Employer Plan

2025 Summary of Health Care Benefits for:

Plan Name: Micron Technology, Inc. Self-Insured Group Health Plan

Plan Sponsor: Micron Technology, Inc.

Third Party Administrator: Blue Cross of Idaho Health Service, Inc.

VALUE PPO MEDICAL PLAN

(part of the Micron Technology, Inc. Self-Insured Group Health Plan)

Benefit Period: January 1, 2025 through December 31, 2025

(Participants are eligible for benefits only from their Effective Date)

VALUE PPO MEDICAL PLAN BENEFIT SUMMARY

This Benefit Summary is an attachment to the Summary of Health Care Benefits, which together constitute a part of your benefits guide, benefits booklet, summary plan description, or other similar governing plan document (as the case may be). The Summary of Health Care Benefits provides a summary of the Value PPO Medical Plan medical benefit option of the Micron Technology, Inc. Self-Insured Group Health Plan (the "Plan"). To the extent there is any conflict between such governing Plan documents of Micron Technology, Inc. (the "Employer" or the "Plan Sponsor" or "Micron") and this Summary of Health Care Benefits, this Summary of Health Care Benefits shall be the governing document upon which Blue Cross of Idaho Health Service, Inc. shall administer claims. Notwithstanding any provision in this document to the contrary, if the resolution of a benefit claim is tied to an individual's eligibility for coverage under the Plan, such eligibility determination shall be resolved by the Plan Sponsor in a manner consistent with Micron Benefits Handbook.

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an Out-of-Network Provider at an In-Network Hospital or Ambulatory Surgical Center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's Copayments, Cost Sharing and/or Deductible.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care Provider, you may owe certain Out-of-Pocket costs, like Copayment, Cost Sharing, or Deductible. You may have additional costs or have to pay the entire bill if you see a Provider or visit a health care facility that isn't in the Plan's network.

"Out-of-Network" means Providers and facilities that haven't signed a contract with the Plan to provide services. Out-of-Network providers may be allowed to bill you for the difference between what the Plan pays and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than In-Network costs for the same service and might not count toward the Plan's Deductible or annual Out-of-Pocket Limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an In-Network facility but are unexpectedly treated by an Out-of-Network Provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

YOU'RE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an Emergency Medical Condition and get emergency services from an Out-of-Network Provider or facility, the most they can bill you is the Plan's In-Network Cost Sharing amount (such as Copayments, Cost Sharing, and Deductibles). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an In-Network Hospital or Ambulatory Surgical Center

When you get services from an In-Network Hospital or Ambulatory Surgical Center, certain Providers there may be Out-of-Network. In these cases, the most those Providers can bill you is the Plan's In-Network Cost Sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These Providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these In-Network facilities, Out-of-Network Providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get Out-of-Network care. You can choose a Provider or facility in the Plan's network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THESE PROTECTIONS:

- You're only responsible for paying your share of the cost (like the Copayments, Cost Sharing, and Deductibles that you would pay if the Provider or facility was In-Network). The Plan will pay any additional costs to Out-of-Network Providers and facilities directly.
- Generally, the Plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "Prior Authorization").
  - Cover emergency services by Out-of-Network Providers.
  - Base what you owe the Provider or facility (Cost Sharing) on what it would pay an In-Network Provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or Out-of-Network services toward your In-Network Deductible and Out-of-Pocket Limit.

If you think you've been wrongly billed, you may contact the U.S. Department of Health & Human Services (HHS) by calling toll-free 1 (800) 985-3059. This telephone line is being operated in coordination with the Department of Treasury, Department of Labor, and the Office of Personnel Management, and HHS will route complaints to the appropriate federal agency.

Visit www.cms.gov/nosurprises for more information about the No Surprises Act and your rights under federal law with respect to payment disputes.

INTRODUCTION AND IMPORTANT INFORMATION ABOUT THIS BENEFIT SUMMARY

This summary is a brief description of the Benefits appearing in the Plan. The Plan describes your benefits and exclusions in detail. It is important that you read the Plan carefully.

Note: In order to receive maximum benefits, some Covered Services require notification to the Third Party Administrator. Please see "Emergency Services – Facility Services" and review Attachment A, Non-Emergency Services Requiring Prior Authorization Notice, of this Benefit Summary for specific details.

Participants should check with the Third Party Administrator to determine if the treatment or service being considered requires Prior Authorization. All Inpatient Admissions and Emergency Admissions require Inpatient Notification Review or Emergency Admission Review, as appropriate.

If a Participant chooses a Noncontracting or a nonparticipating Provider, the Participant may be responsible for any charges that exceed the Maximum Allowance.

To locate a Contracting Provider in your area, please visit the Third Party Administrator's Website at www.bcidaho.com. You may also call the Customer Service Department at 208-286-3410 or 800-358-5527 for assistance in locating a Provider.

PLAN ADMINISTRATION

Micron is the Plan Administrator of the Plan and has contracted with Blue Cross of Idaho Health Service, Inc. ("Third Party Administrator") to serve as the third party administrator of the Plan. Micron has delegated to the Third Party Administrator such general, non-fiduciary, Plan administration services necessary to administer the Plan. Micron has also appointed the Third Party Administrator to serve as the claims fiduciary of the Plan (the "Claims Administrator") and delegated it discretionary authority over claims processing and appeals on behalf of the Plan Administrator. References to the Claims Administrator in this Summary of Health Care Benefits refers only to the Third Party Administrator in its role as Claims Administrator.

NONDISCRIMINATION

No person who is eligible to enroll will be refused enrollment based on health status, health care needs, genetic information, previous medical information, disability, sexual orientation or identity, gender, or age.

DISCRIMINATION IS AGAINST THE LAW

The Plan is administered in compliance with applicable Federal civil rights laws and does not discriminate, exclude or treat less favorably on the basis of race, color, national origin (including limited English proficiency and primary language), age, disability or sex (consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2)).

As the Plan's third party administrator, Blue Cross of Idaho:

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language assistance services to people whose primary language is not English, which may include:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho Civil Rights Coordinator at 1-800-627-1188 (TTY: 711).

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance at:

Civil Rights Coordinator
3000 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018
Fax: 208-331-7493
Email: ***grievancesandappeals@bcidaho.com***
TTY: 711

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.
You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html .***

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY:711).

Arabic انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1188-627-800-1 (للصم والبكم: 711).

Bantu: ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-627-1188 (TTY：711)。

Farsi توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1188-627-800-1 (711:TTY).

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-627-1188（TTY:711）まで、お電話にてご連絡ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-627-1188 (TTY: 711)번으로 전화해 주십시오.

Nepali: ध्यान दनिुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको नमिर्ता भाषा सहायता सेवाहरू नःिशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिविइ: 711) ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-627-1188 (TTY: 711.

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-627-1188 (TTY: 711).

OBSTETRIC OR GYNECOLOGICAL CARE NOTICE:
You do not need Prior Authorization from the Claims Administrator or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining Prior Authorization for certain services or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, please visit our Website at www.bcidaho.com. You may also call our Customer Service Department at 208-286-3410 or 800-358-5527 for assistance in locating a Provider.

MENTAL HEALTH PARITY:
Pursuant to the Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial Cost Sharing restrictions and treatment duration limitations. For further details, please contact 208-286-3410 or 800-358-5527.

DIABETES PREVENTIVE PROGRAM (DPP)
This program is available at no cost to Participants who qualify. You'll be able to choose from an array of national and local programs. Find out if you qualify by taking a one (1) minute survey at www.Solera4me.com/bcidaho or call the Third Party Administrator's Diabetes Prevention Program hotline at 833-868-6895. The Diabetes Prevention Program (DPP) program is a structured lifestyle intervention that includes dietary coaching, lifestyle intervention, and moderate physical activity, all with the goal of preventing the onset of diabetes in individuals who are pre-diabetic. The clinical intervention consists of sixteen (16) intensive "core" sessions of a curriculum in a group-based, classroom-style setting that provides practical training in long-term dietary change, increased physical activity, and behavior change strategies for weight control. After the sixteen (16) core sessions, less intensive monthly follow-up meetings help ensure that the Participant maintain healthy behaviors. The primary goal of the intervention is a 5-7% average weight loss among Participants. Limited to one program, per Benefit Period, per Participant.

WEIGHT MANAGEMENT PROGRAM
This program is available at no cost to Participants who qualify. Wondr Health is an evidence-based, digital counseling program that helps Participants lose weight and improve their quality of life and reverse clinical risk. The program is built to prevent diabetes, reduce the risk of heart disease, reverse metabolic syndrome, and combat other obesity-related diseases. To find out if you qualify, send an email to support@wondrhealth.com or call 855-999-7549. The program includes three different phases to help Participants learn new skills and apply them to their real life: • WondrSkills: Initial skill-building • WondrUp: Personalized skill reinforcement • WondrLast: Long-term skill maintenance

MEDICAL BENEFITS		
Deductibles:	**In-Network**	**Out-of-Network**
Individual	Participant pays the first $900 of In-Network Services for eligible expenses per Benefit Period *(In-Network Covered Services apply to the Out-of-Network Deductible)*	Participant pays the first $1,500 of Out-of-Network Services for eligible expenses per Benefit Period *(Out-of-Network Covered Services apply to the In-Network Deductible)*
Family *(No Participant may contribute more than the Individual Deductible amount toward the Family Deductible)*	Participants pay the first $1,800 of In-Network Services for eligible expenses for all Participants under same Family Coverage per Benefit Period *(In-Network Covered Services apply to the Out-of-Network Deductible)*	Participants pay the first $3,000 of Out-of-Network Services for eligible expenses for all Participants under same Family Coverage per Benefit Period *(Out-of-Network Covered Services apply to the In-Network Deductible)*
Out-of-Pocket Limits: *(See Plan for services that do not apply to the limit)* *(Includes applicable Deductible, Cost Sharing and Copayments)*	**In-Network**	**Out-of-Network**
Individual	Participant pays the first $3,000 of In-Network eligible expenses per Benefit Period	Participant pays the first $6,500 of Out-of-Network eligible expenses per Benefit Period
Family *(No Participant may contribute more than the Individual Out-of-Pocket Limit amount toward the Family Out-of-Pocket Limit)*	Participants pay a combination of $6,000 of In-Network eligible expenses for all Participants under same Family Coverage per Benefit Period *(In-Network Covered Services apply to the Out-of-Network Out-of-Pocket Limits)* *When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for services that do not apply to the limit as listed in the Plan.*	Participants pay a combination of $12,000 of Out-of-Network eligible expenses for all Participants under same Family Coverage per Benefit Period *(Out-of-Network Covered Services apply to the In-Network Out-of-Pocket Limits)* *When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for services that do not apply to the limit as listed in the Plan.*
Be aware that your actual costs for services provided by an Out-of-Network Provider may exceed the Plan's Out-of-Pocket Limit for Out-of-Network services. Except as provided by the No Surprises Act, Out-of-Network Providers can bill you for the difference between the amount charged by the Provider and the amount allowed by the Third Party Administrator, and that amount is not counted toward the Out-of-Network Out-of-Pocket Limit.		

COVERED SERVICES	AMOUNT OF PAYMENT	
	In-Network	**Out-of-Network**
Alternative Therapy Services • **Chiropractic Care** • **Medical Massage Therapy** • **Acupuncture** *(Acupuncture Covered Services must be provided by a state-licensed acupuncturist. In a state that does not license acupuncturists, acupuncture is not a Covered Service.)*	Plan pays 85% of Maximum Allowance after Deductible	**Chiropractic Care Services:** Plan pays 55% of Maximum Allowance after Deductible **Acupuncture and Medical Massage Therapy Services:** Plan pays 85% of Maximum Allowance after Deductible
	(Up to a combined total of 18 visits per Participant, per Benefit Period)	
	In-Network	**Out-of-Network**
Allergy Injections	Participant pays $5 Copayment per visit if this is the only service provided during the visit	Plan pays 55% of Maximum Allowance after Deductible
	In-Network	**Out-of-Network**
Ambulance Transportation Services • **Ground Ambulance Services**	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
• **Air Ambulance Services** *Payment for Out-of-Network Air Ambulance Services is based on the Qualifying Payment Amount. Out-of-Network Air Ambulance Services accumulate towards the In-Network Out-of-Pocket Limit.*	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 85% of Maximum Allowance after In-Network Deductible
	In-Network	**Out-of-Network**
Breastfeeding Support and Supply Services *(Includes rental and/or purchase of manual or electric breast pumps. Limited to one (1) breast pump purchase per Benefit Period, per Participant.)* *(The Plan will reimburse up to a maximum of $150 toward the purchase of a breast pump for nursing mother Participants. The $150 maximum benefit limit does not apply to nursing mothers where a breast pump is Medically Necessary due to the mother or infant health condition. The breast pump benefit is only available to Participants who are mothers or expectant mothers. Any amounts paid in excess of $150 for the breast pump purchase will not be applied to the Deductible or Out-of-Pocket Limit. Participant must purchase the breast pump and submit a direct reimbursement claim form to the Third Party Administrator.)*	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 55% of Maximum Allowance after Deductible

COVERED SERVICES	AMOUNT OF PAYMENT	
Dental Services Related to Accidental Injury	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Diabetes Self-Management Education Services *(Only for accredited Providers approved by the Third Party Administrator)*	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Diagnostic Services *(Includes diagnostic mammograms)*	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Durable Medical Equipment	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
• Exception: Insulin pumps, insulin pump supplies, and continuous glucose monitoring supplies	Plan pays 100% of Maximum Allowance	
Emergency Services – Facility Services *(Copayment waived if admitted; must notify the Third Party Administrator within 72 hours of admission)* *(Copayment does not apply to the In-Network or Out-of-Network Deductibles)* *Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.*	**In-Network**	**Out-of-Network**
	Requires $150 Copayment per hospital Outpatient emergency room visit, after which, Plan pays 85% of Maximum Allowance after In-Network Deductible. Emergency Services accumulate towards the In-Network Out-of-Pocket Limit.	
Emergency Services -Professional Services *Payment for Out-of-Network Emergency Services is based on the Qualifying Payment Amount.*	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after In-Network Deductible. Emergency Services accumulate towards the In-Network Out-of-Pocket Limit.	
Gender Identity Services	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible

COVERED SERVICES	AMOUNT OF PAYMENT	
Hearing Aid Services *(Participant must purchase the hearing aid, and Participant may submit claim for reimbursement from a retail distributor, or Provider may submit claims to the Claims Administrator.)*	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
	(Up to a combined limit of two (2) hearing aids per Participant, per three (3) Benefit Periods. Each hearing aid is limited to $300)	
Home Health Skilled Nursing Care Services	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Home Intravenous Therapy	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 20% of Maximum Allowance after Deductible
Hospice Services	**In-Network**	**Out-of-Network**
	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 55% of Maximum Allowance after Deductible
Hospital Services	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Infertility Treatment and Expenses	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	No benefits
	(Up to a combined annual limit of $7,000, per Benefit Period and a Lifetime Benefit Limit of $20,000, per Participant. Annual limit and Lifetime Benefit Limits include infertility prescription drugs)	
Inpatient Rehabilitation or Habilitation Services	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Maternity Services and/or Involuntary Complications of Pregnancy	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Micron On Site Clinic Center Services *(Additional charges may apply depending on the services performed)*	**In-Network**	**Out-of-Network**
	Participant pays $35 charge per visit	No benefits

COVERED SERVICES	AMOUNT OF PAYMENT	
Morbid Obesity – Surgical Treatment	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	No benefits
	(Up to a combined Lifetime Benefit Limit of $7,500, per Participant)	
Orthotic Devices *(Arch supports limited to one pair or two singles per Participant, per calendar year)* *(Allow orthopedic or corrective shoes, limited to one pair or two singles per Participant, per calendar year)*	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Outpatient Habilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
	(Up to a combined total of 50 visits per Participant, per Benefit Period)	
Outpatient Rehabilitation Therapy Services • Outpatient Occupational Therapy • Outpatient Physical Therapy • Outpatient Speech Therapy	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
	(Up to a combined total of 50 visits per Participant, per Benefit Period)	
Outpatient Cardiac Rehabilitation Therapy Services	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Outpatient Pulmonary Rehabilitation Therapy Services	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Palliative Care Services	**In-Network**	**Out-of-Network**
	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 55% of Maximum Allowance after Deductible
Physician Office Visits	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible

COVERED SERVICES	AMOUNT OF PAYMENT	
Post-Mastectomy/Lumpectomy Reconstructive Surgery	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Prescribed Contraceptive Services *(Includes diaphragms, intrauterine devices (IUDs), implantables, injections and tubal ligation)*	**In-Network**	**Out-of-Network**
	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 55% of Maximum Allowance after Deductible
Prosthetic Appliances *(Up to a combined Lifetime Benefit Limit of $500 per Participant for wigs required due to a covered medical condition)*	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Mental Health and Substance Use Disorder Inpatient and Outpatient Services (Facility and Professional Services)	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Outpatient Applied Behavioral Analysis (ABA)	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Treatment for Autism Spectrum Disorder	**In-Network**	**Out-of-Network**
	Covered the same as any other illness, depending on the services rendered. Please see the appropriate section of the Benefit Summary. Visit limits do not apply to Treatments for Autism Spectrum Disorder, and related diagnoses.	
Skilled Nursing Facility	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
	(Up to a combined total of 30 days per Participant, per Benefit Period)	
Surgical/Medical (Professional Services)	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible

COVERED SERVICES	AMOUNT OF PAYMENT	
Telehealth Services provided by MDLIVE	**In-Network**	**Out-of-Network**
	MDLIVE provides access to the following non-emergency categories of telehealth services: Medical Consultation, Psychotherapy Treatment, Outpatient Medication Management and Psychiatric Evaluation/Medical Service. All MDLIVE services are In-Network and Plan pays 85% of Maximum Allowance after Deductible, per visit. To request a visit, call (888) 920-2975 or visit the Website at www.mdlive.com/bcidaho	
Telehealth Virtual Care Services (Providers other than MDLIVE)	Telehealth Virtual Care Services are available for any category of covered outpatient services. The amount of payment and other conditions for in-person services will apply to Telehealth Virtual Care Services. Please see the appropriate section of the Benefit Summary for those terms.	
Therapy Services *(Including Radiation, Chemotherapy, Renal Dialysis, Growth Hormone and Orthoptics)*	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Transplant Services	**In-Network**	**Out-of-Network**
	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible
Travel and Lodging Reimbursement	**In-Network**	**Out-of-Network**
	Plan pays 100% after Deductible	Plan pays 100% after Deductible
	(Reimbursement is limited to a combined $2,500 per Benefit Period, and a $10,000 Lifetime Benefit Limit, per Participant)	

PREVENTIVE CARE BENEFITS

Free Preventive Care

The preventive care services described in this summary is not an exhaustive list of the preventive care services provided under the Plan. The Plan intends to comply with the Affordable Care Act (ACA) requirement to offer In-Network coverage for certain preventive services without Cost Sharing. To comply with ACA, and in accordance with the recommendations and guidelines described below, the Plan will provide in-Network coverage for:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
- Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
- Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/preventive-care-benefits/. The Plan may, in certain cases, provide preventive services in addition to those required by recommendations and guidelines. For more information, you may contact the Plan Administrator at 208-368-4748 or 1-800-336-8918.

Preventive Care Services	**In-Network**	**Out-of-Network**
For specifically listed Covered Services *Annual adult physical examinations; routine or scheduled well-baby and well-child examinations, including vision, hearing and developmental screenings; Dental fluoride application for Participants age 5 and under; Bone Density; Chemistry Panels; Cholesterol Screening; Colorectal Cancer Screening; Complete Blood Count (CBC); Diabetes Screening; Pap Test; PSA Test; Rubella Screening; Screening EKG; Screening Mammogram; Thyroid Stimulating Hormone (TSH); Transmittable Diseases Screening (Chlamydia, Gonorrhea, Human Immunodeficiency Virus (HIV), Human papillomavirus (HPV), Syphilis, Tuberculosis (TB)); Hepatitis B Virus Screening; Sexually Transmitted Infections assessment; HIV assessment; Screening and assessment for interpersonal and domestic violence; Urinalysis (UA); Abdominal Aortic Aneurysm Screening and Ultrasound; Alcohol and Drug Use Assessment; Breast Cancer (BRCA) Risk Assessment and Genetic Counseling and Testing for High Risk Family History of Breast or Ovarian Cancer; Newborn Metabolic Screening (PKU, Thyroxine, Sickle Cell); Health Risk Assessment for Depression and/or self-harm; Anxiety Screening; Newborn Hearing Test; Lipid Disorder Screening; Nicotine, Smoking and Tobacco-use Cessation Counseling Visit; Dietary Counseling and Physical Activity Behavioral Counseling; Behavioral Counseling for Participants who are overweight or obese; Preventive Lead Screening; Lung Cancer Screening for Participants age 50 and over; Hepatitis C Virus Infection Screening; Screening examinations for school or sports physicals; Urinary Incontinence Screening; For Enrollee or the Enrolled Eligible Dependent spouse: Urine Culture for Pregnant Women; Iron Deficiency Screening for Pregnant Women; Rh (D) Incompatibility Screening for Pregnant Women; Diabetes Screening for Pregnant Women; Perinatal Depression Counseling and Intervention; Behavioral Counseling for Healthy Weight and Weight Gain in Pregnancy.* *The specifically listed Preventive Care Services may be adjusted accordingly to coincide with federal government changes, updates, and revisions.*	Plan pays 100% of Maximum Allowance (Deductible does not apply)	Plan pays 55% of Maximum Allowance after Deductible
For Covered Services not specifically listed	Plan pays 85% of Maximum Allowance after Deductible	Plan pays 55% of Maximum Allowance after Deductible

	In-Network	Out-of-Network
Immunizations *Acellular Pertussis, Anthrax, COVID-19, Cholera, Dengue, Diphtheria, Haemophilus Influenza B, Hepatitis A, Hepatitis B, Human papillomavirus (HPV), Inactivated Poliovirus, Influenza, Japanese Encephalitis, Measles, Meningococcal, Mumps, Pneumococcal (pneumonia), Rabies, Rotavirus, RSV, Rubella, Tetanus, Typhoid, Varicella (Chicken Pox) and Zoster.* *All Immunizations are limited to the extent* ***recommended*** *by the Advisory Committee on Immunization Practices (ACIP) and may be adjusted accordingly to coincide with federal government changes, updates and revisions.* Other immunizations not specifically listed may be covered at the discretion of the Claims Administrator when Medically Necessary.	Listed immunizations require no Copayment, Deductible or Cost Sharing Plan pays 85% of Maximum Allowance after Deductible	Listed immunizations require no Copayment, Deductible or Cost Sharing Plan pays 55% of Maximum Allowance after Deductible
Catapult Health–Preventive Assessment Employer sponsored virtual in home preventive assessment, including a clinical consultation via two-way live video conferencing.	Plan pays 100% of Maximum Allowance for services performed by Catapult Health (Deductible does not apply)	No benefits

PRESCRIPTION DRUG BENEFITS

- The Standard Formulary is available at www.bcidaho.com, and is available to any Participant on request by contacting the Third Party Administrator's Customer Service Department at 208-286-3410 or 800-358-5527.
- Each non Specialty Prescription Drug shall not exceed a 90 day supply at one (1) time
- Each Specialty Prescription Drug shall not exceed a 30 day supply at one (1) time.
- Prescription Drug Services apply to the In-Network Deductibles and Out-of-Pocket Limits.

