Texas Instruments

2021 Retiree Reimbursement Account Summary Plan Description

Issued: September 2020

Table of Contents

IMPORTANT CONTACT INFORMATION

CONTACT:	FOR INFORMATION ABOUT…	PHONE NUMBER/ WEB ADDRESS:
Via Benefits*	Retiree Reimbursement Account (RRA)	844-638-4642 My.ViaBenefits.com/TI
TI Benefits Center at Fidelity**	Address and/or covered spouse (or domestic partner) changes	888-660-1411 netbenefits.com/ti
Medicare	Medicare benefits and claim status	800-633-4227 medicare.gov
Social Security	Social Security benefits	800-772-1213 socialsecurity.gov
TI Alumni Association website	Retiree benefits	tialumni.org

* Via Benefits customer service representatives are available Monday through Friday, from 8:00 a.m. to 9:00 p.m. Eastern time

** TI Benefits Center at Fidelity customer service representatives are available Monday through Friday (excluding all New York Stock Exchange holidays except Good Friday), from 8:30 a.m. to 8:30 p.m. Eastern time

INTRODUCTION

This is the Summary Plan Description (SPD) for the Retiree Reimbursement Account (RRA), a health benefit offered by Texas Instruments Incorporated (TI) through the TI Retiree Health Benefit Plan (the "Plan"), as of January 1, 2021 to certain TI Medicare eligible retirees.

The purpose of the RRA under the Plan is to reimburse Medicare eligible retirees for certain health insurance premiums and health care expenses which are not otherwise reimbursed. Such reimbursements paid by the RRA generally are excludable from the participant's taxable income.

The RRA is intended to qualify as a self-insured medical reimbursement plan for purposes of Sections 105 and 106 of the Internal Revenue Code, as amended (Code), as well as a health reimbursement arrangement as defined in IRS Notice 2002-45. The RRA and the Plan are also intended to be exempt from the Affordable Care Act as the Plan is a separate "retiree-only" plan pursuant to ERISA Section 732(a) and IRC Section 9831(a)(2).

The SPD is written in plain language to help you understand how the RRA works. If there is a conflict between the information in this SPD and the plan document, the plan document will govern.

ELIGIBILITY

Retiree

You are eligible to participate in the Retiree Reimbursement Account (RRA) if you meet one of the following conditions:

- You were a participant in the RRA in the last calendar year, you maintained continuous coverage under an individual medical and/or prescription drug insurance policy purchased through Via Benefits; or
- For anyone who turns age 65, who is enrolled in pre-65 medical coverage through TI Extended Health Benefits immediately prior to first becoming eligible to purchase an individual insurance policy through Via Benefits, or
- For those ages 65 or over, who are currently eligible for enrollment in TI Extended Health Benefits at the time of termination of TI employment.

And you meet all of the following conditions:

- Be eligible for an RRA contribution (see page 8 for more information), and
- Enrolled in Medicare Part A and Part B, and
- Maintain a permanent U.S. address, which cannot be in Puerto Rico, Guam or U.S. Virgin Islands, and
- Enroll within 60 calendar days of first becoming eligible in an individual medical and/or prescription drug insurance policy through Via Benefits.

IMPORTANT NOTE: If you fail to satisfy the requirements to participate in the RRA, you may still purchase one or more individual insurance policies on your own through Via Benefits.

Spouse (or Domestic Partner)

Your spouse (or domestic partner) may be your covered dependent under the RRA if they have obtained the age of 65 years or older; and if **both** of you are enrolled in an individual medical and/or prescription drug insurance policy purchased through Via Benefits. Eligibility requirements for a spouse (or domestic partner) to be recognized for purposes of the RRA follow:

- **Spouse:** Your "spouse" must be recognized under U.S. federal tax law, or
- **Domestic Partner:** Your domestic partner of the same or opposite gender must meet the following criteria:
    - Unmarried,
    - Not be related by blood,
    - Financially interdependent or your domestic partner is primarily dependent on you for care and financial support,

- Share a common residence for at least one year and intend to do so indefinitely,
- Affirm you are in a committed relationship and intend to remain so, and
- Not in a relationship to solely attain benefits.

Only health care expenses incurred by the retiree or their covered spouse (or domestic partner) who are also enrolled in an individual medical and/or prescription drug insurance policy through Via Benefits are eligible to be reimbursed under the RRA.

No expenses of any other person qualifying as a dependent under U.S. federal tax law (e.g., a child) will be reimbursed under the RRA.

IMPORTANT NOTE: If your eligible spouse (or domestic partner) fails to satisfy the requirements to participate in the RRA, they may still purchase one or more individual insurance policies on their own through Via Benefits.

When You Can Make Spouse (or Domestic Partner) Changes

You can only make changes within 30 calendar days of a qualified status change, which includes:

- Changes in legal marital status (marriage, judgment, decree or order resulting from a divorce, legal separation or annulment)
- Changes in a domestic partner relationship
- Changes in employment status for a spouse (or domestic partner)
- Significant changes in cost of health coverage for a spouse (or domestic partner)
- Loss of other health plan coverage, including reaching a plan's lifetime limit on all benefits for a spouse (or domestic partner)
- Death of a covered spouse (or domestic partner)
- Spouse (or domestic partner) goes on or returns from a strike or lockout
- Exhaustion of all available COBRA coverage for a spouse (or domestic partner)
- Changes made by spouse (or domestic partner) during annual enrollment for the plan of the spouse (or domestic partner)

You must notify the TI Benefits Center at Fidelity within 30 calendar days of an appropriate qualified status change. If such change results in your covered spouse (or domestic partner) losing coverage under an individual medical and prescription drug insurance policy through Via Benefits, health care expenses incurred after their coverage ceases will not be eligible for reimbursement under

the RRA. You will need to remove your ineligible spouse (or domestic partner) from the persons whose health care expenses are eligible to be reimbursed under the RRA.

To be eligible to have their health care expenses reimbursed under the RRA, your newly eligible spouse (or domestic partner) will need to purchase an individual medical and/or prescription drug insurance policy through Via Benefits within 60 calendar days of the qualified status change event.

