As you already know, the Aetna HealthFund™ HRA option will not be offered after December 31, 2014. Texas Instruments Incorporated (TI) is still required to notify you of important changes to the TI Employees Health Benefit Plan (the “Plan”). This notification, called a Summary of Material Modification (SMM), reflects the provisions that will apply for 2013 and 2014 in the Aetna HealthFund™ (HRA) option and to alert you to use your HRA in 2014. And, it is intended to update the TI 2013 Health Benefits Guide for HRA-Eligible Employees (also referred to as the Summary Plan Description, or SPD).

Please keep this 2014 SMM with your TI 2013 Health Benefits Guide for HRA-Eligible Employees to maintain a current description of the Plan and its benefits.

The TI 2013 Health Benefits Guide for HRA-Eligible Employees can be found on the Fidelity NetBenefits® website, by logging on to netbenefits.com/ti. Or you can download it from benefits.ti.com. Click the Health tab, then Benefits Guide. To obtain a paper copy, contact the TI Benefits Center through TI HR Connect at 888-660-1411, option 1.
CHANGE #1: Effective 1/1/2013 – Coverage for Prescription Contraceptives for Women enhanced

Prescription Contraceptives for Women will be paid at 100% of the total drug cost when obtained at an in-network pharmacy and by in-network providers. This applies to generic drugs and brand-name drugs (when no generic available). This applies to FDA-approved contraceptive methods including, but not limited to: barrier methods, hormonal methods, and implanted devices. Contraceptive methods that are generally available over-the-counter are covered if the method is both FDA-approved and prescribed for a woman by her health care provider. Contraception for men is not covered. 100% of the total cost of a generic contraceptive drug is covered without cost-sharing. If however, a generic version is not available, or would not be as medically appropriate for the patient as a prescribed brand name contraceptive method (as determined by the attending provider, in consultation with the patient), then coverage is provided without cost-sharing, subject to reasonable medical management. Services, as prescribed by a health care provider, related to patient education and counseling, follow-up and management of side effects of FDA-approved contraceptive methods, counseling for continued adherence, and device removal are covered. These services are covered without cost-sharing, subject to reasonable medical management.

CHANGE #2: Additional Preventive Care Services coverage

Additional preventive care services are covered in 2013 and 2014. These additional services will be paid at 100% for Network Services; no copay, coinsurance or deductibles apply. These additional preventive care services are described below.

- Human Papillomavirus (HPV) DNA test will be covered every 3 years for women age 30 and older, effective 1/1/2013
- Bone Density Screening for Osteoporosis will be covered annually for women age 65 and older and every 2 years for women age 50 and older if at increased risk, effective 1/1/2013
- Aspirin for men and women age 45 and over, when prescribed by a physician, effective 1/1/2014
- Vitamin D supplementation for men and women age 65 and over, when prescribed by a physician, effective 1/1/2014
- Genetic Risk Assessment and BRCA Testing for Breast and Ovarian Cancer is covered once only for any women with increased family history, effective 1/1/2014
- Folic acid supplementation for women planning or capable of pregnancy, when prescribed by a physician, effective 1/1/2014
- Routine iron supplementation for asymptomatic children ages 6 to 12 months, when prescribed by a physician, effective 1/1/2014
- Fluoride supplementation for children from age 6 months through age 5, when prescribed by a physician, effective 1/1/2014
- Counseling about minimizing exposure to ultraviolet radiation to reduce risk of skin cancer for fair-skinned children, adolescents and adults to age 24 years. 1/1/2014
- Testing for Chlamydia or Gonorrhea annually for men and women age 18 and older and sexually active, effective 1/1/2013
- Screening for HIV at least annually for men and women age 18 and older if at increased risk, effective 1/1/2013
- Colorectal cancer screening-Stool Blood Test annually for men and women age 50 and older, effective 1/1/2013
- Diphtheria/Tetanus/Pertussis every 10 years for men and women age 18 and older, effective 1/1/2013
- Screening for autism for children at 18 and 24 months, effective 1/1/2013
- Gonorrhea Prevention Medication once for newborns, effective 1/1/2013
- Papanicolaou (Pap) Test (including ThinPrep™ and HPV testing) every 3 to 5 years for female children who are sexually active, effective 1/1/2013
- HIV screening at least annually for male and female children who are sexually active, effective 1/1/2013
- Testing for Chlamydia, Gonorrhea and Syphilis annually for male and female children who are sexually active, effective 1/1/2013
- Dyslipidemia screening annually for children ages 0 to 18, effective 1/1/2013
- In-Network contraceptive counseling for the first two visits each year.
- Screening and counseling services to aid in the cessation of the use of tobacco products including preventive counseling visits, treatment visits and class visits to aid in the cessation of the use of tobacco products. Note preventive counseling services provided out of Network are covered at 50%.