RETAIL OR THE THIRD PARTY ADMINISTRATOR'S MAIL ORDER PHARMACIES

SPECIALTY PRESCRIPTION DRUGS

The Plan may increase the Cost Sharing listed below to take full advantage of any available drug cost share assistance program offered by drug manufacturers (either directly or indirectly through third parties). This feature, known as the Cost Relief Program, can lower overall costs to the Plan for certain Specialty Prescription Drugs. If a Participant enrolls in the Cost Relief Program, they will not be responsible for the additional Cost Sharing. If a Participant does not enroll, their Cost Sharing may increase, and may not count towards, their Deductible or Out-of-Pocket Limit.

\$100 Individual Deductible; \$200 Family Deductible for Prescription Drugs

	Participating	**Non-Participating**
Tier 1* *(**Retail:** one Copayment for each 30 day supply up to a 90 day supply. **Mail Order:** two Copayments for up to a 90 day supply)*	Participant pays \$10 Copayment per prescription, after Prescription Drug Deductible is met	
Tier 2* *(**Retail:** one Cost Sharing for each 30 day supply up to a 90 day supply. **Mail Order:** 2.5 Cost Sharing for up to a 90 day supply)*	Participant pays 20% Cost Sharing up to \$100 per prescription, after Prescription Drug Deductible is met	
Tier 3* *(**Retail:** one Cost Sharing for each 30 day supply up to a 90 day supply. **Mail Order:** 2.5 Cost Sharing for up to a 90 day supply)*	Participant pays 40% Cost Sharing up to \$150 per prescription, after Prescription Drug Deductible is met	
Tier 4*	Participant pays 25% Cost Sharing up to \$275 per prescription, after Prescription Drug Deductible is met	No benefits

***Specialty Prescription Drug Cost Relief Program**

Please note that certain Specialty Prescription Drugs are only available from an In-Network Specialty Pharmacy, and a Participant will not be able to get them at a Retail Pharmacy. For more information about applicable Cost Sharing amounts available to Specialty Drugs that are eligible for the Cost Relief Program, please see the "Drug Cost Relief Program" section in the Prescription Drug Benefits Section.

ACA Preventive Prescription Drugs	Plan pays 100% for ACA Preventive Prescription Drugs as specifically listed on the Third Party Administrator's Formulary on the Third Party Administrator's Website, www.bcidaho.com. (Deductible does not apply)
HSA Preventive Prescription Drugs	Plan pays 100% for HSA Preventive Prescription Drugs as specifically listed on the Third Party Administrator Formulary on the Third Party Administrator's Website, www.bcidaho.com. (Deductible does not apply)

Prescribed Contraceptives	Plan pays 100% for Women's Preventive Prescription Drugs and devices as specifically listed on the Third Party Administrator's Formulary on the Third Party Administrator's Website, www.bcidaho.com; Deductible does not apply. The day supply allowed shall not exceed a 90 day supply at one (1) time, as applicable to the specific contraceptive drug or supply. The Plan allows the right to request an exception for any FDA-approved, cleared or granted contraceptive not included on the Third Party Administrator's formularies or one that is included with Cost Sharing. Under the exceptions process, if a Participant's attending Provider recommends a particular FDA-approved, cleared or granted contraceptive based on a determination of Medical Necessity with respect to that Participant, the Plan will cover that service or item without Cost Sharing. Contact Customer Service at the telephone number listed on the back of the Enrollee's Identification Card to obtain the appropriate request form.
Note: Certain Prescription Drugs have generic equivalents. If the Participant requests a Brand Name Drug, the Participant is responsible for the difference between the price of the Generic Drug and the Brand Name Drug, regardless of the Preferred or Non-Preferred status.	

Attachment A:
NON-EMERGENCY SERVICES REQUIRING PRIOR AUTHORIZATION ANNUAL NOTICE

NOTICE: ***Prior Authorization is required to determine if the specified services listed below are Medically Necessary and a Covered Service. If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in the Claims Administrator's Medical Necessity decision must be resolved by use of the appeal process described in this Summary of Health Care Benefits.***

If Non-Medically Necessary services are performed by Contracting Providers, without the Prior Authorization, and benefits are denied, the cost of said services are not the financial responsibility of the Participant. The Participant is financially responsible for Non-Medically Necessary services performed by a Provider who does not have a Provider contract with the Third Party Administrator.

The Claims Administrator will respond to a request for Prior Authorization for the services listed below received from either the Provider or the Participant within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination. For additional information, please check with your Provider, call Customer Service at the telephone number listed on the back of the Participant's Identification Card or check the Claims Administrator's Website at www.bcidaho.com.

Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to the Claims Administrator at the time the Prior Authorization request is made. The Claims Administrator retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received.

The following services require Prior Authorization:

Procedures:

- Radiation therapy
- Dental Surgery related to an accident
- Treatment of veins
- Reconstructive and plastic Surgery, including breast, eyelid, jaw and sinus
- Surgery for snoring or sleep problems
- Transplants (organ, tissue, etc.)
- Gender affirming services
- Other Inpatient and Outpatient surgical procedures
- Certain genetic and laboratory testing
- Wound Care and Hyperbaric Oxygen (HCO)

Services:

- Acute Inpatient hospitalization
- Long-term acute care hospital (LTACH) admissions
- Rehabilitation and long-term care facility admissions
- Skilled nursing facility admissions
- Sub-acute and transitional care admissions
- Non-emergency ambulance transport
- Surgical Treatment of Morbid Obesity
- Behavioral Health Services
    - Psychological testing/neuropsychological evaluation testing
    - Electroconvulsive therapy (ECT)
    - Intensive outpatient program (IOP)
    - Partial hospitalization program (PHP)
    - Residential treatment center (RTC)
    - Transcranial Magnetic Stimulation (TMS)
- Advanced Imaging Specialty Health Services:
    - Sleep therapy
    - Magnetic Resonance Imaging (MRI)
    - Computed Tomography (CT)

- Positron Emission Tomography (PET) scan
- Pain management
- Musculoskeletal procedures for spine and joints

Durable Medical Equipment:

- Certain equipment with costs of more than one thousand dollars ($1,000) (including rent-to-purchase items)
- Certain Orthotic Devices and Prosthetic Appliances with costs of more than one thousand dollars ($1,000)

Pharmacy

- Certain Prescription Drugs (find a full list at ***members.bcidaho.com***)
- Chimeric antigen receptor (CAR) T-cell Therapy
- Growth hormone therapy
- Outpatient intravenous (IV) therapy for infusion drugs (find a list at ***members.bcidaho.com***)

PRENATAL EDUCATION PROGRAM

"Bright Beginnings"

Program Goal: To promote healthy prenatal care through education to expectant mothers. The Third Party Administrator provides this program to any employee, or female spouse, who is pregnant. The program provides members with information about nutrition, exercise, prenatal care, and childcare information to help maintain a healthy pregnancy and to deliver a healthy baby.

Enrolling in the Program

If an expectant mother wishes to participate in the Bright Beginnings program and be eligible for the incentive, the expectant mother must enroll by contacting the Third Party Administrator. Simply call Bright Beginnings at (208) 387-6999 or (800) 741-1871.

The Program Includes

Upon enrollment, the expectant mother will receive the *Mayo Clinic Guide to a Healthy Pregnancy* as a gift from the Third Party Administrator. One month prior to delivery, the Third Party Administrator will send out a reminder card that prompts the expectant mother to obtain a list of all visits with their provider both during their pregnancy and after their post-partum visit. Within six months of delivery the expectant mother needs to return the printout from their provider documenting a minimum of eight pre-natal visits and one post-partum visit to the Third Party Administrator. Upon receipt of documentation the mother will receive a $100 gift card and the book, *What to Expect – The First Year*.

Remember

The first step is to call Bright Beginnings at (208) 387-6999 or (800) 741-1871. The expectant mother must see their physician or licensed midwife throughout their pregnancy.

Important Note

This program should not be construed to replace prenatal medical care. All treatment decisions about medical care rest exclusively with the expectant mother and their physician or licensed midwife. The Bright Beginnings program does not grant, or change, any medical policy coverage. All claims submitted to the Claims Administrator will be administered in accordance with the applicable medical policy.

ADOPTION REIMBURSEMENT BENEFIT

Limited to $3,000 benefit maximum per Benefit Period, per eligible participant. Maximum Lifetime Benefit Limit is $12,000. An adoption benefit is available when a Participant meets all of the following conditions:

- Subscriber is the adoptive parent.
- Coverage is in effect on the date an adoption related service is provided or adoption related fee is charged.
- The Participant submits a Micron Adoption Reimbursement Request Form for the adoption benefit along with proof of Qualified adoption expenses.
    - The Micron Adoption Reimbursement Request Form must contain disclosure regarding any other health coverage, or adoption benefits of the adoptive parent(s).
    - Qualified adoption expenses are reasonable and necessary adoption fees, court costs, attorney fees, and other adoption related expenses;
        - which are directly related to, and the principal purpose of which is for, the legal adoption of a child under age 18 by the participant.
        - which are not incurred in violation of State or Federal law or in carrying out any surrogate parenting arrangement
        - which are not expenses in connection with the adoption by an individual of a child who is the child of such individual's spouse, and
        - which are not reimbursed under another Micron self-insured health plan, or another employer program, or otherwise
        - which are not medical, pharmacy, or other expenses of the birth mother.

  The written request must be addressed to:

  Blue Cross of Idaho

  PO Box 7408

  Boise, ID 83707

In the event a Participant adopts more than one newborn from a single pregnancy (for example, twins), or multiple children in a single adoption event (for example siblings), only a single adoption benefit is available (subject to reduction for other coverage below).

In the event the Participant and/or the Participant's spouse are covered by more than one health benefit plan, or separate Micron self-insured Medical Plans, the adoption benefit will be coordinated between or among the plans. The full amount provided by both or all of the plans will not exceed the maximum adoption benefit per Calendar Year, or maximum Lifetime Benefit Limit per plan.

In the event the post-placement evaluation disapproves the adoption placement and a court rules the adoption may not be finalized because of an act or omission of an adoptive parent or parents that affects the child's health or safety, the Participant will be liable for repayment of the adoption benefit. The Participant will refund the full amount of such benefit to the Plan, upon request, within 30 days after the date the child is removed from placement, Participant is responsible for notifying Micron. The Plan will automatically have an equitable lien on such amounts; and such amounts will be held in trust for the benefit of the Plan.

Adoption benefits paid by the Plan are reported to Micron for participant payroll taxation. Adoption benefits are excluded from federal income taxes, however, are subject to FICA taxes and state taxes in some locations.

PREFERRED PROVIDER ORGANIZATION (PPO) MEDICAL PLAN

(part of the Micron Technology, Inc.
Self-Insured Group Health Plan)

Benefit Period: January 1, 2025 through December 31, 2025

(Participants are eligible for benefits only from their Effective Date)

Blue Cross of Idaho has been hired as the Third Party Administrator and the Claims Administrator by the Plan Administrator to perform claims processing and other specified administrative services in relation to the Plan. Blue Cross of Idaho is a trade name for Blue Cross of Idaho Health Service, Inc., an independent licensee of the Blue Cross and Blue Shield Association.

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ERISA

The Plan is subject to the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). See the Additional Administrative Facts and the ERISA sections of the Micron Benefits Handbook for details.

HOW TO SUBMIT CLAIMS

A Participant must submit a claim to the Claims Administrator (Blue Cross of Idaho) in order to receive benefits for Covered Services. There are two ways for a Participant to submit a claim:

1. The Provider can file the claim for the Participant. Most Providers will submit a claim on a Participant's behalf if the Participant shows them the identification card and asks them to send the Claims Administrator the claim, or
2. The Participant can send the Claims Administrator the claim.

To File a Participant's Own Claims

If a Provider prefers that a Participant file the claim, here is the procedure the Participant needs to follow:

1. Ask the Provider for an itemized billing. This should show each service received and its procedure code , the date it was furnished, and the charge for each service. The Claims Administrator cannot accept billings that only say "Balance Due," "Payment Received," or some similar statement.
2. Obtain a Member Claim Form from the Claims Administrator Website, www.bcidaho.com, from the Provider or any of the Claims Administrator's offices, and follow the instructions. Use a separate billing and Member Claim Form for each patient involved.
3. Attach the billing to the Member Claim Form and send it to:
   Blue Cross of Idaho Claims Control
   Blue Cross of Idaho
   PO Box 7408
   Boise, ID 83707

For assistance with claims or health information, please call the Claims Administrator Customer Service at (208) 286-3410 or 1-800-358-5527.

How Blue Cross of Idaho Notifies the Participant

The Claims Administrator makes its claim payment decisions based on the information it has when a claim is received. The Third Party Administrator makes every effort to process claims as quickly as possible. The Third Party Administrator will send a Participant an Explanation of Benefits (EOB) by mail or electronically, if the Participant has consented to electronic delivery, once the claim is processed. The EOB will show all of the payments the Third Party Administrator made on behalf of the Plan and to whom the payments were sent. It will also explain any charges the Third Party Administrator did not pay in full. If a Participant would like a paper copy of their EOB, they may request one from the Third Party Administrator's Customer Service.

Deadline

A claim for Covered Services must be submitted within one year from the date of service and must include all the information necessary for the Claims Administrator to determine benefits.

CONTACT INFORMATION FOR THE THIRD PARTY ADMINISTRATOR

For general information, please contact the Third Party Administrator:

Meridian
Blue Cross of Idaho Health Service, Inc.
Customer Service Department
3000 East Pine Avenue
Meridian, ID 83642

Mailing Address
Blue Cross of Idaho Health Service, Inc.
PO Box 7408
Boise, ID 83707
(208) 286-3410 (Boise Area)
(800) 358-5527

INPATIENT NOTIFICATION SECTION

This section describes procedures that should be followed in order for Participants to receive the maximum benefits available for Covered Services. As specified, Non-Emergency Preadmission Notification or Emergency Admission Notification is required for all Inpatient services.

NOTE: Some Inpatient services also require the Provider to obtain Prior Authorization. Please refer to the Prior Authorization Section.

I. Non-Emergency Preadmission Notification

Non-Emergency Preadmission Notification is a notification to the Third Party Administrator by the Participant and is required for all Inpatient admissions except Covered Services subject to Emergency or Maternity delivery Admission Notification. A Participant should notify the Third Party Administrator of all proposed Inpatient admissions as soon as they know they will be admitted as an Inpatient. The notification should be made before any Inpatient admission. Non-Emergency Preadmission Notification informs the Third Party Administrator, or a delegated entity, of the Participant's proposed Inpatient admission to a Licensed General Hospital, Alcohol or Substance Use Disorder Treatment Facility, Psychiatric Hospital, or any other Facility Provider. This notification alerts the Claims Administrator of the proposed stay. When timely notification of an Inpatient admission is provided by the Participant to the Third Party Administrator payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of this Summary of Health Care Benefits.

For Non-Emergency Preadmission Notification call the Third Party Administrator at the telephone number listed on the back of the Enrollee's Identification Card.

II. Emergency Admission Notification

When an Emergency Admission occurs for Emergency Medical Conditions and notification cannot be completed prior to admission due to the Participant's condition, the Participant, or their representative, should notify the Third Party Administrator within seventy-two (72) hours of the admission. If the admission is on a weekend or legal holiday, the Third Party Administrator should be notified by the end of the next working day after the admission.

This notification alerts the Claims Administrator to the emergency stay.

III. Continued Stay Review

The Claims Administrator will contact the hospital utilization review department and/or the attending Physician regarding the Participant's proposed discharge. If the Participant will not be discharged as originally proposed, the Claims Administrator will evaluate the Medical Necessity of the continued stay and approve or disapprove benefits for the proposed course of Inpatient treatment. Payment of benefits is subject to the specific benefit levels, limitations, exclusions and other provisions of this Summary of Health Care Benefits.

IV. Discharge Planning

The Third Party Administrator will provide information about benefits for various post-discharge courses of treatment.

PRIOR AUTHORIZATION SECTION

NOTICE: ***Prior Authorization is required to determine if the services listed in the Attachment A of the Benefit Summary are Medically Necessary (as determined by the Contracting Provider). If Prior Authorization has not been obtained to determine Medical Necessity, services may be subject to denial. Any dispute involved in the Claims Administrator's Medical Necessity decision must be resolved by use of the appeal process described in this Summary of Health Care Benefits.***

If Non-Medically Necessary services are performed by Contracting Providers, without Prior Authorization, and benefits are denied by the Claims Administrator, the cost of said services are not the financial responsibility of the Participant. The Participant is financially responsible for Non-Medically Necessary services performed by a Noncontracting Provider.

Contracting Providers: Prior Authorization is a request by the Participant's Contracting Provider to the Claims Administrator, or delegated entity, for authorization of a Participant's proposed treatment. The Claims Administrator may review medical records, test results and other sources of information to ensure that it is a Covered Service and make a determination as to Medical Necessity or alternative treatments.

Please refer to Attachment A of the document titled "Benefit Summary", check the Third Party Administrator Website at www.bcidaho.com, or call Customer Service at the telephone number listed on the back of the Participant's Identification Card to determine if the Participant's proposed services require Prior Authorization. To request Prior Authorization, the Contracting Provider must notify the Claims Administrator of the Participant's intent to receive services that require Prior Authorization.

The notification may be completed by telephone call or in writing and must include the information necessary to establish that the proposed services are Covered Services under the Participant's Plan and Medically Necessary. The Claims Administrator will respond to a request for Prior Authorization received from either the Provider or the Participant within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination.

Noncontracting Providers: Please refer to Attachment A of the Benefit Summary, check the Third Party Administrator's Website at www.bcidaho.com, or call Customer Service at the telephone number listed on the back of the Participant's Identification Card to determine if the proposed services require Prior Authorization. The Participant is responsible for obtaining Prior Authorization when seeking treatment from a Noncontracting Provider. The Participant is financially responsible for services performed by a Noncontracting Provider when those services are determined to not be Medically Necessary. The Participant is responsible for notifying the Third Party Administrator if the proposed treatment will be provided by a Noncontracting Provider.

Prior Authorization is not a guarantee of payment. It is a pre-service determination of Medical Necessity based on information provided to the Claims Administrator at the time the Prior Authorization request is made. The Claims Administrator, on behalf of the Plan Sponsor, retains the right to review the Medical Necessity of services, eligibility of services and benefit limitations and exclusions after services are received.

MEDICAL BENEFITS SECTION

This section specifies the benefits a Participant is entitled to receive for Covered Services described, or conditions that must be satisfied to qualify for benefits, subject to the other provisions of this Summary of Health Care Benefits.

I. Benefit Period

The Benefit Period is each calendar year and represents the period of time during which a Participant accumulates annual benefit limits, Deductible amounts and Out-of-Pocket Limits. Please see the cover page of this Summary of Health Care Benefits for the Benefit Period. If the Participant's Effective Date is after January 1, the initial Benefit Period for that Participant will be less than twelve (12) months.

The Benefit Period for Hospice Covered Services is a continuous six (6) month period that begins when a Hospice Plan of Treatment is approved by the Claims Administrator. The Participant may apply to the Claims Administrator for an extension of the Hospice Benefit Period.

II. Deductible

A. Individual

The Individual Deductible is shown in the Benefit Summary.

B. Family

The Family Deductible is shown in the Benefit Summary.

Expenses associated with the following are not included in the Deductible:

1. Amounts that exceed the Maximum Allowance.
2. Amounts that exceed benefit limits.
3. Services covered under a separate Plan, if any.
4. Noncovered services or supplies.
5. Copayments, except for Prescription Drug Copayments.