IMPORTANT NOTE: You have **180 calendar days** after your covered spouse (or domestic partner) ceases to be eligible (such as divorce, the end the domestic partner relationship or death), to request reimbursement of eligible health care expenses incurred before their eligibility ceased.

Imputed Income for domestic partner

If you choose to cover a domestic partner, who is not your dependent for tax purposes, any amount(s) reimbursed through the RRA for your domestic partner will be imputed to you as income and reported to the IRS.

Notification of Address Change

If you and/or your covered spouse (or domestic partner) should change addresses, you should notify the TI Benefits Center at Fidelity as well as Via Benefits.

RRA CONTRIBUTIONS

TI will establish a Retiree Reimbursement Account (RRA) for each eligible retiree and provide for funding of the RRA. Funds in the RRA may be used to reimburse health care expenses as defined in Internal Revenue Code Section 213(d) (explained further below) incurred by the retiree or their covered spouse (or domestic partner). TI will contribute annually each year (typically in January) to your RRA in the amount TI determines based on your years of TI service, when you were hired/rehired by TI and the date you terminated employment with TI. New participants during the calendar year will receive a prorated amount of the annual RRA contribution, based on when you enroll within the 60-calendar-day window (see the When Participation/Funding Begins section).

Your RRA WILL NOT be credited with funds annually if you do not remain continuously enrolled in one of the individual medical and/or prescription drug insurance policies offered through Via Benefits.

The IRS regulations do not permit you to make any contribution to your RRA.

An RRA is merely a bookkeeping account on TI's records and does not bear interest or accrue earnings of any kind.

If you terminated employment on or before January 4, 1993 with five or more years of service and met TI Extended Health Benefits eligibility requirements – TI will contribute annually to an RRA on your behalf as well as that of your covered spouse (or domestic partner). If you have less than five years of service, you and any covered spouse (or domestic partner) will receive no RRA contribution.

If you terminated employment after January 4, 1993, were hired/rehired before January 1, 2001, have 15 or more years of service upon termination of employment and met TI Extended Health Benefits eligibility requirements – TI will contribute annually to an RRA on your behalf. This TI contribution increases with each year of service up to 30 years of service. TIers who terminated employment with 30 years of service or more will receive the largest RRA contribution. Your covered spouse (or domestic partner) will receive no RRA contribution.

If you were hired/rehired on or after January 1, 2001 and met TI Extended Health Benefits eligibility requirements – You and any covered spouse (or domestic partner) will receive no RRA contribution.

To maintain your eligibility to receive an annual RRA contribution you must remain enrolled in an individual medical and/or prescription drug insurance policy through Via Benefits.

IMPORTANT NOTES:

- If you and your eligible spouse (or domestic partner) do not purchase an individual medical and/or prescription drug insurance policy through Via Benefits within 60 calendar days of initial eligibility (see the When Participation/Funding Begins section), you and your eligible spouse (or domestic partner) WILL NEVER be eligible to participate in the RRA. However, you and your eligible spouse (or domestic partner) may still purchase one or more individual insurance policies on your own through Via Benefits.
- If you purchase a medical or prescription drug plan outside of Via Benefits, your medical or prescription plan through Via Benefits will automatically cancel and will result in losing eligibility for RRA.
- If you previously had TI group retiree dental coverage **only,** you are not eligible for an RRA contribution. Additionally if you **only** purchase an individual dental insurance policy through Via Benefits, you are not eligible for an RRA contribution.

The RRA contribution amount may change at any time. TI reserves the right to amend, modify or terminate the RRA and the TI Retiree Health Benefit Plan at any time.

Account Carryover

Contributions remaining in your RRA at the end of a calendar year shall be carried over to the following calendar year to reimburse you or your covered spouse (or domestic partner) for eligible health care expenses incurred during subsequent calendar years.

You can request and receive approved reimbursements based on your RRA balance for the calendar year in which the eligible health care expense was incurred. Claims incurred in prior year(s) cannot be reimbursed with current year's RRA contribution amount. Additionally, eligible health care expenses incurred in a prior calendar year and submitted for reimbursement in a subsequent calendar year are not eligible for reimbursement if there were **NO** remaining funds for the prior calendar year in which the expense was incurred. *For example, if you incur an expense in the prior calendar year and submit that expense in the current calendar year, that expense will only be eligible for reimbursement to the extent funds are remaining from the prior calendar year.*

WHEN PARTICIPATION BEGINS AND ENDS

When Participation/Funding Begins

Retiree

To participate in the Retiree Reimbursement Account (RRA), you must purchase an individual medical and/or prescription drug insurance policy through Via Benefits within the 60-calendar-day window.

- If you are working for TI when you retire at age 65 or older, the 60-calendar-day window starts on the first calendar day of the month following the month in which you terminate employment.
- If you are enrolled in TI Extended Health Benefits when you reach age 65, the 60-calendar-day window starts on the first calendar day of the month in which you turn age 65 unless your birthday is on the first calendar day of the month in which case the 60-calendar-day window starts on the first calendar day of the prior month.

You are eligible to receive funding of the RRA as follows:

- If you are working for TI when you retire at age 65 or older, you are eligible for RRA funding as of the first calendar day following your termination date. Actual funding of the RRA (a proration of the annual RRA contribution) will occur as of the date your insurance policy is in effect through Via Benefits.
- If you are enrolled in TI Extended Health Benefits when you reach age 65, you are eligible for RRA funding as of the first calendar day of the month in which you turn age 65 unless your birthday is on the first calendar day of the month in which case eligibility begins as of the first calendar day of the prior month. For example, if your 65th birthday is on August 8th, your RRA eligibility starts on August 1st. And, if your 65th birthday is on August 1st, your RRA eligibility starts on July 1st. Actual funding of the RRA (a proration of the annual RRA contribution) will occur as of the date your insurance policy is in effect through Via Benefits.

Spouse (or Domestic Partner)

To participate in the RRA, your eligible spouse (or domestic partner) must purchase an individual medical and/or prescription drug insurance policy through Via Benefits within 60 calendar days of initial eligibility (same eligibility as an enrolled participant described above). Funding of the RRA for your eligible spouse (or domestic partner) is prorated as detailed above for a Retiree.