CHANGE #3: Effective 1/1/2014 – Breast Pump coverage expanded

Breast Pump coverage has been expanded to include the following covered expenses:
- The rental of a hospital-grade electric pump for a newborn child for the period of time that the newborn is detained in the hospital.
- The purchase (once every 3 years) of:
  - An electric breast pump (non-hospital grade), if requested within 60 days from the date of the birth of the child; or
  - A manual breast pump, if requested within 12 months from the date of the birth of the child.

Breast Pump Supplies - Coverage is limited to a new set of breast pump supplies for subsequent pregnancies where a covered female would not qualify for the purchase of a new pump (e.g., electric or manual breast pump received with the previous 3 years).

CHANGE #4: Effective 1/1/2014 – Medical Nutrition Therapy benefits have been expanded to allow reimbursement for services received by non-network providers

The coinsurance for medical nutrition therapy services received by non-network providers is now 50% of the Recognized Charge, after the deductible is met.

CHANGE #5: Effective 1/1/2014- Certain Clinical Trials are Covered

The plan covers routine patient care costs related to clinical trials where the participant is eligible to participate in an approved clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition (disease or condition where the likelihood of death is probable unless the course is interrupted). A participant is eligible to participate in an approved clinical trial based on referral from a health care professional participating in the trial or by providing medical and scientific information establishing that participation would be appropriate. A clinical trial is approved if it is a phase I, II, III or IV trial that is federally funded by specified agencies or is conducted under an investigational new drug application reviewed by the FDA.

The plan will not deny (or limit or impose additional conditions on) the coverage of routine patient costs (e.g., e-rays, blood tests, and physician and hospital charges) for items and services furnished in connection with participation in the trial. Routine patient costs do not include: (i) investigational items, devices, or services; (ii) items and services that are provided for data collection and analysis needs and that are not used in the direct clinical management of the patient; or (iii) any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The plan may require the covered individual to participate in the trial through an in-network provider if a network provider is a participant in the clinical trial and the provider accepts the
individual as a participant in the trial. A qualified individual may participate in an approved clinical trial conducted outside the state in which he or she resides.

The plan will not discriminate against the individual on the basis of the individual's participation in a clinical trial.

**CHANGE #6: Effective as of 1/1/2015-Health Reimbursement Arrangements and Aetna HealthFund™ HRA Option will cease to be an Option under the TI Employee Health Benefit Plan**

Effective as of January 1, 2015, the Aetna HealthFund™ HRA Option will cease to be offered as a benefit option under the TI Employee Health Benefit Plan. You must incur any amounts you want to submit for reimbursement under the Health Reimbursement Arrangement (the account feature under this option) by December 31, 2014 and you must submit any such medical expense to Aetna for reimbursement under the Health Reimbursement Arrangement (account) no later than March 31, 2015. Processing of any claims to be submitted for reimbursement under the Health Reimbursement Arrangement (account) (for claims incurred prior to December 31, 2014) must be submitted on or before March 31, 2015. Any amounts remaining in your Health Reimbursement Arrangement (the account under the Aetna HealthFund™ HRA) will be forfeited after processing of all 2014 claims which were submitted on or before March 31, 2015.