III. Out-of-Pocket Limit

The Out-of-Pocket Limit is shown in the Benefit Summary. Eligible Out-of-Pocket expenses include only the Participant's Deductible, Copayments and Cost Sharing, if applicable, for eligible Covered Services. If a Participant is admitted as an Inpatient at the end of a Benefit Period and the hospitalization continues uninterrupted into the succeeding Benefit Period, all eligible Out-of-Pocket expenses incurred for Inpatient Hospital Services are considered part of the Benefit Period in which the date of admission occurred.

A. Out-of-Pocket expenses associated with the following are not included in the In-Network Out-of-Pocket Limit:

1. Amounts that exceed the Maximum Allowance.
2. Amounts that exceed benefit limits.
3. Services covered under a separate Plan, if any.
4. Noncovered services or supplies.

B. Out-of-Pocket expenses associated with the following are not included in the Out-of-Network Out-of-Pocket Limit:

1. Amounts that exceed the Maximum Allowance.
2. Amounts that exceed benefit limits.
3. Dental care Covered Services.
4. Services covered under a separate Plan, if any.
5. Noncovered services or supplies.
6. Vision care Covered Services.
7. Prescription Drug Covered Services.

IV. Providers

All Providers and Facilities must be licensed, certified, accredited and/or registered, where required, to render Covered Services. For the purposes of this Summary of Health Care Benefits, Providers include any facility or individual who

provides a Covered Service while operating within the scope of their license, certification, accreditation and/or registration under applicable state law, unless exempted by federal law.

V. Covered Services

The Benefit Summary, incorporated into this Summary of Health Care Benefits, is an easy reference document that contains general payment information and a descriptive list of Covered Services. The following are Covered Services when obtained in accordance with the terms and conditions of the Plan. Benefits are subject to the Copayments, Deductibles, Cost Sharing, exclusions, limitations, and other provisions as specified in the Plan. The Third Party Administrator shall provide the payment levels specified in the Benefit Summary for the Covered Services listed in this section.

To be eligible for benefits, Covered Services must be Medically Necessary and must be provided to an eligible Participant under the terms of the Plan.

Note: In order to receive benefits, some Covered Services require Prior Authorization. Please review the Prior Authorization Section for more specific details.

A. Acupuncture Services

Benefits for Acupuncture Services are shown in the Benefit Summary.

B. Ambulance Transportation Services

Ambulance transportation services are covered for Medically Necessary transportation of a Participant within the local community by Ambulance under the following conditions:

1. From a Participant's home or scene of Accidental Injury or Emergency Medical Condition to a Licensed General Hospital.
2. Between Licensed General Hospitals.
3. Between a Licensed General Hospital and a Skilled Nursing Facility.
4. From a Licensed General Hospital to the Participant's home.
5. From a Skilled Nursing Facility to the Participant's home.

For purposes of 1., 2. and 3. above, if there is no facility in the local community that can provide Covered Services appropriate to the Participant's condition, then Ambulance Transportation Service means transportation to the closest facility that can provide the necessary service.

Air Ambulance transportation services are covered only when Medically Necessary when geographic restraints prevent Ground Ambulance transportation to the nearest facility that can provide Covered Services appropriate to the Participants condition, or ground transportation would put the health and safety of the Participant at risk.

Ground Ambulance and Air Ambulance services that are not for an Emergency Medical Conditions must be Medically Necessary and require Prior Authorization.

C. Applied Behavioral Analysis (ABA) - Outpatient

Benefits for Applied Behavioral Analysis (ABA) - Outpatient Services are shown in the Benefit Summary.

D. Approved Clinical Trial Services

Coverage is available for routine patient costs associated with an Approved Clinical Trial. Routine patient costs include but are not limited to Office Visits, diagnostic, laboratory tests and/or other services related to treatment of a medical condition. Routine patient costs are items and services that typically are Covered Services for a Participant not enrolled in an Approved Clinical Trial, but do not include:

1. An Investigational item, device, or service that is the subject of the Approved Clinical Trial;
2. Items and services provided solely to satisfy data collection and analysis needs and not used in the direct clinical management of the Participant; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for the particular diagnosis.

E. Breastfeeding Support and Supply Services

The lesser of the Maximum Allowance or billed charge for rental, (but not to exceed the lesser of the Maximum Allowance or billed charge for the total purchase price) or, at the option of the Third Party Administrator, the purchase of breastfeeding support and supplies. The breastfeeding support and supplies must be prescribed by an attending Physician or other Professional Provider within the scope of license and must be supplied by a Provider, except as specifically listed in the Plan. If the Participant and her Provider have chosen a more expensive item than is determined to be the standard and most economical by the Third Party Administrator, the excess charge is solely the responsibility of the Participant. Supply items considered to be personal care items or common household items are not covered.

The Plan will reimburse up to a maximum of $150 toward the purchase of a breast pump for nursing mother Participants. The $150 maximum benefit limit does not apply to nursing mothers where a breast pump is Medically Necessary due to the mother or infant health condition. The breast pump benefit is only available to Participants who are mothers or expectant mothers. Any amounts paid in excess of $150 for the breast pump purchase will not be applied to the Deductible or Out-of-Pocket Limit. Participant must purchase the breast pump and submit a direct reimbursement claim form to the Third Party Administrator.

F. Chiropractic Care Services

1. Benefits are limited to Chiropractic Care Services related to a significant medical condition necessitating appropriate Medically Necessary evaluation and Neuromusculoskeletal Treatment services. Chiropractic Care Services are covered when:
   a) Services are directly related to a written treatment regimen prepared and performed by a Chiropractic Physician.
   b) Services must be related to recovery or improvement in function, with reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time.
2. No benefits are provided for:
   a) Surgery as defined in this Summary of Health Care Benefits to include injections.
   b) Laboratory and pathology services.
   c) Range of motion and passive exercises that are not related to restoration of a specific loss of function.
   d) Massage therapy, if not performed in conjunction with other modalities or manipulations.
   e) Maintenance, palliative or supportive care.
   f) Preventive or wellness care.
   g) Facility-related charges for Chiropractic Care Services, health club dues or charges, or Chiropractic Care Services provided in a health club, fitness facility, or similar setting.
   h) General exercise programs.
   i) Diagnostic Services, except for x-rays to assist in the diagnosis and Neuromusculoskeletal Treatment plan as defined in this Summary of Health Care Benefits.

G. Dental Services Related to Accidental Injury

Dental services which are rendered by a Physician or Dentist and required as a result of Accidental Injury to the jaw, Sound Natural Tooth, mouth, or face. Such services are covered only for the twelve (12) month period immediately following the date of Injury providing the Summary of Health Care Benefits remains in effect during the twelve (12) month period, unless Medically Necessary. Temporomandibular Joint (TMJ) disorder and injuries as a result of chewing or biting are not considered Accidental Injuries, unless the source of the injury is an act of domestic violence. No benefits are available under this section for Orthodontia.

Benefits are provided for repair of damage to a Sound Natural Tooth, lips, gums, and other portions of the mouth, including fractures of the maxilla or mandible. Repair or replacement of damaged dentures, bridges, or other dental appliances is not covered, unless the appliance must be modified or replaced due to Accidental Injury to a Sound Natural Tooth which are abutting the bridge or denture.

Benefits for dental services related to Accidental Injury under this provision shall be secondary to dental benefits available to a Participant under another benefit section or available under a dental policy of insurance, contract, or underwriting plan that is separate and distinct from this Summary of Health Care Benefits.

H. Diabetes Self-Management Education Services - Outpatient

Diabetes Self-Management Education includes instruction in the basic skills of diabetes management through books/educational material as well as an individual or group consultation with a certified diabetes educator, nurse, or dietitian in an American Diabetes Association (ADA) or American Association of Diabetes Educators (AADE) certified program, or other accredited program approved by the Third Party Administrator.

I. Diagnostic Services

Diagnostic Services include mammograms. Tests to determine pregnancy and Pap tests are covered regardless of results. Benefits for Medically Necessary genetic testing are only available when Prior Authorization has been completed and approved by the Third Party Administrator.

J. Durable Medical Equipment (DME)

The lesser of the Maximum Allowance or billed charge for rental, (but not to exceed the lesser of the Maximum Allowance or billed charge for the total purchase price) or, at the option of the Third Party Administrator, the purchase of Medically Necessary Durable Medical Equipment required for therapeutic use. The Durable Medical Equipment must be prescribed by an attending Physician or other Professional Provider within the scope of license. Benefits shall not exceed the cost of the standard, most economical Durable Medical Equipment that is consistent, according to generally accepted medical treatment practices, with the Participant's condition. If the Participant and their Provider have chosen a more expensive treatment than is determined to be the standard and most economical by the Third Party Administrator, the excess charge is solely the responsibility of the Participant. Equipment items considered to be common household items are not covered.

Due to ongoing service requirements and safety issues relating to oxygen equipment, this Summary of Health Care Benefits will not limit the cost of oxygen and the rental of oxygen delivery systems to the purchase price of the system(s).

Cranial molding helmets are covered.

K. Elective Abortion

When the Participant would otherwise be eligible for Maternity Services benefits, applicable Maternity Service benefit for elective abortions shall be provided, to the extent permitted by state law.

L. Gender Identity Services

Transgender Medical Benefits, as listed below, are based on Version 7 of the Standards of Care published by the World Professional Association for Transgender Health (WPATH) in 2012 and are subject to the prior approval requirements of the Plan. There is no lifetime maximum for covered transgender services as outlined in this document.

Covered Services include treatments for the self-determined gender identity of the Participant. Covered Services also include hormone therapy and treatment for the organs possessed by the Participant (e.g. prostate or ovary) regardless of gender identity. Services that include reassignment surgery and hormone therapy may be subject to a Prior Authorization requirement.

The following services are covered with a documented diagnosis of gender dysphoria and do not have a Prior Authorization requirement:

- Reversals and revisions of Surgical treatment
- Mastectomy or breast reduction for female to male patients and augmentation mammaplasty for male to female patients
- Rhinoplasty or nose implants

- Face-lifts
- Lip enhancement or reduction
- Facial bone reduction or enhancement
- Blepharoplasty
- Liposuction of the waist (body contouring)
- Reduction thyroid chondroplasty
- Hair removal
- Voice modification surgery (laryngoplasty or shortening of the vocal cords)
- Skin resurfacing
- Nipple resizing
- Voice therapy

M. Hearing Aid Services

Benefits for Hearing Aid Services are shown in the Benefit Summary.

N. Home Health Skilled Nursing Care Services

The delivery of Skilled Nursing Care services under the direction of a Physician to a Homebound Participant, provided such provider does not ordinarily reside in the Participant's household or is not related to the Participant by blood or marriage. The services must not constitute Custodial Care. Services must be provided by a Medicare certified Home Health Agency and limited to intermittent Skilled Nursing Care. The patient's Physician must review the care at least every thirty (30) days. No benefits are provided during any period of time in which the Participant is receiving Hospice Covered Services.

O. Hospice Services

1. **Conditions**

A Participant must specifically request Hospice benefits and must meet the following conditions to be eligible:

a) The attending or primary Physician must certify that the Participant is a terminally ill patient with a life expectancy of six (6) months or less.
b) The Participant must live within the Hospice's local geographical area.
c) The Participant must be formally accepted by the Hospice.
d) The Participant must have a designated volunteer Primary Care Giver at all times.

2. **Exclusions and Limitations**

No Benefits are provided for:

a) Hospice services not included in a Hospice Plan of Treatment and not provided or arranged and billed through a Hospice.
b) Continuous Skilled Nursing Care except as specifically provided as a part of Respite Care or Continuous Crisis Care.
c) Hospice benefits provided during any period of time in which a Participant is receiving Home Health Skilled Nursing Care benefits.

P. Hospital Services - Inpatient

The following are Covered Services:

1. **Room, Board and General Nursing Services**

Room and board, special diets, the services of a dietician, and general nursing service when a Participant is an Inpatient in a Licensed General Hospital is covered as follows:

a) A room with two (2) or more beds is covered. If a private room is used, the benefit provided in this section for a room with two (2) or more beds will be applied toward the charge for the private room. Any difference between the charges is a noncovered expense and is the sole responsibility of the Participant.
b) If isolation of the Participant is: (a) required by the public health law of a political jurisdiction, or (b) required to prevent contamination of either the Participant or another patient by the Participant, then payment for approved private room isolation charges shall be in place of the benefits for the daily room charge stated in paragraph one (1).
c) Benefits for a bed in a Special Care Unit shall be in place of the benefits for the daily room charge stated in paragraph one (1).

d) A bed in a nursery unit is covered.

2. **Ancillary services**

Licensed General Hospital services and supplies, including:

a) Use of operating, delivery, cast, and treatment rooms and equipment.

b) Prescription Drugs administered while the Participant is an Inpatient.

c) Administration and processing of whole blood and blood products when the whole blood or blood products are actually used in a transfusion for a Participant; whole blood or blood plasma that is not donated on behalf of the Participant or replaced through contributions on behalf of the Participant.

d) Anesthesia, anesthesia supplies, and services rendered by the Licensed General Hospital as a regular hospital service and billed by the Licensed General Hospital in conjunction with a procedure that is a Covered Service.

e) All medical and surgical dressings, supplies, casts, and splints that have been ordered by a Physician and furnished by a Licensed General Hospital; specially constructed braces and supports are not a Covered Service under this section.

f) Oxygen and administration of oxygen.

g) Patient convenience items essential for the maintenance of hygiene provided by a Licensed General Hospital as a regular hospital service in connection with a covered hospital stay. Patient convenience items include, but are not limited to, an admission kit, disposable washbasin, bedpan or urinal, shampoo, toothpaste, toothbrush, and deodorant.

h) Diagnostic Services and Therapy Services as specified in their respective sections in this Summary of Health Care Benefits.

If Diagnostic Services or Therapy Services furnished through a Licensed General Hospital are provided in part or in full by a Physician under contract with the Licensed General Hospital to perform such services, and the Physician bills separately for such services, the Physician's services shall be a Covered Service.

Q. Hospital Services - Outpatient

The following are Covered Services:

1. **Emergency Services**

Medical care to treat an Emergency Medical Condition or an Accidental Injury. Emergency room services include:

- Emergency room Physician and Facility services;
- Freestanding Emergency Department;
- Post-Stabilization Care Services;
- Equipment, supplies and drugs used in the emergency room;
- Inpatient Admission that is necessary even after Stabilization.
- Services and exams for Stabilization of an Emergency Medical Condition; and
- equipment and devices, telemedicine services, Diagnostic Services, preoperative and postoperative services, and other items and services, rendered during the Emergency room visit.

For purposes of this section, Stabilization means that no material deterioration of the Emergency Medical Condition is likely to result from or occur during the transfer of the Participant from a facility.

2. **Surgery**

Licensed General Hospital or Ambulatory Surgical Facility services and supplies including removal of sutures, anesthesia, anesthesia supplies, and services rendered by an employee of the Licensed General Hospital or Ambulatory Surgical Facility who is not the surgeon or surgical assistant, in conjunction with a procedure that is a Covered Service.

R. Hospital Services - Special Services

1. **Preadmission testing**

Tests and studies required with the Participant's admission and accepted or rendered by a Licensed General Hospital on an Outpatient basis prior to a scheduled admission as an Inpatient, if the services would have been available to an Inpatient of a Licensed General

Hospital. Preadmission Testing does not include tests or studies performed to establish a diagnosis.

Preadmission Testing benefits are limited to Inpatient admissions for Surgery. Preadmission Testing must be conducted within seven (7) days prior to a Participant's Inpatient admission.

Preadmission Testing is a Covered Service only if the services are not repeated when the Participant is admitted to the Licensed General Hospital as an Inpatient, and only if the tests and charges are included in the Inpatient medical records.

No benefits for Preadmission Testing are provided if the Participant cancels or postpones the admission to the Licensed General Hospital as an Inpatient. If the Licensed General Hospital or Physician cancels or postpones the admission then benefits are provided.

2. **Dental Related Services**

Hospital benefits may be provided for dental extractions, or other dental procedures if certified by a Physician that a non-dental medical condition requires hospitalization to safeguard the health of the Participant. Non-dental conditions that may receive hospital benefits are:

a) Brittle diabetes.
b) History of a life-endangering heart condition.
c) History of uncontrollable bleeding.
d) Severe bronchial asthma.
e) Children under ten (10) years of age who require general anesthetic.
f) Other non-dental life-endangering conditions that require hospitalization, subject to approval by the Claims Administrator.

S. Infertility Treatment and Expenses

The benefits provided for the Enrollee or the Enrollee's spouse (if a Participant). No benefits are provided for any infertility treatment and expenses for enrolled Eligible Dependent children. Annual and Lifetime Benefit Limits are shown in the Benefit Summary and include Prescription Drugs. Benefits are limited to infertility treatment for Intrauterine Insemination (IUI), In Vitro Fertilization (IVF), Intracytoplasmic Sperm Injections (ICSI), specialized sperm retrieval, and procedures to retrieve oocytes, up to the Lifetime Benefit Limit as shown in the Benefit Summary.

a) No benefits are provided for:
   a. Reversals of tubal ligations or vasectomies
   b. Expenses, procedures or services related to Surrogate pregnancy/delivery or donor eggs
   c. Egg or sperm donor procedures when intended use is not for Micron enrolled Participant, or their spouse or partner.

T. Maternity Services and/or Involuntary Complications of Pregnancy

Nursery care of a newborn infant is not a maternity service.

No benefits are provided for any Normal Pregnancy or Involuntary Complications of Pregnancy for enrolled Eligible Dependent children (if a Participant). However, tests to determine pregnancy are covered. All other diagnostic x-ray and laboratory services related to pregnancy, childbirth, or miscarriage are not covered.

Massachusetts Work Sites

In order to meet Massachusetts credible coverage requirements, the following additional plan benefits apply to Participant's who have coverage through a team member whose work site in the Micron Employee Database is in the State of Massachusetts:

- Maternity Services for Participants who are dependent children are Covered Services.

1. **Normal Pregnancy**

Normal pregnancy includes all conditions arising from pregnancy or delivery, including any condition usually associated with the management of a difficult pregnancy that is not defined below as an involuntary complication of pregnancy.

2. **Involuntary Complications of Pregnancy**
   Involuntary Complications of Pregnancy include, but are not limited to:
   a) Cesarean section delivery, ectopic pregnancy which is terminated, spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible, puerperal infection, eclampsia, and toxemia; and
   b) Conditions requiring Inpatient confinement (when the pregnancy is not terminated), the diagnoses of which are distinct from pregnancy, but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Physician-prescribed bed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy.

3. If you have a birth, benefits for any hospital length of stay in connection with childbirth for the mother or newborn child will include forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a cesarean section delivery. Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours or ninety-six (96) hours as applicable. For stays in excess of forty-eight (48) hours or ninety-six (96) hours, additional benefits may be available under the terms of subsection, "Continued Stay Review", found in the Inpatient Notification Section of this Summary of Health Care Benefits.

U. Medical Foods
Medical Foods for inborn errors of metabolism such as Phenylketonuria (PKU) or when a Provider has diagnosed the presence of inadequate nutritional oral intake related to a medical condition or due to a progressive impairment of swallowing or digestion.

V. Medical Services - Inpatient
Inpatient medical services rendered by a physician or other Professional Provider to a Participant who is receiving Covered Services in a Licensed General Hospital or Skilled Nursing Facility.

Consultation services when rendered to a Participant as an Inpatient of a Licensed General Hospital by another Physician at the request of the attending Physician. Consultation services do not include staff consultations that are required by Licensed General Hospital rules and regulations.

W. Medical Services - Outpatient
The following Outpatient medical services rendered by a Physician or other professional Provider to a Participant who is an Outpatient, provided such services are not related to pregnancy, Chiropractic Care, Mental or Nervous Conditions and/or Substance Use Disorder or Addiction, except as provided specifically elsewhere in this Summary of Health Care Benefits.

1. **Home and Other Outpatient Visits**
   Medical care visits and consultations for the examination, diagnosis, or treatment of a condition, Injury, Disease, or Illness.
2. **Physician Office Visits**
   Medical care visits and consultations for the examination, diagnosis, or treatment of a condition, Injury, Disease, or Illness.
3. **Special Therapy Services**
   Deep Radiation Therapy or Chemotherapy for a malignancy when such therapy is performed in the Physician's office.
4. **Other Therapy Services**
   Other Therapy Services as specified in the Therapy Services section of this Summary of Health Care Benefits.
5. **Telehealth Virtual Care Services**

X. Mental Health and Substance Use Disorder Services

1. Covered Mental Health and Substance Use Disorder Services include Intensive Outpatient Program (IOP), Partial Hospitalization Program (PHP), Residential Treatment Center, psychological testing/neuropsychological evaluation testing and Electroconvulsive Therapy (ECT).
2. **Inpatient Mental Health and Substance Use Disorder Care—**The benefits provided for Inpatient hospital services and Inpatient medical services in this section are also provided for the care of Mental or Nervous Conditions, Alcoholism, Substance Use Disorder or Addiction, or any combination of these.
3. **Outpatient Mental Health and Substance Use Disorder Care—**The benefits provided for Outpatient Hospital Services and Outpatient Medical Services in this section are also provided for Mental or Nervous Conditions, Alcoholism, Substance Use Disorder or Addiction, or any combination of these. The use of Hypnosis to treat a Participant's Mental or Nervous Condition is a Covered Service.
4. **Outpatient Psychotherapy Services—**Covered Services include professional office visit services, family, individual and/or group therapy.

Y. Orthotic Devices

Orthotic Devices include, but are not limited to, Medically Necessary braces, back or special surgical corsets, splints for extremities, trusses, arch supports, orthopedic shoes, and when prescribed by a Physician, Chiropractic Physician, Podiatrist, or Licensed Physical Therapist, or Licensed Occupational Therapist. Other foot support devices and garter belts are not considered Orthotic Devices. Benefits shall not exceed the cost of the standard, most economical Orthotic device that is consistent, according to generally accepted medical treatment practices, with the Participant's condition.