When Participation Ends

Retiree

Your participation in the RRA ends on the earliest of the following dates:

- Date you are rehired by TI as an active employee;
- Date of your death;
- Date your individual medical and prescription drug insurance policy purchased through Via Benefits ends for any reason; or
- Effective date of any TI Retiree Health Benefit Plan amendment terminating your eligibility under the RRA or terminating the RRA.

IMPORTANT NOTES: If your individual medical and/or prescription drug insurance policy coverage stops for any reason (e.g., you decide to not pay the premium or you purchase a medical and/or prescription drug policy outside of Via Benefits), you lose all rights to any future RRA contributions by TI. If you purchase an individual insurance policy through Via Benefits after your previous policy ended, you WILL NEVER be eligible for any future RRA contributions. You may still seek reimbursement for eligible health insurance premiums and health care expenses incurred through the date your policy coverage ended and any RRA contributions before your policy ended will remain in your RRA, no proration.

If your individual medical and prescription drug insurance policy at Via Benefits is dropped for any reason (e.g., you decide to not pay the premium or you purchase a medical and/or prescription drug policy outside of Via Benefits), your eligible dependents under the age of 65 will permanently lose their TI group retiree medical and dental coverage and they WILL NOT be eligible to enroll again at any time in the future.

Death

If you have a spouse (or domestic partner) who is currently enrolled in medical and/or prescription drug coverage through Via Benefits at the time of your death, the joint RRA will continue, as long as they remain eligible for the RRA. If your surviving spouse (or domestic partner) was receiving an annual RRA contribution before your death, they will continue to receive an annual RRA contribution, as long as they remain eligible for the RRA. Otherwise, your surviving spouse (or domestic partner) will not receive an annual RRA contribution. If your covered dependent remarries (or domestic partner commences a new relationship), participation in the RRA WILL END.

If you don't have an eligible spouse (or domestic partner) participating in the RRA at the time of your death, your RRA is immediately forfeited.

IMPORTANT NOTE: Your estate or representative may submit claims for reimbursement of eligible health care expenses incurred during your participation in the RRA. Claims must be submitted within **180 calendar days** of your death.

Spouse (or Domestic Partner)

Your covered spouse's (or domestic partner's) participation in the RRA ends on the earliest of the following dates:

- Date they cease to be a covered dependent for any reason (e.g., divorce or remarriage following retiree's death);
- Date of their death;
- Date individual medical and prescription drug insurance policy through Via Benefits for your covered spouse (or domestic partner) or you ends for any reason other than your death; or
- Effective date of any TI Retiree Health Benefit Plan amendment terminating their eligibility under the RRA or terminating the RRA.

IMPORTANT NOTE: You have **180 calendar days** after your eligibility for the RRA ceases during which you must request reimbursement of eligible health care expenses you incurred before your eligibility ceased.

ELIGIBLE HEALTH CARE EXPENSES

An eligible health care expense is an out-of-pocket expense incurred by you or a covered spouse (or domestic partner) for medical, prescription drug, dental and/or vision care as permitted under Internal Revenue Code Section 213(d). You may use your Retiree Reimbursement Account (RRA) for reimbursement of eligible health care expenses, provided the expense:

- Has been incurred by you or your covered spouse (or domestic partner) while covered under an individual medical and/or prescription drug insurance policy purchased through Via Benefits;
- Does not exceed your RRA balance;
- Is not reimbursed or reimbursable under any private, employer-provided, or public health care reimbursement or insurance arrangement; and
- Is incurred while you are participating in the RRA.

Some common examples of eligible health care expenses include:

- Acupuncture;
- Ambulance services;
- Chiropractic services;
- Contact lenses or glasses used to correct a vision impairment;
- Dental expenses;
- Dermatology;
- Hearing aids;
- Long-term care qualified services that are prescribed by a licensed health care practitioner;
- Out-of-pocket expenses like deductibles, coinsurance and copays;
- Physical therapy;
- Premiums for qualified health plans, as defined under Internal Revenue Code Section 213(d);
- Prescription drugs*****;
- Vision expenses; and

- Wheelchairs.

***IMPORTANT NOTE:** Prescription drug copay/coinsurance are eligible for reimbursement from the RRA. However, there are special considerations for reimbursement of prescription drug out-of-pocket costs. Medicare requires you to pay out-of-pocket a certain amount of prescription drug costs before you are covered by the catastrophic prescription drug coverage. As a result, if you receive reimbursements for prescription drug out-of-pocket costs, it may take longer to reach the catastrophic prescription drug coverage level. You may want to consult with a financial advisor regarding the use of your RRA funds for prescription drug out-of-pocket costs because this may delay when you become eligible for the catastrophic prescription drug coverage. For more information on catastrophic prescription drug coverage, see the section titled Catastrophic Pharmacy Special Reimbursement on page 15.

Some examples of common items that are **not** eligible health care expenses include:

- Cosmetic surgery or similar procedures (unless the surgery is necessary to correct a deformity arising from a congenital abnormality, accident or disfiguring disease);
- Funeral and burial expenses;
- Health club or fitness program dues;
- Household help; and
- Massage therapy.

For more information about what items may or may not be eligible health care expenses, contact Via Benefits or consult IRS Publication 502 “Medical and Dental Expenses”, specifically the sections titled “What Medical Expenses Are Includible” and “What Expenses Are Not Includible”.

Eligible health care expenses are “incurred” when the health care is provided, not when you or your covered spouse (or domestic partner) is billed, charged or pay for the expense. Health insurance premiums covered under the RRA are eligible when invoiced. An expense that has been paid but not incurred (e.g., pre-payment to a physician) may not be reimbursed until the services or treatment giving rise to the expense has been provided. Expenses for any person other than you or your covered spouse (or domestic partner) may not be reimbursed by the RRA.

IMPORTANT NOTE: You have **180 calendar days** after your eligibility for the RRA ceases during which you must request reimbursement of eligible health care expenses you incurred before your eligibility ceased.

