 24 and Nov. 18</b>, you can enroll by phone or through the Your Benefits Resources™ (YBR) Web site at <a href="http://resources.hewitt.com/ti">http://resources.hewitt.com/ti</a> using your Social Security number and Hewitt password. To access YBR through the TI Alumni Association Web site, go to <a href="http://tialumni.org">tialumni.org</a>.</p> <p>TI has extended retiree enrollment this year to give Medicare-eligible retirees more time to compare their TI benefit offerings to Medicare and the new prescription drug benefit.</p> <p><b>Phone Users Only:</b> To allow additional time for you to review the new Medicare Prescription Drug Coverage option, your enrollment window has been extended through <b>Nov. 30</b>. The phone lines are open from 8:30 a.m. through 4:30 p.m. Central time (excluding weekends and the November 24 and 25 TI holidays). For phone enrollment, call the TI Benefits Center through TI SmartLink at (800) 890-2600.</p>
<p>What are the dates for enrollment in Medicare Prescription Drug Coverage?</p>	<p>The initial Medicare Prescription Drug Coverage enrollment period runs from Nov. 15, 2005, through May 15, 2006. If you enroll by Dec. 31, your coverage will begin Jan. 1, 2006. For detailed enrollment information regarding Medicare Prescription Drug Coverage, please visit the Medicare Web site at <a href="http://www.medicare.gov">www.medicare.gov</a> or call (800) MEDICARE (800-633-4227).</p>

<p>What if I am enrolled or plan to enroll in one of TI's HMO plans, how does Medicare Prescription Drug Coverage impact me?</p>	<p>If you are enrolled or plan to enroll in one of the TI-sponsored Medicare Advantage Plans, PacifiCare Secure Horizons HMO or UHC Medicare Complete HMO, they will continue to serve as your prescription drug providers. Both plans have confirmed that their coverage is, on average, at least as good as Medicare's Prescription Drug Coverage. The TI-sponsored Medicare Advantage Plans already provide prescription drug coverage, so you will not be able to enroll in a different Medicare Prescription Drug Plan without dropping the TI-sponsored Medicare Advantage Plan.</p> <p>Due to guidelines related to the new Medicare Prescription Drug Coverage, formularies (list of covered prescription drugs) for the HMO plans will be changing for 2006. Additionally, with the UHC Medicare Complete HMO, there will be changes in copay amounts, mail order will be available, and the annual maximum limit for prescription drug costs will change. Details on these changes will be available in the October timeframe.</p>
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<p>Can I get back into medical coverage through TI Extended Health Benefits Coverage if I elect a Medicare Prescription Drug Plan?</p>	<p>If you enroll in the Medicare Prescription Drug Coverage and would like to re-enroll in the TI Extended Health Benefits Coverage following will happen:</p> <p><b>Prior to May 15, 2006</b>  You will be notified by the TI Benefits Center and given notice that if you do not drop Medicare Prescription Drug Coverage you will be dropped from the plan.</p> <p><b>After May 15, 2006</b>  If no action is taken prior to May 15, 2006, you will be dropped from the TI Extended Health Benefits Coverage. If you terminated prior to January 1, 1998, you will lose medical benefits for the remainder of the year and will be eligible to re-enroll in a TI sponsored health plan during any annual enrollment or within 30 days of an appropriate qualified status change. If you terminated on or after January 1, 1998 you will not be able to re-enroll in a TI sponsored health plan at any time.</p>
<p>How will Medicare administer its prescription drug plan?</p>	<p>For current information on Medicare Prescription Drug Coverage, read <i>Introducing Medicare's New Coverage for Prescription Drugs</i>, which is available at the Medicare Web site at <a href="http://www.medicare.gov">www.medicare.gov</a> or by calling (800) MEDICARE (800-633-4227).</p>

<p>Is assistance available for participants with limited income and resources?</p>	<p>The Medicare Prescription Drug Coverage will provide extra financial assistance to individuals with limited income and resources. Individuals who might be eligible for limited income assistance may have already received a letter from the Social Security Administration. This letter provides information on how to apply for extra financial help toward the cost of the Medicare Prescription Drug Coverage.</p> <p>Any retiree receiving the limited income assistance letter should fill out the application to determine his or her individual costs for Medicare Prescription Drug Coverage before making a decision. Filling out the application does <u>not</u> sign you up for Medicare Prescription Drug Coverage.</p> <p>If you feel you may be eligible for limited income and resources assistance, but you did not receive an application, you may contact SSA at (800) 772-1213 or visit the Web site at <a href="http://socialsecurity.gov">socialsecurity.gov</a>. For more information, call (800) MEDICARE (800-633-4227) or log on to the Medicare Web site at <a href="http://www.medicare.gov">www.medicare.gov</a>.</p>
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**TI RETIREE MEDICAL CAP**

***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>
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<p>How did TI come up with the amount of its retiree medical cap?</p>	<p>Based on TI Health Plan costs in 1992, TI calculated the maximum it would contribute toward premiums for post-1992 retirees with at least 30 years of service at \$6,000 for pre-Medicare retirees and \$1,800 for Medicare-eligible retirees.</p> <p>After reviewing TI Health Plan costs again in 2004, TI made the decision to raise the caps to \$11,000 for pre-Medicare retirees and \$4,000 for Medicare-eligible retirees with at least 30 years of service. TI's maximum contribution is prorated for retirees with service between 15 and 30 years. TI does not contribute to spouse and dependent premiums for post-1992 retirees.</p>
<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>Taking steps to control your healthcare costs is a win-win activity for both you and TI. Here are some ways you can help:</p> <ul style="list-style-type: none"> <li>- Take care of yourself. Exercise regularly, eat healthy, and get regular check-ups.</li> <li>- Ask about generics when filling a prescription.</li> <li>- Do not smoke.</li> <li>- Adhere to treatment plans for chronic conditions.</li> <li>- Prepare and ask questions at doctor visits.</li> </ul>
<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>

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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.