Z. Outpatient Cardiac Rehabilitation Therapy

Cardiac Rehabilitation is a Covered Service for Participants who have a clear medical need and who are referred by their attending Physician and (1) have a documented diagnosis of acute myocardial infarction (MI) within the preceding 12 months; (2) have had coronary artery bypass (CABG) graft Surgery; (3) have percutaneous transluminal coronary angioplasty (PTCA) or coronary stenting; (4) have had heart valve Surgery; (5) have had heart or heart-lung transplantation; (6) have current stable angina pectoris; or (7) have compensated heart failure.

AA. Outpatient Pulmonary Rehabilitation Services

Benefits will be provided for but not limited to the following diagnoses: COPD, chronic bronchitis, asthma, emphysema, bronchiectasis, and restrictive lung disease.

Benefits will be provided for Pulmonary Rehabilitation Services rendered by an approved Provider of an established and medically recognized Outpatient Pulmonary Rehabilitation program, managed and implemented by a registered respiratory therapist licensed in the state of Idaho.

Covered Services are limited to monitored exercise therapy including blood pressure, pulse, and oxygen saturation monitoring; direction of exercise type, intensity and duration; and education regarding disease process and chronic disease management strategies.

AB. Palliative Care Services

A Participant, or a Provider on behalf of the Participant, must specifically request services for Palliative Care. Palliative Care Covered Services are covered when a Provider has assessed that a Participant is in need of Palliative Care for a serious Illness (including remission support), life-limiting injury or end-of-life care, and is limited to the following:

1. Acute Inpatient, Skilled Nursing Facility or Rehabilitation based Palliative Care services.
2. Home Health pain and symptom management services.
3. Home Health psychological and social services including individual and family counseling.
4. Caregiver support rendered by a Provider to a Participant.
5. Advanced care planning limited to face-to-face services between a Provider and a Participant to discuss the Participant's health care wishes if they become unable to make decisions about their care.

AC. Post-Mastectomy/Lumpectomy Reconstructive Surgery

Reconstructive Surgery in connection with a Disease related mastectomy/lumpectomy, including:

1. Reconstruction of the breast on which the mastectomy/lumpectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and treatment of physical complications at all stages of the mastectomy/lumpectomy, including lymphedemas;

in a manner determined in consultation with the attending Physician and the Participant.

AD. Prescribed Contraceptive Services

Covered Services include prescribed devices, injectable, insertable and implantable methods of temporary contraception, such as diaphragms, intrauterine devices (IUDs) and injections. Covered Services include tubal ligation. See the Benefit Summary for additional coverage details.

There are no benefits for:

1. Over-the-counter items including, but not limited to condoms, spermicides, and sponges.
2. Prescribed contraceptives that could otherwise be purchased over-the-counter.

AE. Preventive Services

Benefits are provided for:

1. Preventive Care Covered Services—See Benefit Summary for complete list. Dietary Counseling, also referred to as "medical nutritional counseling", includes the assessment of a Participant's overall nutritional status followed by the assignment of individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. Dietary Counseling is only covered under the Preventive Care Benefit and includes Dietary Counseling for Diabetes. Dietary Counseling is covered only if provided by a doctor of medicine (M.D.), doctor of osteopathy (D.O.), Registered Dietitian, Physician Assistant (P.A.), or a Nurse Practitioner (N.P.).
2. Immunizations—see Benefit Summary for complete list.

AF. Prosthetic Appliances

The purchase, fitting, necessary adjustment, repair, and replacement of Prosthetic Appliances including post-mastectomy prostheses.

Benefits for prosthetic appliances are subject to the following limitations:

1. Benefits are limited to the most appropriate supply or level of service and Cost Effective Prosthetic Appliance. If the Participant and their Provider have chosen a more expensive treatment than is determined to be the standard and most economical by the Claims Administrator, the excess charge is solely the responsibility of the Participant.

2. No benefits are provided for dental appliances or major Artificial Organs, including but not limited to, artificial hearts and pancreases.

3. Following cataract Surgery, benefits for a required contact lens or a pair of eyeglasses are limited to the first contact lens or pair of eyeglasses, which must be purchased within ninety (90) days.

4. Benefits for required contact lens or a pair of eyeglasses for treatment of Keratoconus.

5. No benefits are provided for the rental or purchase of any synthesized, artificial speech or communications output device or system or any similar device, appliance or computer system designed to provide speech output or to aid an inoperative or unintelligible voice, except for voice boxes to replace all or part of a surgically removed larynx.

AG. Inpatient Rehabilitation or Habilitation Services

Benefits are provided for Inpatient Rehabilitation or Habilitation Services subject to the following:

1. Admission for Inpatient Physical Rehabilitation must occur within one hundred twenty (120) days of discharge from an Acute Care Licensed General Hospital.

2. Continuation of benefits is contingent upon approval by the Claims Administrator of a Rehabilitation or Habilitation Services Plan of Treatment and documented evidence of patient progress submitted to the Claims Administrator at least twice each month.

AH. Skilled Nursing Facility

Benefits provided to an Inpatient of a Licensed General Hospital are also provided for services and supplies customarily rendered to an Inpatient of a Skilled Nursing Facility, including twenty-four (24) hour onsite nursing services. If a Participant is admitted for Skilled Nursing Services, the contract terms in effect on the date of the admission will apply to the Skilled Nursing Facility visit for the entire Inpatient stay. However, if a Participant's admission crosses Benefit Periods and the previous Benefit Period limit has been exhausted, the Third Party Administrator will credit the new Benefit Period limit without discharge. Skilled Nursing Facility care does not include Custodial Care, supervised living, or other similar facilities providing primarily a supportive and/or recreational environment, even if some Skilled Nursing Care is provided in such facilities.

No benefits are provided when the care received consists primarily of:

1. Room and board, routine nursing care, training, supervisory or Custodial Care.
2. Care for senile deterioration, mental deficiency, or intellectual disability.
3. Care for Mental or Nervous Conditions and/or Substance Use Disorder or Addiction.
4. Maintenance Physical Therapy, hydrotherapy, Speech Therapy, or Occupational Therapy.

AI. Sleep Study Services

Services rendered, referred, or prescribed by a Physician to diagnose a sleep disturbance or disorder. Services may be performed in a sleep laboratory, monitored by a qualified Sleep Study technician or through a home Sleep Study, via a portable recording device.

AJ. Surgical Services

1. **Surgical Services**
   a) Surgery performed by a Physician or other professional Provider.
   b) Benefits for multiple surgical procedures performed during the same operative session by one or more Physicians or other professional Providers shall be calculated based upon the Third Party Administrator's Maximum Allowance and payment guidelines.

2. **Surgical Supplies**
   When a Physician or other professional Provider performs covered Surgery in the office, Benefits are available for a sterile suture or Surgery tray normally required for minor surgical procedures.

3. **Surgical Assistant**
   Medically Necessary services rendered by a Physician or other appropriately qualified surgical assistant who actively assists the operating surgeon in the performance of covered Surgery where an assistant is required. The percentage of the Maximum Allowance that is used as the actual Maximum Allowance to calculate the amount of payment under this section for Covered Services rendered by a surgical assistant is 20% for a Physician assistant and 10% for other appropriately qualified surgical assistants.

4. **Anesthesia**
   In conjunction with a covered procedure, the administration of anesthesia ordered by the attending Physician and rendered by a Physician or other Professional Provider. The use of Hypnosis as anesthesia is not a Covered Service. General anesthesia administered by the surgeon or assistant surgeon is not a Covered Service.

5. **Second and Third Surgical Opinion**
   a) Services consist of a Physician's consultative opinion to verify the need for elective Surgery as first recommended by another Physician.
   b) Specifications:

(1) Elective Surgery is covered Surgery that may be deferred and is not an emergency.
(2) Use of a second consultant is at the Participant's option.
(3) If the first recommendation for elective Surgery conflicts with the second consultant's opinion, then a third consultant's opinion is a Covered Service.
(4) The third consultant must be a Physician other than the Physician who first recommended elective Surgery or the Physician who was the second consultant.

AK. Surgical Treatment for Morbid Obesity

For Covered Services for the surgical treatment of morbid obesity the Plan shall pay or otherwise satisfy a percentage of the Maximum Allowance, up to the Lifetime Benefit Limit as shown in the Benefit Summary.

Benefits are provided for surgical treatment of morbid obesity subject to the following:

1. Surgery for morbid obesity is Medically Necessary to control other medical conditions that are eligible for Covered Services under the Plan and nonsurgical methods have been unsuccessful in treating the morbid obesity; or
2. Surgery for morbid obesity is considered Medically Necessary when the morbid obesity is the result of persistent and uncontrollable weight gain that constitutes a present or potential threat to life.

AL. Therapy Services

Benefits for Therapy Services include:

1. **Chemotherapy**
2. **Growth Hormone Therapy**
3. **Home Intravenous Therapy (Home Infusion Therapy)**
   Benefits are limited to medications, services and/or supplies provided to or in the home of the Participant, including but not limited to, hemophilia-related products and services and IVIG products and services that are administered via an intravenous, intraspinal, intra-arterial, intrathecal, subcutaneous, enteral, or intramuscular injection or access device inserted into the body.
4. **Occupational Therapy**
   (a) Payment is limited to Occupational Therapy services related to Habilitative and Rehabilitative care where there is a reasonable expectation that the services will produce measurable improvements in the Participant's condition in a reasonable period of time. Occupational Therapy Services are covered when performed by:
   (1) A Physician.
   (2) A Licensed Occupational Therapist provided the Covered Services are related directly to a written treatment regimen prepared by a Licensed Occupational Therapist and approved by a Physician.
   (b) No Benefits are provided for:
   (1) Facility-related charges for Outpatient Occupational Therapy Services, health club dues or charges, or Occupational Therapy Services provided in a health club, fitness facility, or similar setting.
   (2) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Occupational Therapist.
   (3) Maintenance, palliative or supportive care.
   (4) Behavioral modification services.
5. **Physical Therapy**
   a) Payment is limited to Physical Therapy services related to Habilitative and Rehabilitative care where there is a reasonable expectation that the services will produce measurable improvements in the Participant's condition in a reasonable period of time. Physical Therapy Services are covered when performed by:
   (1) A Physician;

(2) A Licensed Physical Therapist provided the Covered Services are related directly to a written treatment regimen prepared by the Physical Therapist.
(3) A Podiatrist.

b) No Benefits are provided for:
(1) The following Physical Therapy services when the specialized skills of a Licensed Physical Therapist are not required:
(A) Range of motion and passive exercises that are not related to the restoration of a specific loss of function but are useful in maintaining range of motion in paralyzed extremities.
(B) Assistance in walking, such as that provided in support for feeble or unstable patients.
(2) Facility-related charges for Outpatient Physical Therapy services, health club dues or charges, or Physical Therapy services provided in a health club, fitness facility, or similar setting; or
(3) General exercise programs, even when recommended by a Physician or a Chiropractic Physician, and even when provided by a Licensed Physical Therapist.
(4) Maintenance, palliative or supportive care.
(5) Behavioral modification services.

6. **Radiation Therapy**

7. **Renal Dialysis**

The Maximum Allowance for Renal Dialysis is 125% of the current Medicare allowed amount for In-Network and Out-of-Network Providers, unless a different rate is negotiated with the treating Provider.

8. **Speech Therapy**

a) Benefits shall be limited to Speech Therapy services related to Habilitative and Rehabilitative care and cochlear implant therapy, where there is a reasonable expectation that the services will produce measurable improvement in the Participant's condition in a reasonable period of time.

b) Speech Therapy services are covered when performed by:
(1) A Physician.
(2) A Speech Therapist provided the services are related directly to a written treatment regimen designed by the Speech Therapist.

c) No benefits are provided for:
(1) Maintenance, palliative or supportive care.
(2) Behavioral modification services.

9. **Orthoptics (Visual Therapy)**

AM. Transplant Services

1. **Autotransplants**

Autotransplants of arteries, veins, ear bones (ossicles), cartilage, muscles, skin, hematopoietic, CAR T-Cell, and tendons; teeth or tooth buds, and other Autotransplants as Medically Necessary.

The applicable benefits provided for hospital services and Surgical Services are provided only for a recipient of Medically Necessary Autotransplant Services. Autologous blood transfusion, FDA approved mechanical or biological heart valves and implanting of artificial pacemakers are not considered Transplants and are a Covered Service if Medically Necessary.

2. **Transplants**

Transplants of corneas, kidneys, bone marrow, livers, hearts, lungs, pancreas, islet tissue, hematopoietic, heart-lung and pancreas-kidney combinations, and other solid organ or tissue Transplants or combinations, and other Transplants as Medically Necessary.

a) The applicable benefits provided for hospital services and Surgical Services in the Plan are provided for a recipient of Medically Necessary Transplant Services.

b) The recipient must have the Transplant performed at an appropriate Recognized Transplant Center to be eligible for benefits for Transplant(s). If the recipient is eligible for Medicare, the recipient must have the Transplant performed at a

Recognized Transplant Center that is approved by the Medicare program for the requested Transplant Covered Service.

c) If the recipient is eligible to receive benefits for these Transplant services, Organ Procurement charges are paid for the donor, even if the donor is not a Participant. Benefits for the donor will be charged to the recipient's coverage.

d) A travel allowance may be available for the Participant and one adult caregiver for those Participants traveling to a Blue Distinction Centers for Transplants (BDCT), or in the case of a kidney transplant from a Recognized Transplant Center. Transplant Services must be Prior Authorized by the Claims Administrator. The Participant will be notified of their eligibility for this travel allowance upon Prior Authorization of the scheduled Transplant services.

3. **Exclusions and Limitations**

In addition to any other exclusions and limitations of the Plan, the following exclusions and limitations apply to Transplant or Autotransplant services.

No benefits are available for the following:

a) Transplants of brain tissue or brain membrane, intestine, pituitary and adrenal glands, hair Transplants, or any other Transplant not specifically named as a Covered Service in this section; or for Artificial Organs, including, but not limited to, artificial hearts or pancreases.

b) Any eligible expenses of a donor related to donating or transplanting an organ or tissue unless the recipient is a Participant who is eligible to receive benefits for Transplant services.

c) The cost of a human organ or tissue that is sold rather than donated to the recipient.

d) Transportation costs, including, but not limited to, Ambulance Transportation Service or air service for the donor, or to transport a donated organ or tissue.

e) Living expenses for the recipient, donor, or family members.

f) Costs covered or funded by governmental, foundation, or charitable grants or programs; or Physician fees or other charges, if no charge is generally made in the absence of health coverage or insurance coverage.

g) Any complication to the donor arising from a donor's Transplant Surgery is not a covered benefit under the transplant recipient's health plan or policy. If the donor is a Third Party Administrator (Blue Cross of Idaho) Participant, eligible to receive benefits for Covered Services, benefits for medical complications to the donor arising from Transplant Surgery will be allowed.

h) Costs related to the search for a suitable donor.

i) No benefits are available for services, expenses, or other obligations of or for a deceased donor (even if the donor is a Participant).

AN. Travel and Lodging Benefits

The Plan provides reimbursement for the Participant and one adult companion for reasonable travel and lodging expenses necessary to receive Covered Services that are unavailable within a fifty (50) mile radius of the Participant's primary home address. Reimbursement is limited to transportation (air or mileage), lodging, and rental car expenses. Lodging are limited to $50.00, per night, per traveler. Transportation and lodging for elective abortions only are limited to two (2) nights. Traveler reimbursement is limited to the Participant and one (1) caregiver. Please see the Benefit Summary for Cost Sharing information, and annual and Lifetime Benefit Limits.

Mileage is reimbursed in accordance with the 2025 IRS medical mileage reimbursement guidelines of $0.21 per mile (as adjusted from time-to-time). Please check with the Third Party Administrator regarding current reimbursement rules prior to travel. Meals and other items not listed in this section are not eligible for reimbursement.

Please contact your HR team for the required reimbursement form to submit eligible expenses for reimbursement. The Third Party Administrator must receive reimbursement requests within 365 days

from the date of travel to be eligible for reimbursement. Reimbursements received are considered taxable income to the Participant.

AO. Treatment for Autism Spectrum Disorder
Treatment for Autism Spectrum Disorder, and related diagnoses.

VI. Additional Amount of Payment Provisions

Except as specified elsewhere in the Plan, the Third Party Administrator will pay benefits for Covered Services after a Participant has satisfied their individual Deductible or, if applicable, the family Deductible has been satisfied:

A. For In-Network Services: Unless stated otherwise, for Covered Services furnished in the state of Idaho, the Third Party Administrator will pay or otherwise satisfy the applicable percentage of the Maximum Allowance (shown in the Benefit Summary) if the Covered Services were rendered by a Contracting Provider (subject to all applicable reimbursement limitations and benefit limitations described herein and in the Benefit Summary as determined by the Third Party Administrator).

For Out-of-Network Services: Unless stated otherwise, for Covered Services rendered in the state of Idaho, the Third Party Administrator will pay or otherwise satisfy a percentage of the Maximum Allowance (shown in the Benefit Summary) if the Covered Services were rendered by a Provider. Several Providers are paid at different rates and/or have different benefit limitations as described in that specific benefit section and in the Benefit Summary.

B. For Covered Services furnished outside the state of Idaho by a Provider, the Third Party Administrator shall provide the benefit payment levels specified in this section according to the following:

1. If the Provider has a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services were rendered, the Third Party Administrator will base the payment on the local plan's Preferred Provider Organization payment arrangement and allow In-Network benefits. The Provider shall not make an additional charge to a Participant for amounts in excess of the Third Party Administrator's payment except for Deductibles, Cost Sharing, Copayments and noncovered services.

2. If the Provider does not have a PPO agreement for claims payment with the Blue Cross and/or Blue Shield plan in the area where the Covered Services are rendered, the Third Party Administrator will base payment on the Maximum Allowance and allow Out-of-Network benefits. Except as provided by the federal No Surprises Act, the Provider is not obligated to accept the Third Party Administrator's payment as payment in full and neither the Third Party Administrator or the Plan Administrator are responsible for the difference, if any, between the Third Party Administrator's payment and the actual charge.

C. A Contracting Provider rendering Covered Services shall not make an additional charge to a Participant for amounts in excess of the Third Party Administrator's payment except for Deductibles, Cost Sharing, Copayments and noncovered services.

D. Neither the Third Party Administrator or the Plan Administrator are responsible for the difference, if any, between the Third Party Administrator's payment and the actual charge, unless otherwise specified. Except as provided by the federal No Surprises Act, Participants are responsible for any such difference, including Deductibles, Cost Sharing, Copayments, charges for noncovered services, and the amount charged by the Noncontracting Provider that is in excess of the Maximum Allowance.

PRESCRIPTION DRUG BENEFITS SECTION

This Prescription Drug Benefits Section specifies the benefits a Participant is entitled to receive for Covered Services described in this section, subject to all of the other provisions of this Summary of Health Care Benefits.

I. Prescription Drug Copayment/Cost Sharing/Deductible/Out-of-Pocket

For the types and levels of benefits coverage regarding Prescription Drugs, see the Benefit Summary.

Diabetic Supplies:
Insulin syringes/needles have no Copayment if purchased within ninety (90) days of insulin purchase.

II. Providers

The following are Providers under this section:

- Licensed Pharmacist
- Participating Pharmacy/Pharmacist
- Physician

III. Dispensing Limitations

Retail:
Each covered prescription for a Prescription Drug is limited to no more than a ninety (90) day supply. Specialty Drugs are limited to no more than a thirty (30) day supply. However, certain prescriptions and Prescription Drugs may be subject to more restrictive day-supply and allowed quantity limitations.

Benefits will be allowed for the dosage prescribed unless otherwise approved by the Employer health Plan.

Mail Order:
Each covered prescription for a Prescription Drug is limited to no more than a ninety (90) day supply. Specialty Drugs are limited to no more than a thirty (30) day supply. However, certain prescriptions and Prescription Drugs may be subject to more restrictive day-supply and allowed quantity limitations. In addition, certain Prescription Drugs may not be available under the Plan by mail order due to circumstances such as unstable shelf life, and required special storage conditions.

Participants may request up to a maximum 90 day supply for a "vacation early refill override" prior to your departure. To obtain a "vacation early refill override" contact the Third Party Administrator with the medication name, strength, directions and dates of travel.

If you are going on an International work assignment for Micron, you may request a one year supply of a prescribed maintenance medication for you or your eligible dependents who will be on assignment with you. To request a "1 year international assignment advance fill", contact the Third Party Administrator with the medication name, strength, directions and dates of travel. The Third Party Administrator will verify your Micron international assignment prior to authorizing the transaction.

IV. Drug Cost Share Assistance Program

If a Participant qualifies for certain non-needs-based drug cost share assistance programs offered by drug manufacturers (either directly or indirectly through third parties), the PBM, at the direction of the Plan, may contact the Participant regarding enrollment in a drug cost relief program (the “Program”). The Program allows Participants to further reduce costs and may eliminate out-of-pocket costs altogether. The PBM will work with manufacturers to get the maximum drug cost share assistance available and will manage enrollment and renewals, when possible, on the behalf of Participants. The list of Prescription Drugs covered by the Program may be updated periodically. Please visit the Third Party Administrator’s Website, members.bcidaho.com, then click on the Pharmacy link, or call the PBM at 1-877-638-4008 for Program details.

Participants currently taking one or more Prescription Drugs included in this Program will have the opportunity to enroll in the program and will receive a welcome letter, followed up with a phone call to provide specific information about the Program as it pertains to applicable medication(s) from the PBM.