Catastrophic Pharmacy Special Reimbursement

Catastrophic Pharmacy Special Reimbursement is automatically provided under the RRA if you purchased an individual medical and/or prescription drug insurance policy through Via Benefits. Catastrophic Pharmacy Special Reimbursement begins after you have reached the catastrophic prescription drug coverage level as defined by Medicare for the applicable calendar year. Medicare prescription drug plans have a coverage gap (also called the "donut hole"). This means that after you and your Medicare prescription drug plan have spent a certain amount of money for covered prescription drugs, you may have to pay more for your prescription drugs up to a certain limit. Once the coverage gap has closed, you are eligible for catastrophic prescription drug coverage.

Eligible expenses are limited to your prescription drug copay/coinsurance (not prescription drug plan premiums) that are incurred on or after the date you enter the catastrophic level. Eligible expenses are reimbursed without any dollar limits.

Eligibility for Medicare catastrophic prescription drug coverage is determined on an individual basis, so you or your covered spouse (or domestic partner) may be eligible. In other words, if you hit the catastrophic level, you will be eligible for reimbursement of prescription drug costs as catastrophic costs, but your covered spouse (or domestic partner) would not be eligible for reimbursement for catastrophic prescription drug costs unless their prescription drug expenses also reach the catastrophic level.

If you or your covered spouse (or domestic partner) reaches the catastrophic level, contact Via Benefits to request a Catastrophic RX Reimbursement form.

> **IMPORTANT NOTE:** Catastrophic Pharmacy Special Reimbursement claims must be incurred during the applicable calendar year and submitted to Via Benefits **by June 30th of the following calendar year**.

If you have any questions, you should contact Medicare or your health insurance carrier.

Custodial Care Special Reimbursement

Custodial Care Special Reimbursement is provided under the RRA for grandfathered individuals. Grandfathered individuals are defined as retirees or their dependents who incurred custodial care claims for the 2015 calendar year under the Blue Cross Blue Shield PPO Medicare-eligible plan and purchased and remain continuously enrolled in an individual medical and/or prescription drug

insurance policy through Via Benefits. Eligible custodial care expenses are reimbursed at 50% of billed amount.

Custodial care must be received in the home and is subject to the following requirements:

- Care must be obtained from a licensed nursing service, but is not limited to the services of an RN, APN or LVN
- Care must be prescribed by the individual's physician
- Care cannot be provided by a person who is a member of the individual's family, spouse's or domestic partner's family

Custodial care is designed to assist the individual in meeting the activities of daily living and to maintain life and/or comfort when there is no reasonable expectation of cure or improvement of sickness or injury. Examples of custodial care include, but are not limited to:

- help in walking or getting in or out of bed;
- assistance in bathing, dressing, feeding, and using toilet facilities;
- preparation of diets and nutritional supplements;
- preparation and administration of medications and treatments;
- provisions of socially necessary services.

If eligible for such benefit, please contact Via Benefits to request a Custodial Care Special Reimbursement form.

IMPORTANT NOTE: Custodial Care Special Reimbursement claims incurred during any calendar year must be submitted to Via Benefits **by June 30th of the following calendar year.**

CONTINUATION OF RRA BENEFITS (COBRA BENEFITS)

COBRA Continuation Coverage

This notice has important information about your right to continuation health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) under the TI Retiree Health Benefit Plan ("the Plan"). **This notice explains COBRA continuation coverage for the RRA benefit, when it may become available to your covered spouse (or domestic partner), and what your covered spouse (or domestic partner) needs to do to receive this benefit.** TI, in accordance with COBRA) allows "qualified beneficiaries" participating in the RRA under the Plan to elect to continue participation in the RRA beyond the date participation is otherwise scheduled to end because of the occurrence of certain events known as "qualifying events." Your covered spouse (or domestic partner) could become a qualified beneficiary if coverage is lost because of a qualifying event.

Qualifying Events – When COBRA continuation coverage is available

If you are the covered spouse (or domestic partner) of a retiree, you will become a qualified beneficiary if your participation in the RRA under the Plan ends due to one of the following qualifying events:

- Divorce or legal separation from the retiree; or
- The end of your domestic partnership with the retiree

A retiree is not a qualified beneficiary because they were previously offered COBRA coverage at the time of retirement.

Electing COBRA Coverage

Once the TI Benefits Center at Fidelity has been notified of the occurrence of a qualifying event, the qualified beneficiary will be provided with instructions on how to elect COBRA continuation coverage. They must elect COBRA continuation coverage within this 60-calendar-day period as specified in the enrollment notice. If they initially decline COBRA continuation coverage within the specified 60-calendar-day period, they may still elect COBRA continuation coverage provided such election is made within the specified 60-calendar-day period. However, in no event can they elect COBRA continuation coverage after the specified 60-calendar-day period.

36-Month COBRA Continuation Coverage Period

COBRA continuation coverage for loss of RRA benefits is available for up to 36 months following the qualifying event, but will end earlier upon the occurrence of any of the following events:

- The date the qualified beneficiary's RRA is exhausted;
- The date the qualified beneficiary notifies the Plan Administrator that they wish to discontinue coverage under the RRA;
- The date the qualified beneficiary fails to pay the required monthly premium (for individual insurance policy coverage through Via Benefits or COBRA RRA premiums) when due or following the end of any applicable grace period;
- The date the qualified beneficiary becomes covered under another health plan, outside of the individual insurance policies offered through Via Benefits; or
- The date that TI ceases to offer the RRA under the Plan.

Premiums

A qualified beneficiary will have to pay the applicable COBRA premium, which generally equals 102% of the Plan costs for a 12-month period. Because the cost of COBRA continuation coverage is based on the amount of the applicable premium, the cost for COBRA continuation coverage will increase if the cost of premium under Via Benefits increases.

Qualified beneficiaries must make their first premium payment for RRA COBRA continuation coverage no later than 45 calendar days after the date of their election.

After they make their first payment for RRA COBRA continuation coverage, they will be required to make periodic premium payments. There is a 30-calendar-day grace period following the date regularly scheduled monthly premiums are due.