**CHANGE #7: Effective as of 1/1/2013-the “Recognized Charge” Definition beginning on page 14 and ending on page 15 just before “Additional Information” is replaced with the following which defines how Out-of-Network benefits are paid**

The covered expense is only that part of a charge which is the Recognized Charge.

As to medical, vision and hearing expenses, the Recognized Charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services and other services or supplies not mentioned below:
  - the 80th percentile of the Prevailing Charge Rate;
  - For the Geographic Area where the service is furnished.

As to prescription drug expenses, the Recognized Charge for each service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- 110% of the Average Wholesale Price (AWP) or other similar resource. Average Wholesale Price (AWP) is the current average wholesale price of a prescription drug listed in the Medi-Span weekly price updates (or any other similar publication chosen by Aetna).

A service or supply will be treated as a covered expense under the Other Health Care benefits category when Aetna determines that a network provider is not available to provide the service or supply. This includes situations in which you are admitted to a network hospital and non-network physicians, who provide services to you during your stay, bill you separately from the network hospital. In those instances, the Recognized Charge for that service or supply is the lesser of:

- What the provider bills or submits for that service or supply; and
- For professional services:
  - the 80th percentile of the Prevailing Charge Rate
  - For the Geographic Area where the service is furnished.

If Aetna has an agreement with a provider (directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply, then the Recognized Charge is the rate established in such agreement.
Aetna may also reduce the Recognized Charge by applying Aetna Reimbursement Policies. Aetna Reimbursement Policies address the appropriate billing of services, taking into account factors that are relevant to the cost of the service such as:

- the duration and complexity of a service;
- whether multiple procedures are billed at the same time, but no additional overhead is required;
- whether an assistant surgeon is involved and necessary for the service;
- if follow up care is included;
- whether there are any other characteristics that may modify or make a particular service unique; and
- when a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided.

Aetna Reimbursement Policies are based on Aetna’s review of: the policies developed for Medicare; the generally accepted standards of medical and dental practice, which are based on credible scientific evidence published in peer-reviewed literature generally recognized by the relevant medical or dental community or which is otherwise consistent with physician or dental specialty society recommendations; and the views of physicians and dentists practicing in the relevant clinical areas. Aetna uses a commercial software package to administer some of these policies.

As used above, Geographic Area and Prevailing Charge Rates are defined as follows:

- Geographic Area: This means an expense area grouping defined by the first three digits of the U.S. Postal Service zip codes. If the volume of charges in a single three digit zip code is sufficient to produce a statistically valid sample, an expense area is made up of a single three digit zip code. If the volume of charges is not sufficient to produce a statistically valid sample, two or more three digit zip codes are grouped to produce a statistically valid sample. When it is necessary to group three digit zip codes, the grouping never crosses state lines.
- Prevailing Charge Rates: These are rates reported by FAIR Health, a nonprofit company, in their database. FAIR Health reviews and, if necessary, changes these rates periodically. Aetna periodically updates its systems with these changes within 180 days after receiving them from FAIR Health. This means that the Recognized Charge is based on the version of the rates in use by Aetna on the date that the service or supply was provided.

CHANGE #8: Effective as of 1/1/2013. All Network Services shall be paid at Aetna’s negotiated rate with the provider and all Out-of-Network Benefits shall be paid at the Recognized Charge as defined above.

CHANGE #9: Effective as of 1/1/2013. The paragraph above the chart of Deductibles and Coinsurance on page 17 has the following sentence added at the end of such paragraph:

All benefit maximums, deductible and co-insurance Limits are on a combined basis combining both in-Network and Out-of-Network expenses and prescription drug costs are applied to the medical Out-of-Pocket Limit below.

CHANGE #10: Effective as of 1/1/2013, Footnote #4 on page 17 is modified by removing “emergency room”.

CHANGE #11: Effective as of 1/1/2013, Out-of-Network Nutrition Counseling is covered at 50% coinsurance.