Any cost share assistance the Participant receives from the Program will not accumulate to their Deductible and Out-of-Pocket limit. Participation in this Program could exhaust a Participant's access to a manufacturer's copay assistance later in a year when they may no longer have coverage under the Plan or another health plan.

Nonparticipation

Participation in this Program is voluntary. However, Participants that do not enroll in the Program will be responsible for the increased portion of the cost of the Specialty Drug. The cost will depend on the Specialty Drug prescribed and the level of cost share assistance that would have been available to the Participant under the Program but will not be more than forty-five percent (45%) of the Allowed Charge.

Because certain Specialty Drugs under the Program are not classified as "essential health benefits" in accordance with the Affordable Care Act, Participant Cost Sharing for Specialty Drugs under the Program do not count towards a Participant's Deductible or Out-of-Pocket Limit. If a Participant has already met their Deductible and/or Out-of-Pocket Limit with other claims, they will still be required to pay a portion of the cost for these Specialty Drugs. A list of Specialty Drugs that are not considered to be "essential health benefits" under the Program is available.

V. Amount of Payment

Except for Specialty Prescription Drugs available under the Program described in Section IV, the Third Party Administrator or its designated Pharmacy Benefits Manager (PBM), will provide the following benefits for Covered Services:

A. The amount of payment for a covered Prescription Drug dispensed by a Participating Pharmacist is the balance remaining after subtracting the Prescription Drug Copayment, Cost Sharing and/or Deductible, if applicable, from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

B. For a covered Prescription Drug dispensed by a Physician or a Licensed Pharmacist who is not a Participating Pharmacist, the Participant is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to the Claims Administrator or its PBM. The amount of payment for a covered Prescription Drug is the balance remaining after subtracting the Prescription Drug Copayment, Cost Sharing and/or Deductible, if applicable, from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

C. The amount of payment for a covered Prescription Drug dispensed by a mail order Participating Pharmacy is the balance remaining after subtracting the Prescription Drug Copayment, Cost Sharing and/or Deductible, if applicable, from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.

D. Submission of a prescription to a pharmacy is not a claim. If a Participant receives Covered Services from a pharmacy and believes that the Copayment, Cost Sharing or other amount is incorrect, the Participant may then submit a written claim to the Claims Administrator requesting reimbursement of any amounts the Participant believes were incorrect. Refer to the Inquiry and Appeals Procedures in the General Provisions Section.

VI. Mandatory Generic Drug Substitution

Certain Prescription Drugs are restricted to Generics for payment by the Third Party Administrator. Even if the Participant, the Physician or other duly licensed Provider requests the Brand Name Drug, the Participant is responsible for the difference between the price of the Generic and Brand Name Drug, plus any applicable Brand Name Drug Deductible/Copayment/Cost Sharing. The difference between the price of the Generic and Brand Name Drug shall not apply to the applicable Deductible and/or Out of Pocket Limits.

VII. Utilization Review

Prescription Drug benefits include utilization review of Prescription Drug usage for the Participant's health and safety. If there are patterns of over-utilization or misuse of drugs the Participant's personal Physician and Pharmacist will be notified. The Third Party Administrator reserves the right to limit benefits to prevent over-utilization or misuse of Prescription Drugs.

VIII. Prior Authorization

Certain Prescription Drugs may require Prior Authorization. If the Participant's Physician or other Provider prescribes a drug, which requires Prior Authorization, the Participant will be informed by the Provider or Pharmacist. To obtain Prior Authorization the Participant's Physician must notify the Claims Administrator or its designated agent, describing the Medical Necessity for the prescription. The Claims Administrator or its designated agent, will respond to a request for Prior Authorization received from either the Participant's Physician or the Participant within seventy-two (72) hours for an expedited request or fourteen (14) days for a standard request of the receipt of the medical information necessary to make a determination.

IX. Covered Services

As listed on the Formulary, Generic and Brand Name Prescription Drugs, certain allowed Compound Drugs and Diabetic Supplies. The drugs or medicines must be directly related to the treatment of an Illness, Disease, medical condition or Accidental Injury and must be dispensed pursuant to a written prescription by a Licensed Pharmacist or Physician on or after the Participant's Effective Date. Benefits for Prescription Drugs are available up to the dispensing limitations stated in Item III. of this section.

Smoking cessation Prescription Drugs are a Covered Service. Generic weight loss Prescription Drugs are a Covered Service. There are no benefits for Brand Name weight loss Prescription Drugs under the Plan.

X. Definitions

A. **Allowed Charge**—the amount payable for a Prescription Drug dispensed to a Participant based on the reimbursement formula determined between the Third Party Administrator and its PBM plus the dispensing fee for a Prescription Drug dispensed by a retail pharmacy.

B. **Brand Name Drug**—a Prescription Drug, approved by the FDA, that is protected by a patent and is marketed and supplied under the manufacturer's brand name.

C. **Compound Drug**—a customized medication derived from two or more raw chemicals, powders or devices, of which at least one ingredient is a federal legend drug, prepared by a Pharmacist according to a prescriber's specifications.

D. **Diabetic Supplies**—supplies that can be purchased at a Participating Pharmacy using the Participant's pharmacy benefit. Includes: insulin syringes, insulin pen needles, lancets, test strips (blood glucose and urine), and insulin pump supplies (reservoirs and syringes, administration sets, and access sets).

E. **Formulary**—a list of Covered Prescription Drugs approved by the Third Party Administrator in accordance with the Pharmacy and Therapeutics Committee clinical review. This list is managed and subject to periodic review and amendment by the Third Party Administrator and the Pharmacy and Therapeutics Committee. Prescription Drugs covered by the Prescription Drug Benefit are organized into tiers. Generally, lower tiers contain Prescription Drugs that are more Cost Effective and provide a greater value when considering both clinical and financial attributes while higher tiers contain Prescription Drugs that are generally more expensive. Prescription Drugs on lower tiers may include a greater proportion of Preferred and Non-Preferred Generic Drugs while Prescription Drugs on higher tiers may include more Preferred and Non-Preferred Brand Name Drugs and Specialty Prescription Drugs.

F. **ACA Preventive Drugs** – ACA Mandated Preventive Drugs.

G. **Generic Drug**—a Prescription Drug, approved by the FDA, that has the same active ingredients, strength, and dosage as its Brand Name Drug counterpart.

H. **Nonparticipating Pharmacy/Pharmacist**—a Licensed Pharmacist, a retail, mail-order or Specialty Pharmacy that has not entered into a contract with the Third Party Administrator's PBM for the purpose of providing Prescription Drug Covered Services to Participants under the Plan.

I. **Participating Pharmacy/Pharmacist**—a Licensed Pharmacist, a retail, mail-order or Specialty Pharmacy that has a contract with the Third Party Administrator's PBM for the purpose of providing Prescription Drug Covered Services to Participants.

J. **Pharmacy and Therapeutics Committee**—a committee of Physicians and Licensed Pharmacists established by the Third Party Administrator that recommends policy regarding the evaluation, selection, and therapeutic use of various drugs. The Committee also decides which drugs are eligible for benefits.

K. **Prescription Drugs**—drugs, biologicals and compounded prescriptions that are FDA approved and can be dispensed only according to a written prescription given by a Physician and/or duly licensed Provider, that are listed and accepted in the *United States Pharmacopeia, National Formulary,* or

AMA Drug Evaluations published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription."

L. **Specialty Drugs**—are injectable and non-injectable medications that are typically used to treat complex conditions and meet one or more of the following criteria:
   a. are biotech-derived or biological in nature;
   b. are significantly higher cost than traditional medications;
   c. are used in complex treatment regimens; require special delivery, storage and handling;
   d. require special medication-administration training for patients;
   e. require on-going monitoring of medication adherence, side effects, and dosage changes;
   f. are available through limited-distribution channels; and
   g. may require additional support and coordinated case management.

M. **Specialty Pharmacy**—a duly licensed Pharmacy that primarily dispenses Specialty Drugs.

N. **Usual Charge**—the lowest retail price being charged by a Licensed Pharmacist for a Prescription Drug at the time of purchase by a Participant.

X. Prescription Drug Exclusions and Limitations

In addition to any other exclusions and limitations of the Plan, the following exclusions and limitations apply to this section and throughout the entire Summary of Health Care Benefits, unless otherwise specified.

Third-Party Payer Exclusion:

If a Participant receives a discount, direct or indirect support, or other cost reduction, in any form, including but not limited to a coupon or discount card from a pharmaceutical manufacturer, pharmacy, other health care Provider, or Cost Sharing from a prohibited third party organization, the cost reduction or amount discounted toward the purchase of the Prescription Drug will not be applied to the Participant's applicable Deductible amounts, and will not be applied to the Participant's Out of Pocket Limit.

The Plan prohibits direct or indirect payment by third parties unless it meets the standards set below.

Family, friends, religious institutions, private, not-for-profit foundations such as Indian tribes, tribal organizations, urban Indian organizations, state and federal government programs or grantees or sub-grantees such as the Ryan White HIV/AIDS Program and other similar entities are not prohibited as third-party payers. Cost Sharing contributions made from permitted third parties will be applied to the Participant's applicable Deductible and/or Out-of-Pocket Limit. The Third Party Administrator, Plan Administrator and Plan Sponsor are not responsible for reporting these payments as income. Participants are separately responsible to determine the tax consequences of these payments.

Each of the following criteria must be met for the Third Party Administrator to accept a third party payment:

1. the assistance is provided on the basis of the Participant's financial need;
2. the institution/organization is not a healthcare Provider; and
3. the institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

To assist in appropriately applying Cost Sharing contributions made from a permitted third party to the Participants applicable Deductible and/or Out-of-Pocket Limit, the Participant is encouraged to provide notification to the Third Party Administrator if they receive any form of assistance for payment of their Contribution, Cost Sharing, Copayment or Deductible amounts.

The Third Party Administrator will inform the Participant in writing of the reason for rejecting or otherwise refusing to treat a third party payment as a payment from the Participant.

Certain Prescription Drug Regimens:

A. No benefits are provided for the following:

1. Over-the-counter drugs other than insulin, even if prescribed by a Physician. Notwithstanding this exclusion, through the determination of the Third Party Administrator's Pharmacy and Therapeutics Committee, the Third Party Administrator may choose to cover certain over-the-counter medications when Prescription Drug benefits are provided under this Summary of Health Care Benefits. Such approved over-the-counter medications must be identified by the Third Party Administrator in writing and will specify the procedures for obtaining benefits for such approved over-the-counter medications. Please note that the fact a particular over-the-counter drug or medication is covered does not require the Third Party Administrator to cover or otherwise pay or reimburse the Participant for any other over-the-counter drug or medication.
2. Charges for the administration or injection of any drug, except for vaccinations listed on the Prescription Drug Formulary.
3. Therapeutic devices or appliances, including hypodermic needles, syringes, support garments, and other non-medicinal substances except Diabetic Supplies, regardless of intended use.
4. Drugs labeled "Caution—Limited by Federal Law to Investigational Use," or experimental drugs, even though a charge is made to the Participant.
5. Immunization agents, except for vaccinations listed on the Prescription Drug Formulary, biological sera, blood or blood plasma. Benefits may be available under the Medical Benefits Section.
6. Medication that is to be taken by or administered to a Participant, in whole or in part, while the Participant is an Inpatient in a Licensed General Hospital, rest home, sanatorium, Skilled Nursing Facility, extended care facility, convalescent hospital, nursing home, or similar institution which operates or allows to operate on its premises, a facility for dispensing pharmaceuticals.
7. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.
8. Any newly FDA approved Prescription Drug, biological agent, or other agent until it has been reviewed and approved by the Third Party Administrator's Pharmacy and Therapeutics Committee.
9. Any Prescription Drug, biological or other agent, which is:
    a) Prescribed primarily to aid or assist the Participant in weight loss, including all anorectics, whether amphetamine or nonamphetamine, except as specifically listed as a Covered Service under the Prescription Drug section.
    b) Prescribed primarily to retard the rate of hair loss or to aid in the replacement of lost hair.
    c) Prescribed primarily for personal hygiene, comfort, beautification, or for the purpose of improving appearance.
    d) Prescribed primarily to increase growth.
    e) Provided by or under the direction of a Home Intravenous Therapy Company, Home Health Agency or other Provider approved by the Third Party Administrator. Benefits are available for this Therapy Service under the Medical Benefits Section, and only as preauthorized and approved when Medically Necessary.
10. Lost, stolen, broken or destroyed medications, except in the case of loss due directly to a natural disaster.

ELIGIBILITY AND ENROLLMENT SECTION

I. Eligibility and Enrollment

All Eligible Employees will have the opportunity to apply for coverage under this Summary of Health Care Benefits. Please see the Enrollment and Eligibility Information Medical and Dental Plans of the Micron Benefits Handbook.

DEFINITIONS SECTION

For reference, most terms defined in this section are capitalized throughout the Plan and the Summary of Health Care Benefits. Other terms may be defined where they appear in this Summary of Health Care Benefits. Definitions in this Summary of Health Care Benefits shall control over any other definition or interpretation unless the context clearly indicates otherwise.

Accidental Injury—an objectively demonstrable impairment of bodily function or damage to part of the body caused by trauma from a sudden, unforeseen external force or object, occurring at a reasonably identifiable time and place, and without a Participant's foresight or expectation, which requires medical attention at the time of the accident. The force may be the result of the injured party's actions, but must not be intentionally self-inflicted unless caused by a medical condition or domestic violence. Contact with an external object must be unexpected and unintentional, or the results of force must be unexpected and sudden.

Acute Care—Medically Necessary Inpatient treatment in a Licensed General Hospital or other Facility Provider for sustained medical intervention by a Physician and Skilled Nursing Care to safeguard a Participant's life and health. The immediate medical goal of Acute Care is to stabilize the Participant's condition, rather than upgrade or restore a Participant's abilities.

Admission—begins the first day a Participant becomes a registered hospital bed patient or a Skilled Nursing Facility patient and continues until the Participant is discharged.

Adverse Benefit Determination—any denial, reduction, rescission of coverage, or termination of, or the failure to provide payment for, a benefit for services or ongoing treatment under the Plan.

Advisory Committee on Immunization Practices (ACIP)—a committee consisting of immunization field experts who provide guidance to the Center for Disease Control (CDC) and the Department of Health and Human Services (HHS), on the effective control of vaccine-preventable diseases in the United States. The committee develops written recommendations for the routine administration of vaccines to children and adults; to include dose, route, frequency of administration, precautions and contraindications.

Air Ambulance—medical transport by rotary wing air ambulance or fixed wing air ambulance as those terms are used in Medicare Regulations, including transportation that is certified as either a fixed wing or rotary wing air ambulance and such services and supplies as may be Medically Necessary.

Alcoholism—a behavioral or physical disorder manifested by repeated excessive consumption of alcohol to the extent that it interferes with a Participant's health, social, or economic functioning.

Alcoholism or Substance Use Disorder Treatment—a Provider that is acting under the scope of its license, where required, that is primarily engaged in providing detoxification and Rehabilitative care for Alcoholism, or Substance Use Disorder, or Addiction.

Ambulatory Surgical Facility (Surgery Center)—a Facility Provider that is Medicare Certified and/or otherwise acting under the scope of its license, where required, with a staff of Physicians, which:

1. Has permanent facilities and equipment for the primary purpose of performing surgical procedures on an Outpatient basis.
2. Provides treatment by or under the supervision of Physicians and provides Skilled Nursing Care while the Participant is in the facility.
3. Does not provide Inpatient accommodations.
4. Is not primarily a facility used as an office or clinic for the private practice of a Physician or other Professional Provider.

Amendment (Amend)—a formal document signed by the Plan Sponsor. The Amendment adds, deletes or changes the provisions of the Plan and applies to all covered persons, including those persons covered before the Amendment becomes effective, unless otherwise specified.

American Psychiatric Association—an organization composed of medical specialists who work together to ensure effective treatment for all persons with a mental disorder.

American Psychological Association—a scientific and professional organization that represents psychology in the United States.

Applied Behavior Analysis (ABA)—the process of systematically applying interventions based upon the principles of learning theory to make changes to socially significant behavior to a meaningful degree, and to demonstrate the interventions are responsible for the improvement in behavior.

Approved Clinical Trial—a phase I, phase II, phase III, or phase IV clinical trial conducted in relation to prevention, detection, or treatment of cancer or other life-threatening condition.

Artificial Organs—permanently attached or implanted man-made devices that replace all or part of a Diseased or nonfunctioning body organ, including, but not limited to, artificial hearts and pancreases.

Autism Spectrum Disorder—means any of the pervasive developmental disorders, autism spectrum disorders, or related diagnoses as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Autotransplant (or Autograft)—the surgical transfer of an organ or tissue from one (1) location to another within the same individual.

Benefit Period—the specified period of time in which a Participant's benefits for incurred Covered Services accumulate toward annual benefit limits, Deductible amounts and Out-of-Pocket Limits. The Benefit Period is the calendar year.

Benefit Summary—a listing of certain Covered Services specifying Cost Sharing, Copayments, Deductibles, and Benefit limitations and maximums under this Summary of Health Care Benefits.

BlueCard—a program to process claims for most Covered Services received by Participants outside of the Third Party Administrator's service area while capturing the local Blue Cross and/or Blue Shield Plan's Provider discounts.

Blue Distinction Centers for Transplants (BDCT)—the BDCT are major hospitals and research institutions located throughout the United States that are designated for Transplants.

Certified Nurse-Midwife—an individual licensed to practice as a Certified Nurse Midwife.

Certified Registered Nurse Anesthetist—a licensed individual registered as a Certified Registered Nurse Anesthetist.

Chiropractic Care—services rendered, referred, or prescribed by a Chiropractic Physician.

Chiropractic Physician—an individual licensed to practice chiropractic.

Claims Administrator —Blue Cross of Idaho has been hired as the Claims Administrator by the Plan Administrator to perform claims administration and other specified administrative services in relation to the Plan and solely with respect to those Plan benefits described in the Summary of Healthcare Benefits. The Claims Administrator has been appointed by the Plan Administrator as the claims fiduciary of the Plan to exercise discretionary authority over claims processing and appeals on behalf of the Plan Administrator with respect to the benefits described in the Summary of Healthcare Benefits. The Claims Administrator is not an insurer of health benefits under this Summary of Health Care Benefits. The Claims Administrator is not responsible for Plan financing and does not guarantee the availability of benefits under this Summary of Health Care Benefits. Other than in its capacity as claims fiduciary, the Claims Administrator is not a fiduciary of the Plan and does not exercise discretionary authority over the administration of the Plan.

Clinical Laboratory Improvement Amendments (CLIA)—a Centers for Medicare & Medicaid Services (CMS) program which regulates all human performed laboratory testing in the United States to ensure quality laboratory testing.

Clinical Nurse Specialist—an individual licensed to practice as a Clinical Nurse Specialist.

Clinical Psychologist—an individual licensed to practice clinical psychology.

Congenital Anomaly—a condition existing at or from birth, which is a significant deviation from the common form or function of the body, whether caused by a hereditary or a developmental defect or Disease. In this Summary of Health Care Benefits, the term significant deviation is defined to be a deviation which impairs the function of the body and includes but is not limited to the conditions of cleft lip, cleft palate, webbed fingers or toes, sixth toes or fingers, or defects of metabolism and other conditions that are medically diagnosed to be Congenital Anomalies.

Continuous Crisis Care—Hospice Nursing Care provided during periods of crisis in order to maintain a terminally ill Participant at home. A period of crisis is one in which the Participant's symptom management demands predominantly Skilled Nursing Care.

Contracting Provider—a Provider that has entered into a written agreement with the Third Party Administrator regarding payment for Covered Services rendered to a Participant under a PPO program. To find Contracting Providers visit www.bcidaho.com or call Customer Service at the telephone number listed on the back of the Participant's Identification Card.

Contribution—the amount paid or payable by the Employer or Eligible Employee into the Plan.

Copayment—a designated dollar and/or percentage amount, separate from Cost Sharing, that a Participant is financially responsible for and must pay to a Provider at the time certain Covered Services are rendered.

Cost Effective—a requested or provided medical service or supply that is Medically Necessary in order to identify or treat a Participant's health condition, illness or injury and that is:

1. Provided in the most cost-appropriate setting consistent with the Participant's clinical condition and the Provider's expertise. For example, when applied to services that can be provided in either an Inpatient hospital setting or Outpatient hospital setting, the Cost Effective setting will generally be the outpatient setting. When applied to services that can be provided in a hospital setting or in a physician office setting, the Cost Effective setting will generally be the physician office setting.
2. Not more costly than an alternative service or supply, including no treatment, and at least as likely to produce an equivalent result for the Participant's condition, Disease, Illness or injury.

Cost Sharing—the percentage of the Maximum Allowance or the actual charge, whichever is less, a Participant is responsible to pay Out-of-Pocket for Covered Services after satisfaction of any applicable Deductibles or Copayments, or both.

Covered Service—when rendered by a Provider, a service, supply, or procedure specified in this Summary of Health Care Benefits for which benefits will be provided to a Participant.

Custodial Care—care designated principally to assist a Participant in engaging in the activities of daily living, or services which constitute personal care, such as help in walking and getting in and out of bed, assistance in eating, dressing, bathing, and using the toilet; preparation of special diets; and supervision of medication, which can usually be self-administered and does not require the continuing attention of trained medical or paramedical personnel. Custodial Care is normally, but not necessarily, provided in a nursing home, convalescent home, rest home, or similar institution.

Deductible—the amount a Participant is responsible to pay Out-of-Pocket before the Third Party Administrator begins to pay benefits for most Covered Services. The amount credited to the Deductible is based on the Maximum Allowance or the actual charge, whichever is less.