Keep the TI Benefits Center at Fidelity and Via Benefits Informed of Address Changes

Qualified beneficiaries should notify the TI Benefits Center at Fidelity and Via Benefits of any address changes.

CLAIM FILING AND REIMBURSEMENT

Via Benefits administers and processes reimbursements for the Retiree Reimbursement Account (RRA).

Auto reimbursement for individual insurance policy premiums

The RRA offers an “auto reimbursement” feature which permits automatic reimbursement of your individual insurance policy premiums from your RRA. If you enroll with a health insurance carrier that accepts “auto reimbursement” payments, you have the option during enrollment to elect such feature. You can turn auto reimbursement on and off from your online account or you can contact Via Benefits to make changes. It may take up to three months for auto reimbursement to be set up. Ongoing automatic reimbursements will usually arrive about the same time each month.

Filing a claim for reimbursement

After expenses are submitted and processed by your health insurance carrier, you may submit any eligible expenses for reimbursement to the RRA.

To file a claim for reimbursement, you must do so, online, by fax or through the mail. When you submit your claim, you should include the following:

- The amount of the health care expense for which you are requesting reimbursement;
- The date you incurred the health care expense;
- The name of the person, organization, or other provider to whom you paid the health care expenses; and
- A written bill or explanation of benefits (EOB) from the health care service provider stating that you incurred the health care expense and the amount of the expense not covered by insurance.

Additionally Via Benefits may require you, at its discretion, to submit a bill, receipt, or other written evidence or certification of payment or proof of your obligation to pay the health care expense. Verbal or handwritten information, illegible receipts, and statements with only a forwarding balance (no service detailed) are not accepted.

Expenses incurred outside the U.S. – Contact Via Benefits Customer Service to request special instructions for reimbursement of eligible expenses incurred outside the U.S.

Receiving Reimbursements

You can request and receive approved reimbursements based on your RRA balance for the calendar year in which the eligible health care expense was incurred. Claims incurred in prior year(s) cannot be reimbursed with current

year's RRA contribution amount. Additionally, eligible health care expenses incurred in a prior calendar year and submitted for reimbursement in a subsequent calendar year are not eligible for reimbursement if there were **NO** remaining funds for the prior calendar year in which the expense was incurred. *For example, if you incur an expense in the prior calendar year and submit that expense in the current calendar year, that expense will only be eligible for reimbursement to the extent funds are remaining from the prior calendar year.*

Direct Deposit

You have the option of signing up for direct deposit of reimbursements to an account (i.e. checking, savings) set up in your name at a financial institution. You can set up or cancel direct deposit by calling Via Benefits or by accessing your online account. Reimbursements through direct deposit take approximately three to five business days following claim approval for receipt, while reimbursement checks mailed to you usually take approximately seven to 14 calendar days following claim approval. If you don't set up direct deposit, you will be mailed a reimbursement check.

Are benefits taxable

The RRA is intended to meet certain requirements of existing U.S. federal tax law, under which the benefits received generally are not taxable to you. If you have any questions about the tax treatment of the RRA, you should consult your own tax advisor.

Overpayments/Erroneous Reimbursements

If it is later determined that you or your covered spouse (or domestic partner) received a TI contribution and/or reimbursement in error (e.g., you were reimbursed from your RRA for an expense that is subsequently found unsubstantiated and/or ineligible), you or your covered spouse (or domestic partner) will be required to refund the overpayment or erroneous reimbursement.

If you do not refund the TI contribution and/or reimbursement, the Claims Administrator reserves the right to offset future reimbursements equal to the contribution and/or reimbursement made in error. If such treatment is not feasible, the Claims Administrator may withhold such funds from any future RRA contributions. If all other attempts to recoup the contribution and/or reimbursement are unsuccessful, TI may treat this amount as a bad debt, which may have tax implications for you.

APPEAL INFORMATION

You may designate a representative or provider to act on your behalf only to pursue a claim for a benefit. Your designation of a representative must be in writing. For more information about how to designate a representative, you may call the Claims Administrator.

This Summary Plan Description does not address the treatment of claims (eligibility for enrollment and/or coverage of services) involving any individual insurance policy, as these claims are administered solely by the insurance carrier.

Eligibility Claim Appeal Information

Claims for Eligibility

Claims for eligibility relate to whether you or your spouse (or domestic partner) are enrolled in or covered under the RRA. Examples of claims for eligibility include claims regarding whether TI established an RRA for you and whether you timely purchased and continuously maintained an individual medical and/or prescription drug insurance policy through Via Benefits. Claims for eligibility do not address whether a particular treatment or benefit is reimbursable under the RRA.

First Level of Appeal

If you believe you or your covered spouse (or domestic partner) was incorrectly denied eligibility for the RRA benefits sponsored by TI, you may request your claim be reviewed. To appeal, you will need to provide in writing the reasons why you do not agree with the determination within 180 calendar days after you receive notice of the initial denial based on eligibility. Send your appeal to:

TI Benefits Center at Fidelity
P.O. Box 770003
Cincinnati, OH 45277-1060

You may ask to review your file and any relevant documents and may submit written issues, comments and additional information.

Notice of an Adverse Benefit Determination

You may receive an Adverse Benefit Determination from the Plan Administrator on your first level appeal. An "**Adverse Benefit Determination**" means a denial, reduction, or termination of RRA benefits based on eligibility for coverage.

This written determination will be provided within 60 calendar days of receipt of your first level appeal and will contain the information described in the Notice of Benefit Determination on Appeal section below.

Second Level of Appeal

If you believe the Plan Administrator incorrectly made an Adverse Benefit Determination pertaining to the eligibility claim of you or your covered spouse (or domestic partner), you may request a review of the claim for a second time. To appeal, you will need to provide in writing within 90 calendar days after you receive notice of the Adverse Benefit Determination on eligibility the reasons why you do not agree with the determination and any issues, comments and additional information related to your appeal.

The Administration Committee is the appointed Plan Administrator for purposes of second level claim appeals related to eligibility. Send your appeal to:

TI Benefits Center at Fidelity
P.O. Box 770003
Cincinnati, OH 45277-1060

You may ask to review your file and any relevant documents.