CHANGE #12: Effective as of 1/1/2013, Covered Out-of-Network Behavioral Health services are reimbursed at 50% of the Recognized Charge.
CHANGE #13: Walk-In Clinic Coverage - Effective 01/01/2013

Walk-in-Clinic
Walk-in Clinics are free standing health care facilities. They are an alternative to a physician’s office visit for treatment of:

- unscheduled, non-emergency illnesses and injuries;
- the administration of certain immunizations; and
- individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a physician. Neither an emergency room nor a hospital's outpatient department should be considered a Walk-in-Clinic.

CHANGE #14: Other Covered Expenses – Effective 1/1/2013.

The following are additional Other Covered Expenses:

Acupuncture services provided by a physician if the service is performed as a form of anesthesia in connection with a covered surgical procedure. Acupuncturists are covered as conditionally eligible providers. Conditionally eligible providers are those that, in certain states, an insurer is mandated to reimburse as provider types.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)
Covered expenses include charges made by a physician, a dentist and hospital for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

  Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles, and nerves), for surgery needed to:

  - Treat a fracture, dislocation, or wound.
  - Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
  - Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement or repair of teeth.
  - Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Hospital services and supplies received for a stay required because of your condition.

Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:

(a) Natural teeth damaged, lost, or removed; or
(b) Other body tissues of the mouth fractured or cut due to injury.

Cognitive Rehabilitation.

Cognitive rehabilitation is considered as adjunctive treatment of cognitive deficits (e.g., attention, language, memory, reasoning, executive functions, problem solving, and visual processing) which is medically necessary when all of the following are met:
Neuropsychological testing has been performed and neuropsychological results will be used in treatment-planning and directing rehabilitation strategies.

The cognitive deficits have been acquired as a result of neurologic impairment due to traumatic brain injury, brain surgery, stroke, or encephalopathy.

The member has been seen and evaluated by a neuropsychiatrist or neuropsychologist, and

The member is expected to make significant cognitive improvement (e.g., member is not in a vegetative or custodial state).

**Network Benefits for Specialty Care Drugs**

Specialty care drugs are covered at the network level of benefits only when dispensed through a network retail pharmacy or Aetna's specialty pharmacy network. Refer to Aetna's website, [www.aetna.com](http://www.aetna.com), to review the list of specialty care drugs required to be dispensed through a retail pharmacy or Aetna's specialty pharmacy network. The list may be updated from time to time.

The initial prescription for specialty care drugs must be filled at a network retail pharmacy or at Aetna's specialty pharmacy network.

You are required to obtain specialty care drugs at Aetna's specialty pharmacy network for all prescription drug refills after the initial fill.

**CHANGE #15 – Coordination of Benefits – Effective 1/1/2013**

**Coordination of Benefits – What Happens When There is More Than One Health Plan**

**Other Plans Not Including Medicare**

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:
   — secondary to the plan covering the person as a dependent; and
   — primary to the plan covering the person as other than a dependent;

   The benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:
   — covers the person as other than a dependent; and
   — is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered
one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   (a) If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
   (b) If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
   (c) If there is not such a court decree:

       — If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
       — If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:

— laid-off or retired employee; or
— the dependent of such person.
shall be determined after the benefits of any other plan which covers such person as:

— an employee who is not laid-off or retired; or
— dependent of such person.

If the other plan does not have a provision:

— regarding laid-off or retired employees; and
— as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

— regarding right of continuation pursuant to federal or state law; and
— as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any "other plan" both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim
transaction" is a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules. If the contract includes both medical and dental coverage, those coverages will be considered separate plans. The Medical/Pharmacy coverage will be coordinated with other Medical/Pharmacy plans. In turn, the dental coverage will be coordinated with other dental plans. In order to administer this provision, Aetna can make or recover payments.

Other Plan
This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Effect of Medicare
Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:
  - having refused it;
  - having dropped it; or
  - having failed to make proper request for it.
- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan’s benefits for a person to be figured before benefits are figured under Medicare.