Dentist—an individual licensed to practice Dentistry.

Dentistry or Dental Treatment—the treatment of teeth and supporting structures, including, but not limited to, the replacement of teeth.

Diagnostic Imaging Provider—a person or entity that is licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of license) to render Covered Services.

Diagnostic Service—a test or procedure performed on the order of a Physician or other Professional Provider because of specific symptoms, in order to identify a particular condition, Disease, Illness, or Accidental Injury. Diagnostic Services include, but are not limited to:

1. Radiology services.
2. Laboratory and pathology services.
3. Cardiographic, encephalographic, and radioisotope tests.

Disease—any alteration in the body or any of its organs or parts that interrupts or disturbs the performance of vital functions, thereby causing or threatening pain, weakness, or dysfunction. A Disease can exist with or without a Participant's awareness of it, and can be of known or unknown cause(s).

Durable Medical Equipment—items which can withstand repeated use, are primarily used to serve a therapeutic purpose, are generally not useful to a person in the absence of Accidental Injury, Disease or Illness, and are appropriate for use in the Participant's home.

Durable Medical Equipment Supplier—a business that is licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of license) to sell or rent Durable Medical Equipment.

Effective Date—the date when coverage for a Participant begins under this Summary of Health Care Benefits. Please see the Enrollment and Eligibility Information Medical and Dental Plans of the Micron Benefits Handbook.

Electroconvulsive Therapy (ECT)—Electroconvulsive Therapy (ECT) is a treatment for severe forms of depression, bipolar disorder, schizophrenia and other serious mental illnesses that uses electrical impulses to induce a convulsive seizure.

Eligible Dependent—a person eligible for enrollment under an Enrollee's coverage. Please see the Enrollment and Eligibility Information Medical and Dental Plans of the Micron Benefits Handbook.

Eligible Employee—an employee who is entitled to apply as an Enrollee. Please see the Enrollment and Eligibility Information Medical and Dental Plans of the Micron Benefits Handbook.

Emergency Admission Notification—notification by the Participant to the Third Party Administrator of an Emergency Inpatient Admission resulting in an evaluation conducted by the Claims Administrator to determine the Medical Necessity of a Participant's Emergency Inpatient Admission and the accompanying course of treatment.

Emergency Inpatient Admission—Medically Necessary Inpatient admission to a Licensed General Hospital or other Inpatient Facility due to the sudden, acute onset of a medical condition, Mental or Nervous Condition, Substance Use Disorder or Addiction, or an Accidental Injury which requires immediate medical treatment to preserve life or prevent severe, irreparable harm to a Participant.

Emergency Medical Condition—a condition reflected by sudden and unexpected symptoms that are severe enough that a reasonably prudent layperson with average knowledge of health and medicine would expect extreme consequences to result without immediate medical care. These consequences include placing the health of the individual (or, regarding a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. Emergency Medical Conditions, include but are not limited to, heart attacks, cerebrovascular accidents, poisonings, loss of consciousness or respiration, and convulsions, Mental or Nervous Condition, Substance Use Disorder or Addiction.

Employer—Micron Technology, Inc.

Enrollee—an Eligible Employee who has enrolled for coverage and has satisfied eligibility and enrollment requirements. Please see the Enrollment and Eligibility Information Medical and Dental Plans of the Micron Benefits Handbook.

Family Coverage—enrollment of an Enrollee and one (1) or more Eligible Dependent(s) under the Plan.

Freestanding Diabetes Facility—a person or entity that is recognized by the American Diabetes Association, and/or otherwise acting under the scope of its license, where required, to render Covered Services.

Freestanding Dialysis Facility—a Medicare Certified Facility Provider, or other Facility Provider acting under the scope of its license, that is primarily engaged in providing dialysis treatment, maintenance, or training to patients on an Outpatient or home care basis.

Freestanding Emergency Department—a health care facility that is geographically distinct and licensed separately from a hospital under applicable state law and provides emergency services.

Ground Ambulance—a licensed ground vehicle that is specially designed and equipped for transporting the sick and injured.

Habilitation (or Habilitative)—developing skills and functional abilities necessary for daily living and skills related to communication of persons who have never acquired them.

Health Benefit Plan—any hospital or medical policy or certificate, any subscriber contract provided by a hospital or professional service corporation, or managed care organization subscriber contract. Health Benefit Plan does not include policies or certificates of insurance for specific Disease, hospital confinement indemnity, accident-only, credit, dental, vision, Medicare supplement, long-term care or disability income insurance, student health benefits-only coverage issued as a supplement to liability insurance, Workers' Compensation or similar insurance, automobile medical payment insurance, or nonrenewable short-term coverage issued for a period of twelve (12) months or less.

Homebound—confined primarily to the home as a result of a medical condition. The term connotes that it is "a considerable and taxing effort" to leave the home due to a medical condition and not because of inconvenience.

Home Health Agency—any agency or organization that provides Skilled Nursing Care services and other therapeutic services.

Home Health Aide—an individual employed by a Hospice, under the direct supervision of a licensed registered nurse (R.N.), who performs and trains others to perform, intermittent Custodial Care services which include, but are not limited to, assistance in bathing, checking vital signs, and changing dressings.

Home Health Skilled Nursing Care Services—the delivery of Skilled Nursing Care services under the direction of a Physician to a Homebound Participant. Home Health Skilled Nursing is generally intended to transition a Homebound patient from a hospital setting to a home or prevent a hospital stay, provided such nurse does not ordinarily reside in the Participant's household or is not related to the Participant by blood or marriage.

Home Intravenous Therapy Company—a licensed, where required, and/or Medicare Certified (and/or otherwise acting under the scope of its license) pharmacy or other entity that is principally engaged in providing services, medical supplies, and equipment for certain home infusion Therapy Covered Services, to Participants in their homes or other locations outside of a Licensed General Hospital.

Hospice—a Medicare Certified (and/or otherwise acting under the scope of its license, if required) public agency or private organization designated specifically to provide services for care and management of terminally ill patients, primarily in the home.

Hospice Nursing Care—Skilled Nursing Care and Home Health Aide services provided as a part of the Hospice Plan of Treatment.

Hospice Plan of Treatment—a written plan of care that describes the services and supplies for the Medically Necessary care and treatment to be provided to a Participant by a Hospice. The written plan of care must be established and periodically reviewed by the attending Physician.

Hypnosis—an induced passive state in which there is an increased responsiveness to suggestions and commands, provided that these do not conflict seriously with the subject's conscious or unconscious wishes.

Illness—a deviation from the healthy and normal condition of any bodily function or tissue. An Illness can exist with or without a Participant's awareness of it, and can be of known or unknown cause(s).

In-Network Services—Covered Services provided by a Contracting Provider.

Inpatient—a Participant who is admitted as a bed patient in a Licensed General Hospital or other Facility Provider and for whom a room and board charge is made.

Intensive Outpatient Program—Intensive Outpatient Program (IOP) is a treatment program that includes extended periods of therapy sessions, several times a week for a minimum of three (3) hours per day, a minimum of three (3) days per week and a minimum of nine (9) hours per week. It is an intermediate setting between traditional therapy sessions and partial hospitalization.

Investigational—any technology (service, supply, procedure, treatment, drug, device, facility, equipment or biological product), which is in a developmental stage or has not been proven to improve health outcomes such as length of life, quality of life, and functional ability. A technology is considered investigational if, as determined by the Claims Administrator, it fails to meet any one of the following criteria:

- The technology must have final approval from the appropriate government regulatory body. This applies to drugs, biological products, devices, and other products/procedures that must have approval from the U.S. Food and Drug Administration (FDA) or another federal authority before they can be marketed. Interim approval is not sufficient. The condition for which the technology is approved must be the same as that the Claims Administrator is evaluating.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should consist of current published medical literature and investigations published in peer-reviewed journals. The quality of the studies and consistency of results will be considered. The evidence should demonstrate that the technology can measure or alter physiological changes related to a Disease, Injury, Illness, or condition. In addition, there should be evidence that such measurement or alteration affects health outcomes.
- The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
- The technology must be as beneficial as any established alternatives.
- The technology must show improvement that is attainable outside the investigational setting. Improvements must be demonstrated when used under the usual conditions of medical practice.

If a technology is determined to be investigational, all services specifically associated with the technology, including but not limited to associated procedures, treatments, supplies, devices, equipment, facilities or drugs will also be considered investigational.

In determining whether a technology is investigational, the Claims Administrator considers the following source documents: Blue Cross Blue Shield Association's Evidence Positioning System assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by the Claims Administrator, and Blue Cross of Idaho Medical Policies. The Claims Administrator also considers current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

Keratoconus—a developmental or dystrophic deformity of the cornea in which it becomes cone-shaped due to a thinning and stretching of the tissue in its central area.

Licensed General Hospital—a short term, Acute Care, general hospital that:

1. Is an institution licensed in the state in which it is located and is lawfully entitled to operate as a general, Acute Care hospital.
2. Is primarily engaged in providing Inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians for compensation from and on behalf of its patients.
3. Has functioning departments of medicine and Surgery.
4. Provides twenty-four (24) hour nursing service by or under the supervision of licensed R.N.s.
5. Is not predominantly a:

a. Skilled Nursing Facility
b. Nursing home
c. Custodial Care home
d. Health resort
e. Spa or sanatorium
f. Place for rest
g. Place for the treatment or Rehabilitative care of Alcoholism or Substance Use Disorder or Addiction
h. Place for the treatment or Rehabilitative care of Mental or Nervous Conditions
i. Place for Hospice care
j. Residential Treatment Center
k. Transitional Living Center

Licensed Marriage and Family Therapist (LMFT)—a licensed individual providing diagnosis and treatment of Mental or Nervous Conditions.

Licensed Pharmacist—an individual licensed to practice pharmacy.

Licensed Rehabilitation Hospital—a Facility Provider principally engaged in providing diagnostic, therapeutic, and Physical Rehabilitation Services to Participants on an Inpatient basis.

Lifetime Benefit Limit—the greatest aggregate amount payable by the Third Party Administrator, on behalf of the Plan Administrator and on behalf of a Participant for specified Covered Services during all periods in which the Participant has been continuously enrolled or covered under any agreement, certificate, contract, or plan administered on behalf of Micron Technology, Inc.

Maximum Allowance—for Covered Services under the terms of the Plan, Maximum Allowance is the lesser of the billed charge or the amount established by the Third Party Administrator as the highest level of compensation for a Covered Service. If the Covered Services are rendered outside the state of Idaho by a Noncontracting or Contracting Provider with a Blue Cross and/or Blue Shield affiliate in the location of the Covered Services, the Maximum Allowance is the lesser of the billed charge or the amount established by the affiliate as compensation.

The Maximum Allowance is determined using many factors, as applicable, including pre-negotiated payment amounts; diagnostic related groupings (DRGs); a resource based relative value scale (RBRVS); ambulatory payment classifications (APCs); the Provider's charge(s); the charge(s) of Providers with similar training and experience within a particular geographic area; Medicare reimbursement amounts; Qualifying Payment Amount, amount determined under an Independent Dispute Resolution (IDR) in accordance with surprise medical billing requirements under the federal No Surprises Act; and/or the cost of rendering the Covered Service. Moreover, Maximum Allowance may differ depending on whether the Provider is Contracting or Noncontracting.

In addition, Maximum Allowance for Covered Services provided by Contracting or Noncontracting Dentists is determined using many factors, including pre-negotiated payment amounts, a calculation of charges submitted by Contracting Idaho Dentists, and/or a calculation of the average charges submitted by all Idaho Dentists.

Medicaid—Title XIX (Grants to States for Medical Assistance Programs) of the United States Social Security Act as amended.

Medical Food—a food which is formulated to be consumed or administered orally or enterally under the supervision of a Physician.

Medically Necessary (or Medical Necessity)—the Covered Service or supply recommended by the treating Provider to identify or treat a Participant's condition, Disease, Illness or Accidental Injury and which is determined by the Claims Administrator to be:

1. The most appropriate supply or level of service, considering potential benefit and harm to the Participant.
2. Proven to be effective in improving health outcomes:
    a. For new treatment, effectiveness is determined by peer reviewed scientific evidence; or

b. For existing treatment, effectiveness is determined first by peer reviewed scientific evidence, then by professional standards, then by expert opinion.

3. Not primarily for the convenience of the Participant or Provider.
4. Cost Effective for this condition.

The fact that a Provider may prescribe, order, recommend, or approve a service or supply does not, in and of itself, necessarily establish that such service or supply is Medically Necessary under this Summary of Health Care Benefits.

The term Medically Necessary as defined and used in the Plan is strictly limited to the application and interpretation of the Plan, and any determination of whether a service is Medically Necessary hereunder is made solely for the purpose of determining whether services rendered are Covered Services.

In determining whether a service is Medically Necessary, the Claims Administrator considers the medical records and, the following source documents: Blue Cross Blue Shield Association's Evidence Positioning System assessments, the Blue Cross and Blue Shield Association Medical Policy Reference Manual as adopted by the Claims Administrator, and Blue Cross of Idaho Medical Policies. The Claims Administrator also considers current published medical literature and peer review publications based upon scientific evidence, and evidence-based guidelines developed by national organizations and recognized authorities.

Medicare—Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

Medicare Certified—Centers for Medicare and Medicaid Services (CMS) develops standards that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These minimum health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries.

These standards are the minimum health and safety requirements that providers and suppliers must meet in order to be Medicare and Medicaid Certified.

Mental or Nervous Conditions—means and includes mental disorders, mental Illnesses, psychiatric Illnesses, mental conditions, and psychiatric conditions (whether organic or inorganic, whether of biological, nonbiological, chemical or nonchemical origin and irrespective of cause, basis, or inducement). Mental and Nervous Conditions, include but are not limited to: psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

Neuromusculoskeletal Treatment—means and includes diagnosis and treatment in the form of manipulation and adjustment of the vertebrae, disc, spine, back, neck and adjacent tissues in an Outpatient office or clinic setting and for acute or Rehabilitative purposes.

Noncontracting Provider—a Professional Provider or Facility Provider that has not entered into a written agreement with the Third Party Administrator regarding payment for Covered Services rendered to a Participant under a PPO program. To find Contracting Providers visit www.bcidaho.com or call Customer Service at the telephone number listed on the back of the Participant's Identification Card.

Nurse Practitioner—an individual licensed to practice as a Nurse Practitioner.

Occupational Therapist—an individual licensed to practice occupational therapy.

Office Visit—any direct, one-on-one examination and/or exchange, conducted in the Provider's office, between a Participant and a Provider, or members of their staff for the purposes of seeking care and rendering Covered Services. For purposes of this definition, a Medically Necessary visit by a Physician to a Homebound Participant's place of residence may be considered an Office Visit.

Optometrist—a person who is licensed and specializes in optometry to examine, measure and treat certain visual defects by means of corrective lenses or other methods that do not require a license as a physician.

Organ Procurement—Diagnostic Services and medical services to evaluate or identify an acceptable donor for a recipient and a donor's surgical and hospital services directly related to the removal of an organ or tissue for such purpose. Transportation for a donor or for a donated organ or tissue is not an Organ Procurement service.

Orthotic Devices—any rigid or semi-rigid supportive devices that restrict or eliminate motion of a weak or Diseased body part.

Out-of-Network Services—any Covered Services rendered by a Noncontracting Provider.

Out-of-Pocket Limit—the amount of Out-of-Pocket expenses incurred during one (1) Benefit Period that a Participant is responsible for paying. Eligible Out-of-Pocket expenses include only the Participant's Deductible, Copayments, and Cost Sharing for eligible Covered Services.

Outpatient—a Participant who receives services or supplies while not an Inpatient.

Palliative Care—is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening Illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical and psychosocial.

Partial Hospitalization Program—Partial Hospitalization Program (PHP) is a treatment program that provides interdisciplinary medical and psychiatric services. Partial Hospitalization Program (PHP) involves a prescribed course of psychiatric treatment provided on a predetermined and organized schedule and provided in lieu of hospitalization for a patient who does not require full-time hospitalization.

Participant—an Enrollee or an enrolled Eligible Dependent covered under the Plan.

Physical Rehabilitation—Medically Necessary non-acute therapy rendered by qualified health care professionals. Physical Rehabilitation is intended to restore a Participant's physical health and well-being as close as reasonably possible to the level that existed immediately prior to the occurrence of a condition, Disease, Illness, or Accidental Injury.

Physical Therapist—an individual licensed to practice physical therapy.

Physician—a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine.

Physician Assistant—an individual licensed to practice as a Physician Assistant.

Plan(s)— the Micron Technology, Inc. Self-Insured Group Health Plan maintained by the Plan Sponsor for the purpose of providing health care benefits to the Plan Participants.

Plan Administrator— the Plan Administrator, Micron Technology, Inc. has all discretionary authority to interpret the provisions and control the operation and administration of the Plan within the limits of the law; provided the Plan Administrator has delegated the responsibility for claims processing and appeals to the Claims Administrator that serves as the claims fiduciary of the Plan on behalf of the Plan Administrator, as described in the Summary of Healthcare Benefits. All decisions made by the Plan Administrator (or the Claims Administrator as claims and appeals fiduciary), including final determination of Medical Necessity, shall be final and binding on all parties. Micron Technology, Inc., also reserves the right to modify eligibility clauses for new Plan participants who join the Plan as a result of a merger, acquisition or for any employee who was covered under a labor agreement plan during a previous period of employment to which Micron Technology, Inc. contributes, provided that coverage under the Plan begins within 31 days of the date coverage under the previous Plan terminates. Micron Technology, Inc. may choose to hire a consultant and/or Third Party Administrator to perform specified duties in relation to the Plan. Micron Technology, Inc. also has the right to amend, modify or terminate the Plan. The administration of the Plan document is under the supervision of the Plan Administrator, Micron Technology, Inc.

Plan Sponsor—Micron Technology, Inc.

Podiatrist—an individual licensed to practice podiatry.

Post-Service Claim—any claim for a benefit under the Plan that does not require Prior Authorization before services are rendered.

ost-Stabilization Care Services—any additional items and services that are Covered Services after a Participant is stabilized and as part of Outpatient observation or Inpatient or Outpatient stay with respect to the visit in which the emergency services are furnished.

Preadmission Testing—tests and studies required in connection with a Participant's Inpatient admission to a Licensed General Hospital that are rendered or accepted by the Licensed General Hospital on an Outpatient basis. Preadmission tests and studies must be done prior to a scheduled Inpatient admission to the Licensed General Hospital, provided the services would have been available to an Inpatient of that hospital. Preadmission Testing does not include tests or studies performed to establish a diagnosis.

Preferred Blue PPO—a preferred provider organization product offered through the Third Party Administrator.

Prescription Drugs—drugs, biologicals, and compounded prescriptions that are FDA approved and can be dispensed only according to a written prescription given by a Physician and/or duly licensed provider, that are listed with approval in the *United States Pharmacopeia*, *National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that are prescribed for human consumption, and that are required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription."

Pre-Service Claim—any claim for a benefit that requires Prior Authorization before services are rendered.

Primary Care Giver—a person designated to give direct care and emotional support to a Participant as part of a Hospice Plan of Treatment. A Primary Care Giver may be a spouse, relative, or other individual who has personal significance to the Participant. A Primary Care Giver must be a volunteer who does not expect or claim any compensation for services provided to the Participant.

Primary Care Provider—a Professional Provider who is generally the first contact when a Participant seeks medical treatment. Benefits may include services for infants and children, immunizations, screening for infectious and communicable diseases, treating minor injuries and common complaints, and managing chronic disease. A Primary Care Provider includes, but is not limited to, general/family practice, pediatrics, internal medicine, obstetric and gynecology.

Prior Authorization—the Provider's or the Participant's request to the Claims Administrator, or delegated entity, for a Medical Necessity determination of a Participant's proposed treatment. The Claims Administrator or the delegated entity may review medical records, test results and other sources of information to make the determination. Prior Authorization is not a determination of benefit coverage. Benefit coverage and eligibility for payment is determined solely by the Claims Administrator.

Prosthetic and Orthotic Supplier—a person or entity that is licensed, where required, and Medicare Certified (or otherwise acting under the scope of its license) to render Covered Services.

Prosthetic Appliances—Prosthetic Appliances are devices that replace all or part of an absent body organ, including contiguous tissue, or replace all or part of the function of a permanently inoperative or malfunctioning body organ.

Provider—a person or entity that is licensed, certified, accredited and/or registered, where required, to render Covered Services. Providers include any facility or individual who provides a Covered Service while operating within the scope of their license, certification, accreditation and/or registration under applicable state law, unless exempted by federal law.

Psychiatric Hospital—a Facility Provider principally engaged in providing diagnostic and therapeutic services and Rehabilitation Services for the Inpatient treatment of Mental or Nervous Conditions, Alcoholism or Substance Use Disorder or Addiction. These services are provided by or under the supervision of a staff of Physicians, and continuous nursing services are provided under the supervision of a licensed R.N.

Qualifying Payment Amount—the median contracted rates recognized by the Third Party Administrator as the maximum payment for the same or similar Covered Services provided by a Provider in same or similar specialty, in the

same geographic area (increased by the consumer price index) in accordance with surprise medical billing requirements under the federal No Surprises Act.

Radiation Therapy Center—a Facility Provider that is primarily engaged in providing Radiation Therapy Services to patients on an Outpatient basis.