Notice of Final Adverse Benefit Determination

A representative of the Administration Committee will provide you with written notice of the final determination. This determination will be provided within 60 calendar days of receipt of your second level appeal.

You may receive a Final Adverse Benefit Determination on behalf of the Administration Committee. If this occurs, the notice of Final Adverse Benefit Determination will contain the information (if applicable) described in the Notice of Benefit Determination on Appeal section below.

If You Need Assistance

If you need assistance with the eligibility claim review processes, you may call the Texas Instruments eligibility claims and appeals unit managed by Fidelity at 877-208-0936, Monday through Friday (excluding all New York Stock Exchange holidays except Good Friday) between 8:30 a.m. and 8:30 p.m. Eastern time.

Claim Filing and Appeals Procedures

Interpretation of Plan Provisions

The Plan Administrator has granted the Claims Administrator the discretion to interpret and determine initial claims and first level appeals in accordance with the RRA terms of the RRA offered through the Plan and Internal Revenue Code Section 213(d).

The Plan Administrator is the final interpreter of the RRA under the Plan and may correct any defect, supply any omission, or reconcile any inconsistency or ambiguity in such manner as it deems advisable in regards to claims

administration. All final determinations and actions concerning claims administration and interpretation of benefits shall be made by the Plan Administrator.

Any powers to be exercised by the Claims Administrator or the Plan Administrator shall be exercised in a non-discriminatory manner and shall be applied uniformly to assure similar treatment of persons in similar circumstances.

First Level of Appeal

If you believe you or your spouse (or domestic partner) was incorrectly denied reimbursement from the RRA, you may request your claim be reviewed. To appeal, you will need to provide in writing the reasons why you do not agree with the determination within 180 calendar days after you receive notice of the initial denial. Send your appeal to:

By mail to:
Via Benefits
P.O. Box 981155
El Paso, TX 79998-1155

By fax to: 866-886-0879

You may ask to review your file and any relevant documents and may submit written issues, comments and additional information.

Notice of an Adverse Benefit Determination

You may receive an Adverse Benefit Determination from the Plan Administrator on your first level appeal. An "**Adverse Benefit Determination**" means a denial, in whole or in part, or your claim for reimbursement under the RRA offered through the Plan.

This written determination will be provided within 30 calendar days of receipt of your first level appeal and will contain the information described in the Notice of Benefit Determination on Appeal section below. If the Plan Administrator determines that an extension of this time period is necessary due to matters beyond the control of the Plan, the Plan Administrator will notify you within the initial 30-calendar-day period that an extension of up to an additional 15 calendar days will be required. If the extension is necessary because you failed to provide sufficient information to allow the claim to be decided, you will be notified and you will have up to 45 calendar days to provide the additional information.

In the event any new or additional information (evidence) or rationale is considered, relied upon or generated by the Plan Administrator in connection with the appeal, the Plan Administrator will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond.

Second Level of Appeal

If you believe the Plan Administrator incorrectly made an Adverse Benefit Determination pertaining to the claim of you or your spouse (or domestic partner), you may request a review of the claim for a second time. To appeal, you will need to provide in writing within 90 calendar days after you receive notice of the Adverse Benefit Determination the reasons why you do not agree with the determination and any issues, comments and additional information related to your appeal.

The Administration Committee is the appointed Plan Administrator for purposes of second level claim appeals related to reimbursement under the RRA. Send your appeal to:

Texas Instruments
Plan Administrator
ATTN: Formal Appeals
P.O. Box 650311, MS 3905
Dallas, TX 75265

You may ask to review your file and any relevant documents.

Notice of Final Adverse Benefit Determination

A representative of the Administration Committee will provide you with written notice of the final determination. This determination will be provided within 30 calendar days of receipt of your second level appeal.

You may receive a Final Adverse Benefit Determination on behalf of the Administration Committee. If this occurs, the notice of Final Adverse Benefit Determination will contain the information (if applicable) described in the Notice of Benefit Determination on Appeal section below.

If You Need Assistance

If you need assistance with the claim review processes, you may call the Plan Administrator through TI HR Connect at 888-660-1411. In addition, for questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272) or at askebsa.dol.gov.

Notice of Benefit Determination on Appeal

Every notice of an appeal decision will be provided in writing or electronically and, if an adverse determination, will include:

- the reason(s) for the denial and the Plan provisions on which the denial is based;

- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures; and
- a description of your right to request, free of charge, all documentation relevant to your claim.

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review. You or your Plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office. You may also contact the Plan Administrator.

Deadline for Bringing a Legal Action

If you do not agree with any decision and you have exhausted your administrative appeals outlined above, you may only file a civil action under Section 502(a) of ERISA if you file such complaint in a federal court within one (1) year of the date such claim was denied in the final level of the appeal process outlined above. You may not file a civil action after the expiration of this deadline.

THIS FORM WAS PREPARED FOR COMPLIANCE WITH U.S. FEDERAL HIPAA PRIVACY. YOU SHOULD CONSULT THE APPLICABLE STATE LAWS FOR STATE DIFFERENCES

NOTICE OF PRIVACY RIGHTS – HEALTH CARE RECORDS

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is effective as of September 23, 2013, and applies to health information received about you by the Texas Instruments Incorporated Retiree Health Benefit Plan (the "Plan"). You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). The Privacy Regulations were most recently amended effective January 17, 2013. Additionally, the Genetic Information Nondiscrimination Act of 2008 ("GINA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH") under the American Recovery and Reinvestment Act of 2009 ("ARRA") both amended the privacy requirements under the Privacy Regulations. As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan, including genetic information (your "Protected Health Information" or "PHI"). This notice is intended to inform you about how the Plan will use or disclose your Protected Health Information, your privacy rights with respect to the Protected Health Information, the Plan's duties with respect to your Protected Health Information, your right to file a complaint with the Plan or with the U.S. Department of Health and Human Services and the office to contact for further information about the Plan's privacy practices. The following uses and disclosures of your Protected Health Information may be made by the Plan:

For Payment. Your Protected Health Information may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, and disclosures to obtain reimbursement under insurance, reinsurance or stop loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your Protected Health

Information may be disclosed to other health plans maintained by Texas Instruments Incorporated for any of the purposes described above. Disclosures for purposes of payment must meet the minimally necessary standard.