Recognized Transplant Center—a Licensed General Hospital that meets any of the following criteria:

1. Is approved by the Medicare program for the requested Transplant Covered Services.
2. Is included in the Blue Cross and Blue Shield System's National Transplant Networks.
3. Has arrangements with another Blue Cross and/or Blue Shield Plan for the delivery of the requested Transplant Covered Services, based on appropriate approval criteria established by that Plan.
4. Is approved by the Claims Administrator based on the recommendation of the Claims Administrator's Medical Director.

Registered Dietitian—a professional trained in foods and the management of diets (dietetics) who is credentialed by the Commission on Dietetic Registration of the American Dietetic Association, or otherwise acting under the scope of their license, where required.

Rehabilitation (or Rehabilitative)—restoring skills and functional abilities necessary for daily living and skills related to communication that have been lost or impaired due to disease, illness or injury.

Rehabilitation or Habilitation Plan of Treatment—a written plan established and reviewed periodically by an attending Physician which describes the services and supplies for the Rehabilitation or Habilitation care and treatment to be provided to a Participant.

Residential Treatment Center—a Facility Provider licensed by the appropriate state/local authorities as a Residential Treatment Center that is primarily engaged in providing twenty-four (24) hour level of care, including twenty-four (24) hour onsite or on call nursing services and a defined course of therapeutic intervention and special programming in a controlled environment. Care includes treatment with a range of diagnostic and therapeutic behavioral health services that cannot be provided through existing community programs. Residential Treatment Center does not include Custodial Care, outdoor behavioral health programs, half-way houses, supervised living, group homes, boarding houses or other similar facilities providing primarily a supportive and/or recreational environment, even if Mental Health or Substance Use Disorder counseling is provided in such facilities.

Respite Care—care provided to a Homebound Participant as part of a Hospice Plan of Treatment. The purpose of Respite Care is to provide the Primary Care Giver a temporary period of rest from the stress and physical exhaustion involved in caring for the Participant at home.

Skilled Nursing Care—nursing service that must be rendered by or under the direct supervision of a licensed R.N. to maximize the safety of a Participant and to achieve the medically desired result according to the orders and direction of an attending Physician. The following components of Skilled Nursing Care distinguish it from Custodial Care that does not require professional health training:

1. The observation and assessment of the total medical needs of the Participant.
2. The planning, organization, and management of a treatment plan involving multiple services where specialized health care knowledge must be applied in order to attain the desired result.
3. Rendering to the Participant, direct nursing services that require specialized training.

Skilled Nursing Facility—a licensed Facility Provider primarily engaged in providing Inpatient Skilled Nursing Care to patients requiring convalescent care rendered by or under the supervision of a Physician. Other than incidentally, a Skilled Nursing Facility is not a place or facility that provides minimal care, Custodial Care, ambulatory care, or part-time care services; or care or treatment of Mental or Nervous Conditions, Alcoholism, or Substance Use Disorder or Addiction.

Sleep Study—the continuous monitoring of physiological parameters, such as brain and breathing activity of the Participant during sleep.

Sound Natural Tooth—for avulsion or traumatic tooth loss, a Sound Natural Tooth is considered to be one in which the existing conditions of the tooth and its supporting structures did not influence the outcome of the Injury in question,

is without impairment, including but not limited to periodontal or other conditions, and is not in need of the treatment provided for any reason other than the Accidental Injury.

For injuries related to fracture of the coronal surface, a Sound Natural Tooth is considered to be one which has not been restored by, including but not limited to, a crown, inlay, onlay or porcelain restoration, or treated by endodontics.

Special Care Unit—a designated unit within a Licensed General Hospital that has concentrated facilities, equipment, and support services to provide an intensive level of care for critically ill patients.

Specialist Provider—a Professional Provider with an MD or DO designation that has received specialized training and has been certified in a specialty recognized by the American Board of Medical Specialties (ABMS) including, but not limited to cardiology, dermatology, endocrinology, gastroenterology, neurology, etc. A Specialist Provider generally provides expert advice or treatment for conditions that are beyond the scope and training of a Primary Care Provider.

Substance Use Disorder or Addiction—a behavioral or physical disorder manifested by repeated excessive use of a drug or alcohol to the extent that it interferes with a Participant's health, social, or economic functioning.

Summary of Health Care Benefits—this description of the benefits provided under the Plan.

Surgery—within the scope of a Provider's license, the performance of:

1. Generally accepted operative and cutting procedures.
2. Endoscopic examinations and other invasive procedures using specialized instruments.
3. The correction of fractures and dislocations.
4. Customary preoperative and postoperative care.

Surrogate—a woman who agrees to become pregnant and give birth to a child for another individual or couple (the "Intended Parents") in order to give the child to the Intended Parents whether or not the Surrogate is the genetic mother of the child and whether or not the Surrogate does so for compensation.

Telehealth Virtual Care Services—health care services conducted with technology that includes live audio and video communication between the Participant and a Provider in compliance with state and federal laws. No benefits are available for visits conducted by (a) audio-only communication when treatment by such method is not permitted under applicable law at the time of visit, (b) e-mail or (c) fax.

Temporomandibular Joint (TMJ) Syndrome—jaw joint conditions including temporomandibular joint disorders and craniomandibular disorders, and all other conditions of the joint linking the jaw bone and skull and the complex muscles, nerves, and other tissues relating to that joint.

Therapy Services—Therapy Services include only the following:

1. Radiation Therapy—treatment of Disease by x-ray, radium, or radioactive isotopes.
2. Chemotherapy—treatment of malignant Disease by chemical or biological antineoplastic agents.
3. Renal Dialysis—treatment of an acute or chronic kidney condition, which may include the supportive use of an artificial kidney machine.
4. Physical Therapy—treatment by physical means, hydrotherapy, heat or similar modalities, physical agents, biomechanical and neurophysiological principles, or devices to relieve pain, restore maximum function, or prevent disability following a condition, Disease, Illness, Accidental Injury, or loss of a body part.
5. Occupational Therapy—treatment that employs constructive activities designed and adapted for a physically disabled Participant to help satisfactorily accomplish the ordinary tasks of daily living and tasks required by the Participant's particular occupational role.
6. Speech Therapy—corrective treatment of a speech impairment resulting from a condition, Illness, Disease, Surgery, or Accidental Injury; or from Congenital Anomalies, or previous therapeutic processes.
7. Growth Hormone Therapy—treatment administered by intramuscular injection to treat children with growth failure due to pituitary disorder or dysfunction.
8. Home Intravenous Therapy (Home Infusion Therapy)—treatment provided in the home of the Participant or other locations outside of a Licensed General Hospital, that is administered via an intravenous, intraspinal, intra-arterial, intrathecal, subcutaneous, enteral, or intramuscular injection or

access device inserted into the body, at or under the direction of a Home Health Agency or other Provider approved by the Claims Administrator.

9. Orthoptics (Visual Therapy)—treatments developing or improving visual skills and abilities; improving visual comfort, ease, and efficiency; and changing visual processing or interpretation of visual information.

Transplant—surgical removal of a donated organ or tissue and the transfer of that organ or tissue to a recipient.

Treatments for Autism Spectrum Disorder—means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an Autism Spectrum Disorder, or related diagnoses, by a licensed Physician or a licensed psychologist, including but not limited to behavioral health treatment, pharmacy care, psychiatric care, psychological care, and therapeutic care.

EXCLUSIONS AND LIMITATIONS SECTION

In addition to the exclusions and limitations listed elsewhere in this Summary of Health Care Benefits, the following exclusions and limitations apply, unless otherwise specified.

I. General Exclusions and Limitations

There are no benefits for services, supplies, drugs or other charges that are:

A. Not Medically Necessary. If services requiring Prior Authorization are performed by a Contracting Provider and benefits are denied as not Medically Necessary, the cost of said services are not the financial responsibility of the Participant. However, the Participant could be financially responsible for services found to be not Medically Necessary when provided by a Noncontracting Provider.

B. In excess of the Maximum Allowance.

C. For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures, unless necessary to treat an Accidental Injury or unless an attending Physician certifies in writing that the Participant has a non-dental, life-endangering condition which makes hospitalization necessary to safeguard the Participant's health and life.

D. Not prescribed by or upon the direction of a Physician or other Professional Provider; or which are furnished by any individuals or facilities other than Licensed General Hospitals, Physicians, and other Providers.

E. Investigational in nature.

F. Provided for any condition, Disease, Illness or Accidental Injury to the extent that the Participant is entitled to benefits under occupational coverage, obtained or provided by or through the Employer under state or federal Workers' Compensation Acts, or under Employer Liability Acts, or other laws providing compensation for work-related injuries or conditions. This exclusion applies whether or not the Participant claims such benefits or compensation, or recovers losses from a third party.

G. Provided or paid for by any federal governmental entity or unit except when payment under the Plan is expressly required by federal law, or provided or paid for by any state or local governmental entity or unit where its charges therefore would vary, or are or would be affected by the existence of coverage under this Summary of Health Care Benefits.

H. Provided for any condition, Accidental Injury, Disease or Illness suffered as a result of any act of war or any war, declared or undeclared.

I. Furnished by a Provider who is related to the Participant by blood or marriage and who ordinarily dwells in the Participant's household.

J. Received from a dental, vision, or medical department maintained by or on behalf of an employer, a mutual benefit association, labor union, trust or similar person or group.

K. For Surgery intended mainly to improve appearance or for complications arising from Surgery intended mainly to improve appearance, except for:

1. Reconstructive Surgery necessary to treat an Accidental Injury, infection, or other Disease of the involved part; or
2. Reconstructive Surgery to correct Congenital Anomalies in a Participant who is a dependent child.
3. Benefits for reconstructive Surgery to correct an Accidental Injury are available even though the accident occurred while the Participant was covered under a prior insurer's coverage.

L. Rendered prior to the Participant's Effective Date.

M. For personal hygiene, comfort, beautification (including non-surgical services, drugs, and supplies intended to enhance the appearance) even if prescribed by a Physician.

N. For exercise or relaxation items or services even if prescribed by a Physician, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs, spas, hot tubs, whirlpool baths, waterbeds or swimming pools.

O. For convenience items including but not limited to Durable Medical Equipment such as bath equipment, cold therapy units, duplicate items, home traction devices, or safety equipment.

P. For relaxation or exercise therapies, including but not limited to, educational, art, aroma, dance, sex, sleep, electro sleep, vitamin, chelation, homeopathic, or naturopathic, massage, or music even if prescribed by a Physician, except as specified as a Covered Service in the Plan.

Q. Recreational therapy or therapeutic recreation programs, which can include, but are not limited to, diabetes camps, adventure therapy, and/or wilderness therapy (which can include, but are not limited to, programs for outdoor behavioral health, childhood diabetes, and childhood cancer).

R. For telephone consultations; and all computer or Internet communications, except as provided by MDLive or in connection with Telehealth Virtual Care Services.

S. For failure to keep a scheduled visit or appointment; for completion of a claim form; for interpretation services (not required to be provided by law as determined by the Third Party Administrator); or for personal mileage, transportation, food or lodging expenses unless specified as a Covered Service in the Plan, or for mileage, transportation, food or lodging expenses billed by a Physician or other Professional Provider.

T. For Inpatient admissions that are primarily for Diagnostic Services or Therapy Services; or for Inpatient admissions when the Participant is ambulatory and/or confined primarily for bed rest, special diet, behavioral problems, environmental change, or for treatment not requiring continuous bed care.

U. For Inpatient or Outpatient Custodial Care; or for Inpatient or Outpatient services consisting mainly of educational therapy, behavioral modification, self-care or self-help training, except as specified as a Covered Service.

V. For any cosmetic foot care, including but not limited to, treatment of corns, calluses, and toenails (except for surgical care of ingrown or Diseased toenails).

W. Related to Dentistry or Dental Treatment, even if related to a medical condition; or Orthoptics, eyeglasses or Contact Lenses, or the vision examination for prescribing or fitting eyeglasses or Contact Lenses, unless specified as a Covered Service.

X. For hearing aids or examinations for the prescription or fitting of hearing aids, except as specified as a Covered Service.

Y. For any treatment of sexual dysfunction, or sexual inadequacy, including erectile dysfunction and/or impotence, except for:

1. Related to a prostatectomy.
2. Related to Injury, and such services are covered only for the thirty (30) month period immediately following the date of Injury provided the Plan remains in effect during the thirty (30) month period, unless Medically Necessary.

Z. Billed by a Licensed General Hospital for the Participant's failure to vacate a room on or before the Licensed General Hospital's established discharge hour.

AA. Not directly related to the care and treatment of an actual condition, Illness, Disease or Accidental Injury.

AB. Furnished by a facility that is primarily a nursing home, a convalescent home, or a rest home.

AC. For Acute Care, Rehabilitative care, diagnostic testing except as specified as a Covered Service in the Plan; for Mental or Nervous Conditions and Substance Use Disorder or Addiction services not recognized by the American Psychiatric and American Psychological Associations.

AD. Incurred by an Eligible Dependent child for care or treatment of any condition arising from or related to pregnancy, childbirth, delivery, or an Involuntary Complication of Pregnancy, unless specifically provided as a Covered Service in the Plan.

AE. For any of the following:

1. For appliances, splints or restorations necessary to increase vertical tooth dimensions or restore the occlusion, except as specified as a Covered Service;
2. For implants in the jaw; for pain, treatment, or diagnostic testing or evaluation related to the misalignment or discomfort of the temporomandibular joint (jaw hinge), including splinting services and supplies;
3. For alveolectomy or alveoloplasty when related to tooth extraction.

AF. For weight control or treatment of obesity or morbid obesity, even if Medically Necessary, including but not limited to Surgery for obesity, except as listed as a Covered Service, or as specifically provided by the Weight Management Program and Generic weight loss Prescription Drugs listed as a Covered Service. For reversals or revisions of Surgery for obesity, except when required to correct a life-endangering condition.

AG. For use of operating, cast, examination, or treatment rooms or for equipment located in a Contracting or Noncontracting Provider's office or facility, except for emergency room facility charges in a Licensed General Hospital, unless specified as a Covered Service.

AH. For the reversal of sterilization procedures, including but not limited to, vasovasostomies or salpingoplasties.

AI. Except as listed as a Covered Service in this Summary of Health Care Benefits, any treatment for reproductive procedures, including but not limited to, ovulation induction procedures and pharmaceuticals, intrauterine insemination, in vitro fertilization, embryo transfer or similar procedures, or procedures that in any way augment or enhance a Participant's reproductive ability, including but not limited to laboratory services, radiology services or similar services related to treatment for reproduction procedures. Any expenses, procedures or services related to Surrogate pregnancy, delivery or donor eggs.

AJ. For Transplant services and Artificial Organs, except as specified as a Covered Service.

AK. For acupuncture, except as specified as a Covered Service.

AL. For surgical procedures that alter the refractive character of the eye, including but not limited to, radial keratotomy, myopic keratomileusis, Laser-In-Situ Keratomileusis (LASIK), and other surgical procedures of the refractive-keratoplasty type, to cure or reduce myopia or astigmatism, even if Medically Necessary, unless specified as a Covered Service in a Vision Benefits Section, if any. Additionally, reversals, revisions, and/or complications of such surgical procedures are excluded, except when required to correct an immediately life-endangering condition.

AM. For Hospice, except as specified as a Covered Service.

AN. For pastoral, spiritual, bereavement or marriage counseling.

AO. For homemaker and housekeeping services or home-delivered meals.

AP. Payment for items or services not permitted under applicable state law or for the treatment of injuries sustained while committing a felony, voluntarily taking part in a riot, or while engaging in an illegal act or occupation, unless such injuries are a result of a medical condition or domestic violence.

AQ. For treatment or other health care of any Participant in connection with an Illness, Disease, Accidental Injury or other condition which would otherwise entitle the Participant to Covered Services under this Summary of Health Care Benefits, if and to the extent those benefits are payable to or due the Participant under any medical payments provision, no fault provision, uninsured motorist provision, underinsured motorist provision, or other first party or no fault provision of any automobile, homeowner's, or other similar policy of insurance, contract, or underwriting plan.

In the event the Third Party Administrator for any reason makes payment for or otherwise provides benefits excluded by the above provisions, the Plan Administrator shall succeed to the rights of payment or reimbursement of the compensated Provider, the Participant, and the Participant's heirs and personal representative against all insurers, underwriters, self-insurers, or other such obligors contractually liable or obliged to the Participant, or their estate for such services, supplies, drugs or other charges so provided by the Third Party Administrator in connection with such Illness, Disease, Accidental Injury or other condition.

AR. For which a Participant would have no legal obligation to pay in the absence of coverage under this Summary of Health Care Benefits or any similar coverage; or for which no charge or a different charge is usually made in the absence of health coverage or insurance coverage or charges in connection with work for compensation or charges; or for which reimbursement or payment is contemplated under an agreement with a third party.

AS. For immunizations except as specifically provided as a Covered Service.

AT. For breast reduction Surgery or Surgery for gynecomastia.

AU. For nutritional supplements.

AV. For replacements or nutritional formulas except, when administered enterally due to impairment in digestion and absorption of an oral diet and is the sole source of caloric need or nutrition in a Participant, or except as specified as a Covered Service.

AW. For vitamins and minerals, unless required through a written prescription and cannot be purchased over the counter.

AX. For alterations or modifications to a home or vehicle.

AY. For special clothing, including shoes (unless permanently attached to a brace).

AZ. Provided to a person enrolled as an Eligible Dependent, but who no longer qualifies as an Eligible Dependent due to a change in eligibility status that occurred after enrollment.

AAA. Provided outside the United States, which if had been provided in the United States, would not be a Covered Service.

AAB. For Outpatient pulmonary and/or Outpatient cardiac Rehabilitation, except as specified as a Covered Service in the Plan.

AAC. For complications arising from the acceptance or utilization of services, supplies or procedures that are not a Covered Service.

AAD. For the use of Hypnosis, as anesthesia or other treatment, except as specified as a Covered Service.

AAE. For dental implants, appliances (with the exception of sleep apnea devices), and/or prosthetics, and/or treatment related to Orthodontia, even when Medically Necessary, unless specified as a Covered Service.

AAF. For arch supports, orthopedic shoes, and other foot devices, except as specified as a Covered Service.

AAG. For wigs, unless specified as a Covered Service.

AAH. For surgical removal of excess skin that is the result of weight loss or gain, including but not limited to association with prior weight reduction (obesity) Surgery.

AAI. For the purchase of Therapy or Service Dogs/Animals and the cost of training/maintaining said animals.

AAJ. Procedures considered cosmetic in nature except as specified in the Plan with a documented diagnosis of gender dysphoria.

AAK. Any newly FDA approved Prescription Drug, biological agent, or other agent until it has been reviewed and implemented by the Third Party Administrator's Pharmacy and Therapeutics Committee (unless otherwise required by law to be provided sooner).

AAL. For the treatment of injuries sustained by the Participant while the Participant is operating a motor vehicle under the influence of alcohol and/or narcotics. For purposes of the Plan exclusion, "Under the influence" as it relates to alcohol means having a whole blood alcohol content of .08 or above or a serum blood alcohol content of .10 or above as measured by a laboratory approved by the State Police or a laboratory certified by the Centers for Medicare and Medicaid Services. For purposes of the Plan exclusion, "Under the influence" as it relates to narcotics means impairment of driving ability caused by the use of narcotics not prescribed or administered by a Physician.

AAM. Rendered after exhaustion of an established benefit limit, unless authorized at the discretion of the Plan Sponsor and in accordance with the specific medical criteria established by the Claims Administrator.

AAN. All services, supplies, devices and treatment that are not FDA approved.

AAO. Any services, interventions occurring within the framework of an educational program or institution; or provided in or by a school/educational setting; or provided as a replacement for services that are the responsibility of the educational system.

GENERAL PROVISIONS SECTION

I. Benefits to Which Participants are Entitled

A. Subject to all of the terms of this Summary of Health Care Benefits, a Participant is entitled to benefits for Covered Services in the amounts specified in the benefit sections and/or in the Benefit Summary.

B. Benefits will be provided only if Covered Services are prescribed by, or performed by, or under the direction of a Physician or other Professional Provider and are regularly and customarily included in such Providers' charges.

C. Covered Services are subject to the availability of Licensed General Hospitals and other Facility Providers and the ability of the employees of such Providers and of available Physicians to provide such services. The Plan Administrator and/or the Third Party Administrator shall not assume nor have any liability for conditions beyond its control which affect the Participant's ability to obtain Covered Services.

D. The Employer intends the Plan to be permanent, but because future conditions affecting the Employer cannot be anticipated or foreseen, the Employer reserves the right to amend, modify, or terminate the Plan at any time, which may result in the termination or modification of the Participants' Coverage. Expenses incurred prior to the Plan modification or termination will be paid as provided under the terms of the Plan prior to its modification or termination.

II. Notice of Claim

The Claims Administrator will process claims for benefits according to the Plan. A claim for Covered Services must be submitted within one year from the date of service and must include all the information necessary for the Claims Administrator to determine benefits.

III. Release and Disclosure of Medical Records and Other Information

In order to effectively apply the provisions of the Plan, the Claims Administrator may obtain information from Providers and other entities pertaining to any health related services that the Participant may receive or may have received in the past. The Claims Administrator may also disclose to Providers and other entities, information obtained from the Participant's transactions, Contributions, payment history and claims data necessary to allow the processing of a claim and for other health care operations. To protect the Participant's privacy, the Claims Administrator treats all information in a confidential manner. For further information regarding the Third Party Administrator's privacy policies and procedures, the Participant may request a copy of the Third Party Administrator's Notice of Privacy Practices by contacting Customer Service at the number provided in the Plan. In addition, you may obtain a copy of the Plan's Notice of Privacy Practices by visiting www.micronhealth.com or by calling (208) 368- HR4U (4748) or toll-free (800) 336- 8918.