For Treatment. Your Protected Health Information may be used or disclosed by the Plan for purposes of treating you. For example, if your doctor requests information on what other drugs you are currently receiving.

For the Plan's Operations. Your Protected Health Information may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances; however, your genetic information, if any, contained in your PHI will not be disclosed for underwriting, premium rating, renewal of coverage, or for securing or placing a contract for reinsurance of risk. Disclosures for purposes of health care operations must meet the minimally necessary standard. The Plan may disclose your Protected Health Information for purposes of referring you to case management or a pharmacy benefit manager.

When Required by Law. The Plan may also be required to disclose or use your Protected Health Information for certain other purposes when the Plan is required by law to disclose or use your Protected Health Information. For example, if certain types of wounds occur that require reporting, or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena.

For Workers' Compensation. The Plan may disclose your Protected Health Information without authorization as authorized by and to the extent necessary to comply with laws relating to workers' compensation or similar programs established by law that provide benefits for work-related injuries or illnesses.

Pursuant to Your Authorization. Any other use or disclosure of your Protected Health Information will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.

For Appointment Reminders and Health Plan Operations. Your Protected Health Information may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, refill reminders,

information on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. Information may be provided to the sponsor of the Plan provided that the sponsor has certified that this information will not be used for any other benefits, employee benefit plans or employment related activities.

Other Uses or Disclosures of Protected Health Information

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release:

Disclosure of your Protected Health Information to family members, other relatives and your close personal friends involved in your health care or the payment for your health care is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care;
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected;
- the information is needed for notification purposes; or
- if you are deceased, your Protected Health Information is relevant to such person’s involvement, unless you have previously expressed to the Plan your preference that such information not be disclosed after your death.

Uses and disclosures for which authorization or opportunity to object is not required:

Use and disclosure of your Protected Health Information is allowed without your authorization or any opportunity to agree or object under the following circumstances:

- When required by law.
- When permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Protected Health Information may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.
- When authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been

or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.

- When the disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under U.S. federal or state laws when the parents or other representatives may not be given access to a minor's Protected Health Information.
- When the Protected Health Information is immunization records for a student or prospective student that is disclosed to the school to comply with a state or other law requiring the student to provide proof of immunization prior to admitting the student to school.
- The Plan may disclose your Protected Health Information to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your Protected Health Information when required for judicial or administrative proceedings. For example, your Protected Health Information may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.
- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances.
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose Protected Health Information for research,

subject to certain conditions.

- When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.
- The Plan may disclose your Protected Health Information to your employer, provided certain requirements are met, and provided that the Protected Health Information is not used for any other employment decision and it is not further disclosed or used; however, no genetic information may be used in underwriting or obtaining bids for coverage.
- The Plan may use your Protected Health Information (excluding any genetic information) for underwriting purposes. The Plan is prohibited from using or disclosing Protected Health Information that is genetic information of an individual for such purposes.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization. State laws may provide you with additional rights or protections.

Uses and Disclosures Requiring an Authorization

The Plan may only use your Protected Health Information if you provide your written authorization to so use your Protected Health Information for the following uses or disclosures:

- Any access to psychotherapy notes from your treatment or counseling sessions (whether individual or group);
- If the Plan wants to use your Protected Health Information for marketing purposes, for example using your phone number to contact you to try to sell you a product unrelated to your health care; or
- If the Plan wants to sell your Protected Health Information. (This notice regarding the selling of your Protected Health Information is required to comply with the Privacy Regulations. The Plan has no intention to sell your Protected Health Information.)

You may revoke any authorization that you have previously provided to the Plan. You should contact the Plan in writing to revoke any prior written authorization.

The Plan's Obligations

The Plan is required by law to maintain the privacy of the Protected Health Information it creates or receives, to provide individuals with notice of its legal duties and privacy practices with respect to Protected Health Information, and to

notify affected individuals following a breach of unsecured Protected Health Information. The Plan is required to abide by the terms of the Plan's current privacy notice.

Rights You May Exercise

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your protected health information in writing. The Plan is required to comply with your request only if (1) the disclosure is to a health care plan for purposes of carrying out payment or health care operations, and (2) the PHI pertains solely to a health care item or service for which the health care provider involved has already been paid in full. Otherwise, the Plan is not required to agree to any restriction you may request.

In certain circumstances, the Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243.

To Access. You have the right to request access to your Protected Health Information and to inspect and copy your Protected Health Information in the designated record set under the policies and procedures established by the Plan. The designated record set is the series of codes that make up each electronic claim. This does not include psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or Protected Health Information that is maintained by a covered entity that is a clinical laboratory. The requested information will be provided within 30 calendar days if the information is maintained on site or within 60 calendar days if the information is maintained offsite. A single 30-calendar-day extension is allowed if the Plan is unable to comply with the deadline. To the extent that the Plan uses or maintains an electronic health record you have a right to obtain a copy of your PHI from the Plan in an electronic format. In addition, you may direct the Plan to transmit a copy of your PHI in such electronic format directly to an entity or person designated by the individual.

You or your personal representative will be required to complete a form to request access to the Protected Health Information in your designated record set. Requests for access to Protected Health Information should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243. If access is denied, you or your personal representative will be provided with a written denial setting forth the

basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the U.S. Department of Health and Human Services.

To Amend. You have the right to request an amendment to your Protected Health Information in writing under the policies established by the Plan. The Plan has 60 calendar days after the request is made to act on the request. A single 30-calendar-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your Protected Health Information. Requests for amendment of Protected Health Information in a designated record set should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243. You or your personal representative will be required to complete a written form to request amendment of the Protected Health Information in your designated record set.

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your Protected Health Information, other than those for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your Protected Health Information during the six years prior to the date of your request. However, such accounting need not include Protected Health Information disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own Protected Health Information; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan.

If the accounting cannot be provided within 60 calendar days, an additional 30 calendar days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To Request a Paper Copy of this Notice. An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, contact the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243.

To Request Confidential Communication. You have the right to request to receive confidential communications of your Protected Health Information. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate certain reasonable requests to receive communications of PHI by alternative means or at alternative locations. Such requests should be made to the Privacy Official at 214-479-1069, privacy_official@list.ti.com or Texas Instruments Incorporated, Attention: Privacy Official, 13570 N. Central Expressway, MS 3905, Dallas, Texas 75243.

A Note About Personal Representatives. You may exercise your rights through a personal representative (e.g., having your spouse or domestic partner call for you). Your personal representative will be required to produce evidence of their authority to act on your behalf before that person will be given access to your Protected Health Information or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a signed authorization completed by you;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your Protected Health Information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all Protected Health Information the Plan maintains. Any Protected Health Information that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all Protected Health Information it receives or maintains.

Any revised version of this notice will be distributed within 60 calendar days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing Protected Health Information or when requesting Protected Health Information from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of Protected Health Information necessary to accomplish the intended purpose of the use, disclosure or request.

However, the minimum necessary standard will not apply in the following situations: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual; (3) disclosures made to the U.S. Department of Health and Human Services; (4) uses or disclosures made pursuant to an authorization you signed; (5) uses or disclosures in the designated record set; (6) uses or disclosures that are required by law; (7) uses or disclosures that are required for the Plan's compliance with legal regulations; and (8) uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan may use or disclose a “Limited Data Set” which may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set. Disclosures of a Limited Data Set need not be included in any accounting of disclosures by the Plan. Effective for uses or disclosures on and after February 17, 2010, the minimally necessary shall be defined as the Limited Data Set, or the minimal amount necessary as determined by the recipient, until such time as regulations defining what constitutes the minimally necessary are promulgated and effective.

You have the right to file a complaint with the Plan or the U.S. Department of Health and Human Services if you believe that your privacy rights have been violated. You will not be retaliated against for filing a complaint, but such complaint must be filed within 180 calendar days of any alleged violation.

You may file a complaint with the Plan by sending a letter describing when you believe the violation occurred and what you believe the violation was to Texas Instruments Incorporated, Attention: Privacy Complaint Official, 13570 N. Central

Expressway, MS 3999, Dallas, Texas 75243, calling 214-479-1242, or sending an email to privacy_complaint_official@list.ti.com.

You may also file a complaint by sending a letter to the U.S. Department of Health and Human Services Office for Civil Rights, 200 Independence Avenue S.W., Room 509F, HHH Building, Washington, DC 20201, calling 877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

If you would like to receive further information, you should contact the Privacy Official or the Privacy Complaint Official for the Plan. This notice will remain in effect until you are notified of any changes, modifications or amendments.

OTHER IMPORTANT INFORMATION

TI's Right to End or Change the RRA or Plan

This RRA has been established as a benefit option under the TI Retiree Health Benefit Plan with the intention of being maintained for an indefinite period. However, TI, as the Plan Sponsor, has the right to cancel or change the RRA and/or the Plan.

Plan Interpretation

TI reserves the right and sole and complete discretion to interpret ERISA-governed RRA benefits, as well as the right to delegate these duties to a Claims Administrator. TI's Administration Committee's discretionary interpretations of the RRA offered through the Plan (including any internal administrative policies or procedures under which it is operated) will be final and binding. Please note that decisions on benefit coverage for fully-insured individual insurance policies are made by the health insurance carriers for the individual insurance policies you select and purchase.

In no event may an agent of TI or the Claims Administrator change the terms of the RRA benefits. If you are in doubt about the provisions of the RRA under the Plan, contact the designated Claims Administrator.

ERISA

ERISA Guidelines

The Employee Retirement Income Security Act of 1974 (ERISA) protects your rights as a participant in the RRA under the TI Retiree Health Benefit Plan and ensures you receive appropriate information.

TI Retiree Health Benefit Plan offering the RRA

Type of Plan
Medical – Care Reimbursement

Employer Identification Number: 75-0289970

Plan Number: 502

Plan Trustee
The Northern Trust Company
Corporate Financial Services
50 South LaSalle Street
Chicago, Illinois 60603

Plan Year
January 1 through December 31

Sponsoring Employer
Texas Instruments Incorporated
12500 TI Boulevard
Dallas, Texas 75243

Agent for Service of Legal Process
Cynthia Trochu, Secretary
Texas Instruments Incorporated
12500 TI Boulevard
Dallas, Texas 75243

RRA Claims/Plan Administrators:

Third Party Administrator:

Via Benefits
10975 South Sterling View Drive
Suite A-1 South
Jordan, UT 84905
844-638-4642
My.ViaBenefits.com/TI

Claims Administrator:
All reimbursement forms, and supporting documentation, must be provided to the Claims Administrator. Forms should not be mailed to the Third Party Administrator:

Claim Submission Agent / Claims Administrator:
Via Benefits
P.O. Box 981155
El Paso, TX 79998-1155
Fax: 866-886-0879

Plan Administrator:

TI Retiree Health Benefit Plan
Attn: Plan Administrator
P.O. Box 650311, MS 3905
Dallas, Texas 75265

Your Rights Under ERISA

As a participant in the RRA offered through the Plan as described in this Summary Plan Description, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

You may examine, without charge, at the Plan Administrator's office or at other specified locations, all documents governing the Plan, and a copy of the latest summary annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

You may obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including copies of the latest summary annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

You may receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people that are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do

so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for benefits is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time frames.

Additional Rights Under ERISA

Under ERISA, there are steps you can take to enforce the above listed rights. For instance, if you request a copy of Plan documents or the latest summary annual report from the Plan and do not receive them within 30 calendar days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a calendar day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for RRA benefits which is denied or ignored, in whole or part and you have exhausted your administrative appeals, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's RRA money, or you are discriminated against for asserting your rights and you have exhausted your appeals, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about RRA benefits under the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.