IV. Exclusion of General Damages

Liability under this Summary of Health Care Benefits for benefits conferred hereunder, including recovery under any claim or breach of the Plan, shall be limited to the actual benefits for Covered Services as provided herein and shall specifically exclude any claim for punitive damages, general damages, including but not limited to, alleged pain, suffering or mental anguish, or for economic loss, or consequential loss or damages.

V. Payment of Benefits

The Third Party Administrator (Blue Cross of Idaho) provides administrative claims payment services only and assumes no obligation with respect to funding Plan benefits.

A. As a condition of Plan participation, the Participant authorizes the Third Party Administrator, on behalf of the Plan Administrator, to make payments directly to Providers rendering Covered Services to the Participant for benefits provided under the Plan. Notwithstanding this authorization, the Third Party Administrator, on behalf of the Plan Administrator, reserves and shall have the right to make such payments directly to the Participant. Except as provided by law, the Third Party Administrator's right, on behalf of the Plan Administrator, to pay a Participant directly is not assignable by a Participant nor can it be waived without the Third Party Administrator's concurrence, on behalf of the Plan Administrator, nor may the right to receive benefits for Covered Services under this Summary of Health Care Benefits be transferred or assigned, either before or after Covered Services are rendered. Payments will also be made in accordance with any assignment of rights required by state Medicaid plan.

B. The Plan prohibits direct or indirect payment by third parties unless it meets the standards set below.

Family, friends, religious institutions, private, not-for-profit foundations such as Indian tribes, tribal organizations, urban Indian organizations, state and federal government programs or grantees or sub-grantees such as the Ryan White HIV/AIDS Program and other similar entities are not prohibited as third-party payers from paying contribution on behalf of an individual receiving medical treatment. Cost Sharing contributions made from permitted third parties will be applied to the Participants applicable Deductible and/or Out-of-Pocket Limit. The Third Party Administrator, Plan Administrator and Plan Sponsor are not responsible for reporting these payments as income. Participants are separately responsible to determine the tax consequences of these payments.

Each of the following criteria must be met for the Third Party Administrator or the Plan Administrator to accept a third party payment:

1. the assistance is provided on the basis of the Participant's financial need;
2. the institution/organization is not a healthcare Provider; and
3. the institution/organization is not financially interested. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

To assist in appropriately applying Cost Sharing contributions made from a permitted third party to the Participants applicable Deductible and/or Out-of-Pocket Limit, the Participant is encouraged to provide notification to the Third Party Administrator if they receive any form of assistance for payment of their Contribution, Cost Sharing, Copayment or Deductible amounts.

Contributions submitted in violation of this provision will not be accepted and the Enrollee's Plan may be terminated for non-payment. Cost Sharing contributions made from non-permitted third parties will not be applied to the Participants applicable Deductible and/or Out-of-Pocket Limit. The Third Party Administrator will inform the Participant in writing of the reason for rejecting or otherwise refusing to treat a third party payment as a payment from the Participant.

Except as otherwise provided for in this Section V.B, no payments for claims will be made for any charges or expenses that Participants are not obligated to pay or for which Participants are not billed, including any Cost-Sharing, Copayment or Deductible amounts and any amounts waived pursuant to any "fee-forgiving " arrangement of a Provider.

C. Once Covered Services are rendered by a Provider, the Third Party Administrator, shall not be obliged to honor Participant requests not to pay claims submitted by such Provider, and the Third Party Administrator, shall have no liability to any person because of its rejection of such request; however, in its sole discretion, for good cause, the Claims Administrator may nonetheless deny all or any part of any Provider claim.

VI. Participant/Provider Relationship

A. The choice of a Provider is solely the Participant's.

B. The Third Party Administrator does not render Covered Services but only makes payment for Covered Services received by Participants. The Third Party Administrator and the Plan Administrator are not liable for any act or omission or for the level of competence of any Provider, and have no responsibility for a Provider's failure or refusal to render Covered Services to a Participant.

C. The use or nonuse of an adjective such as Contracting or Noncontracting is not a statement as to the ability of the Provider.

VII. Participating Plan

The Third Party Administrator may, in its sole discretion, make an agreement with any appropriate entity (referred to as a Participating Plan) to provide, in whole or in part, benefits for Covered Services to Participants, but it shall have no obligation to do so.

VIII. Coordination of the Plan's Benefits with Other Benefits

This Maintenance of Benefits (MOB) provision applies when a Participant has health care coverage under more than one (1) . Contract is defined below.

The Order of Benefit Determination Rules govern the order in which each Contract will pay a claim for benefits. The Contract that pays first is called the Primary Contract. The Primary Contract must pay benefits in accordance with its policy terms without regard to the possibility that another Contract may cover some expenses. The Contract that pays after the Primary Contract is the Secondary Contract.

A. Definitions

1. A Contract is any of the following that provides benefits or services for medical or dental care or treatment. If separate Contracts are used to provide coordinated coverage for members of a group, the separate Contracts are considered parts of the same Contract and there is no MOB among those separate contracts.
   a) Contract includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, Closed Panel Plans or other forms of group or group type coverage (whether insured or uninsured), including the Plan; medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

   b) Contract does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefit for non-medical components of long-term care policies; Medicare supplement policies; Medicare or any other federal governmental plans, unless permitted by law.

   Each Contract for coverage under a) or b) is a separate Contract. If a Contract has two (2) parts and MOB rules apply only to one (1) of the two (2), each of the parts is treated as a separate Contract.

2. This Contract means, in a MOB provision, the part of the Contract providing the health care benefits to which the MOB provision applies and which may be reduced because of the benefits of other Contracts. Any other part of the Contract providing health care benefits is separate from the Plan. A Contract may apply one (1) MOB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, any may apply under MOB provision to coordinate other benefits.

3. The Order of Benefit Determination Rules determine whether This Contract is a Primary Contract or Secondary Contract when the Participant has health care coverage under more than one (1) Contract. When This Contract is primary, it determines payment for its benefits first before those of any other Contract without considering any other Contract's benefits. When This Contract is secondary, it determines its benefits after those of another Contract and will reduce the benefits it pays when the benefits payable under the Primary Contract equal or exceed the benefits which would have been payable under This Contract had benefits payments under This Contract been determined first. .

4. Allowable Expense is a health care expense, including Deductibles, Cost Sharing and Copayments, that is covered at least in part by any Contract covering the Participant. When a Contract provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Contract covering the Participant is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense.

The following are examples of expenses that are not Allowable Expenses:

a) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable Expense, unless one of the Contracts provides coverage for private hospital room expenses.

b) If a Participant is covered by two (2) or more Contracts that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.

c) If a Participant is covered by two (2) or more Contracts that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees it not an Allowable Expense.

d) If a Participant is covered by one (1) Contract that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Contract that provides its benefits or services on the basis of negotiated fees, the Primary Contract's payment arrangement shall be the Allowable Expense for all Contracts. However, if the provider has contracted with the Secondary Contract to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary Contract's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the Secondary Contract to determine its benefits.

e) The amount of any benefit reduction by the Primary Contract because a covered person has failed to comply with the Contract provisions is not an Allowable Expense. Examples of these types of Contract provisions include second surgical opinions, pre-certificate of admissions, and preferred provider arrangements.

5. Closed Panel Plan is a Contract that provides health care benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

6. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

B. Order of Benefit Determination Rules

When a Participant is covered by two (2) or more Contracts, the rules for determining the order of benefit payments are as follows:

1. The Primary Contract pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Contract.

2. a) Except as provided in Paragraph 2.b) below, a Contract that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Contracts state that the complying Contract is primary.

   b) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Contract provided by the Contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

3. A Contract may consider the benefits paid or provided by another Contract in calculating payment of its benefits only when it is secondary to that other Contract.

4. Each Contract determines its order of benefits using the first of the following rules that apply:
   a) Non-Dependent or Dependent. The Contract that covers the Participant other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Contract and the Contract that covers the Participant as a dependent is the Secondary Contract. However, if the Participant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Contract covering the Participant as a dependent; and primary to the Contract covering the Participant as other than a dependent (e.g. a retired employee); then the order of benefits between the two Contracts is reversed so that the Contract covering the Participant as an employee, member, policyholder, subscriber or retiree is the Secondary Contract and the other Contract is the Primary Contract.

   b) Dependent Child Covered Under More Than One Contract. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Contract the order of benefits is determined as follows:
      (1) For a dependent child whose parents are married or are living together, whether or not they have ever been married: The Contract of the parent whose birthday falls earlier in the calendar year is the Primary Contract; or if both parents have the same birthday, the Contract that has covered the parent the longest is the Primary Contract.
      (2) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         i. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Contract of that parent has actual knowledge of those terms, that Contract is primary. This rule applies to Contract year commencing after the Contract is given notice of the court decree;
         ii. If a court decree states that both parents are responsible for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (1) shall determine the order of benefits;
         iii. If a court decree states both parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage, the provisions of Subparagraph (1) above shall determine the order of benefits;

iv. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The Contract covering the Custodial Parent;
2. The Contract covering the spouse of the Custodial Parent;
3. The Contract covering the non-Custodial Parent; and then
4. The Contract covering the spouse of the non-Custodial Parent.

For a dependent child covered under more than one Contract of individuals who are not the parents of the child, the provisions of Subparagraph (1) or (2) above shall determine the order of benefits as if those individuals were the parents of the child.

c) Active Employee or Retired or Laid-off Employee. The Contract that covers a Participant as an active employee, that is, an employee who is neither laid off nor retired, is the Primary Contract. The Contract covering that same Participant as a retired or laid-off employee is the Secondary Contract. The same would hold true if a Participant is a dependent of an active employee and that same Participant is a dependent of a retired or laid-off employee. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

d) COBRA or State Continuation Coverage. If a Participant whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Contract, the Contract covering the Participant as an employee, member, subscriber or retiree or covering the Participant as a dependent of an employee, member, subscriber or retiree is the Primary Contract and the COBRA or state or other federal continuation coverage is the Secondary Contract. If the other Contract does not have this rule, and as a result, the Contracts do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled 4.a) can determine the order of benefits.

e) Longer or Shorter Length of Coverage. The Contract that covered the Participant as an employee, member, policyholder, subscriber, or retiree longer is the Primary Contract and the Contract that covered the Participant the shorter period of time is the Secondary Contract.

f) If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Contracts meeting the definition of Contract. In addition, This Contract will not pay more than it would have paid had it been the Primary Contract.

C. Effect on the Benefits of this Contract

1. When This Paragraph Applies. This Paragraph C. applies when, in accordance with Paragraph B., "Order of Benefit Determination Rules," This Contract is a Secondary Contract as to one (1) or more other Contracts. If the benefits of This Contract may be reduced under this paragraph, such other Contract or Contracts are referred to as "the other Contracts" in subparagraph 2. immediately below.

2. Reduction in This Contract's Benefits. The benefits of This Contract will be reduced when:

a) The benefits payable under the Other Contract equal or exceed the benefits which would have been payable under This Contract had benefits payment under This Contract been determined first, then there is no benefit payable under This Contract.

*EXAMPLE: Other Contract benefit - $960 or 80%
This Contract benefit - $960 or 80%
No benefits available under This Contract. Other Contract benefits as determined first are equal to benefits under This Contract.

and,

b) The benefits payable for Covered Services under the Other Contract are less than the benefits which would have been payable under This Contract had benefits been determined first, then the benefits shall equal those benefits payable under This Contract, less the benefits payable under the Other Contract.

*EXAMPLE: Other Contract benefit - $840 or 70%
This Contract benefit - $960 or 80%
Benefits payable under This Contract must equal 80% or (960 - 840 = $120).

*The above examples do not necessarily reflect the benefits payable under This Contract and are used only to show how benefits would be determined under This Contract and an Other Contract.

When the benefits of This Contract are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Contract.

D. Facility of Payment

A payment made under another Contract may include an amount that should have been paid under This Contract. If it does, the Third Party Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Contract. The Third Party Administrator will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

E. Right of Recovery

If the amount of the payments made by the Third Party Administrator is more than it should have paid under this MOB provision, it may recover the excess from one or more of the Participants it has paid or for whom it has paid; or any other Participant or organization that may be responsible for the benefits or services provided for the covered Participant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

IX. Benefits for Medicare Eligibles who are Covered Under the Plan

A. Any Eligible Employee or spouse of an Eligible Employee who becomes or remains a Participant of the Employer covered by this Summary of Health Care Benefits after becoming eligible for Medicare (due to reaching age sixty-five (65)) is entitled to receive the benefits of the Plan as primary.

B. Any Eligible Employee, spouse of an Eligible Employee or dependent child of an Eligible Employee who becomes or remains a Participant of the Employer covered by this Summary of Health Care Benefits after becoming eligible for Medicare due to disability is entitled to receive the benefits of the Plan as primary.

C. A Participant with end stage renal disease (ESRD) is generally eligible for Medicare starting with the 4th month of dialysis treatments or the month they are admitted to a Medicare-certified hospital for a kidney transplant (or for health care services they will need before the transplant) if the transplant takes place in that same month or within the next two (2) months. A Participant should enroll for Medicare Part A and Part B (or a Medicare Advantage Plan) as soon as possible (but no later than the end of the 30-month coordination period described below), regardless of their age. Detailed information regarding Medicare eligibility and enrollment is available at www.medicare.gov.

If a Participant with ESRD is eligible for coverage under this Summary of Health Care Benefits as an employee with current employment status or as a spouse or family member of an employee with current employment status, the Plan will continue as the primary coverage for up to 30 months after the earliest date that the Participant is, or could upon filing an application become, entitled to Medicare on the basis of ESRD (this period is referred to as the "30-month coordination period"). Thereafter, the Plan will only pay as the Participant's secondary coverage to the benefits provided by, or the benefits that would have been provided by, Medicare.

Importantly, the Plan will pay secondary to Medicare after the 30-month coordination period regardless of whether the Participant actually enrolls for, pays applicable contribution for, maintains, claims, or receives Medicare benefits. If a Participant fails to enroll for Medicare when first eligible, the Plan will still pay secondary to the benefits that would have been provided by Medicare as if they had enrolled. This could result in the Participant having no coverage for the dialysis treatment or for other services or treatments until they enroll. Without such coverage, a Participant could be personally liable for the full cost of medical services and supplies that Medicare would have paid to facilities and providers if the Participant had enrolled in, or filed an application for benefits under, Medicare.

D. The Employer's retirees, if covered under this Summary of Health Care Benefits, and Eligible Employees or spouses of Eligible Employees (if a Participant) who are not subject to paragraphs A., B. or C. of this provision and who are Medicare eligible, will receive the benefits of the Plan reduced by any benefits available under Medicare. This applies even if the Participant fails to enroll in Medicare or does not claim the benefits available under Medicare.

X. Incorporated by Reference

All of the terms, limitations and exclusions of coverage contained in this Summary of Health Care Benefits are incorporated by reference into all sections, endorsements, riders, and Amendments and are as effective as if fully expressed in each one unless specifically noted to the contrary.

XI. Inquiry and Appeals Procedures

If the Participant's claim for benefits is denied and an Adverse Benefit Determination is issued, the Participant must first exhaust any applicable internal appeals process described below prior to pursuing legal action.

A. Informal Inquiry

For any initial questions concerning a claim, a Participant should call or write the Third Party Administrator's Customer Service Department. The Third Party Administrator's phone numbers and addresses are listed on the Explanation of Benefits (EOB) form and in the Contact Information section of this Summary of Health Care Benefits.

B. Formal Appeal

A Participant who wishes to formally appeal a Pre-Service Claim decision may do so through the following process:

1. A Participant may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. The Plan Administrator requires that a Participant execute an "Appointment of Authorized Representative" form before the Third Party Administrator, on behalf of the Plan Administrator determines that an individual has been authorized to act on behalf of the Participant. The form can be found on the Third Party Administrator's Website at www.bcidaho.com.

2. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. Urgent claim appeals, and the documents in support of such appeals may be submitted by phone or facsimile. The appeal should set forth the reasons why the Participant contends the decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

3. After receipt of the appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by the Claims Administrator's Medical Director or physician designee. For non-urgent claim appeals, the Claims Administrator will mail a written reply to the Participant within fifteen (15) days after receipt of the written appeal. Urgent claim appeals will be notified orally within seventy-two (72) hours. If the original decision is upheld, the reply will state the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible taking into account the medical exigencies of each claim.

4. Furthermore, the Participant or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

5. If the original, non-urgent claim decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator requesting further review. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within thirty (30) days of the Claims Administrator's mailing of the initial reconsideration decision. The Claims Administrator's Medical Director who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information. A final decision on the appeal will be made within fifteen (15) days of its receipt.

C. A Participant who wishes to formally appeal a Post-Service Claims decision may do so through the following process:

1. A Participant may have an authorized representative pursue a benefit claim or an appeal of an Adverse Benefit Determination on their behalf. The Plan Administrator requires that a Participant execute an "Appointment of Authorized Representative" form before the Third Party Administrator, on behalf of the Plan Administrator determines that an individual has been authorized to act on behalf of the Participant. The form can be found on the Third Party Administrator's Website at www.bcidaho.com.

2. A written appeal must be sent to the Appeals and Grievance Coordinator within one hundred eighty (180) days after receipt of the notice of Adverse Benefit Determination. This written appeal should set forth the reasons why the Participant contends the decision was incorrect. Any written comments, documents or other relevant information may be submitted with the appeal.

3. After receipt of the written appeal, all facts, including those originally used in making the initial decision and any additional information that is sent or that is otherwise relevant, will be reviewed by the Claims Administrator's Medical Director, or physician designee if the appeal requires medical judgment. The Claims Administrator shall mail a written reply to the Participant within thirty (30) days after receipt of the written appeal. If the original decision is upheld, the reply will list the specific reasons for denial and the specific provisions on which the decision is based. Each appeal will be processed as quickly as possible.

4. Furthermore, the Participant or their authorized representative has the right to reasonable access to, and copies of all documents, records, and other information that are relevant to the appeal.

5. If the original decision is upheld upon reconsideration, the Participant may send an additional written appeal to the Appeals and Grievance Coordinator requesting *further review*. This appeal must set forth the reasons for requesting additional reconsideration and must be sent within sixty (60) days of the Claims Administrator's mailing of the initial reconsideration decision. A Medical Director of the Claims Administrator who is not subordinate to the Medical Director or physician designee who decided the initial appeal, will issue a final decision after consideration of all relevant information, if the appeal requires medical judgment. A final decision on the appeal will be made within thirty (30) days of its receipt. If the appeal does not require medical judgment, a Vice President of the Claims Administrator who did not decide the initial appeal will issue the decision.

D. Participant's Rights to an Independent External Review

Please read this carefully. It describes a procedure for review of a disputed health claim by a qualified professional who has no affiliation with the Plan Administrator or the Claims Administrator. If a Participant or their authorized representative requests an independent external review of a claim, the decision made by the independent reviewer will be binding and final on the Plan. The Participant or their authorized representative will have the right to further review the claim by a court, arbitrator, mediator or other dispute resolution entity, as more fully explained below under "Binding Nature of the External Review Decision."

If the Claims Administrator issues a final Adverse Benefit Determination of a Participant's request to provide or pay for a health care service or supply, a Participant may have the right to have the Claims Administrator's decision reviewed by health care professionals who have no association with the Claims Administrator. A Participant has this right only if the Claims Administrator's denial decision involved:

- The Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a Participant's health care service or supply, or
- Determination that a Participant's health care service or supply was Investigational.

A Participant must first exhaust the internal grievance and appeal processes described in this Summary of Health Care Benefits. Exhaustion of that process includes completing all levels of appeal. Exhaustion of the appeals process is not required if the Claims Administrator failed to respond to a standard appeal within thirty-five (35) days in writing or to an urgent appeal within three business days of the date the Participant filed the appeal, unless the Participant requested or agreed to a delay. The Claims Administrator may also agree to waive the exhaustion requirement for an external review request. The Participant may file for an internal urgent appeal with the Claims Administrator and for an expedited external review with the Idaho Department of Insurance at the same time if the Participant's request qualifies as an "urgent care request" defined below.

A Participant may submit a written request for an external review to:

Idaho Department of Insurance
ATTN: External Review
700 W State St, 3rd Floor

Boise ID 83720-0043

For more information and for an external review request form:

- See the department's Website, www.doi.idaho.gov, or
- Call the department's telephone number, (208) 334-4250, or toll-free in Idaho, 1-800-721-3272.

A Participant may act as their own representative in a request or a Participant may name another person, including a Participant's treating health care provider, to act as an authorized representative for a request. If a Participant wants someone else to represent them, a Participant must include a signed "Appointment of an Authorized Representative" form with the request before the Claims Administrator determines that an individual has been authorized to act on behalf of the Participant. The form can be found on the Claims Administrator's Website www.bcidaho.com. A Participant's written external review request to the Idaho Department of Insurance must include a completed form authorizing the release of any medical records the independent review organization may require to reach a decision on the external review, including any judicial review of the external review decision pursuant to ERISA, if applicable. The department will not act on an external review request without a Participant's completed authorization form. If the request qualifies for external review, the Claims Administrator's final Adverse Benefit Determination will be reviewed by an independent review organization selected by the Idaho Department of Insurance. The Plan Administrator will pay the costs of the review.

Standard External Review Request: A Participant must file a written external review request with the Idaho Department of Insurance within four (4) months after the date the Claims Administrator issues a final notice of denial.

1. Within seven (7) days after the Idaho Department of Insurance receives the request, the Idaho Department of Insurance will send a copy to the Claims Administrator.
2. Within fourteen (14) days after the Claims Administrator receives the request from the Idaho Department of Insurance, we will review the request for eligibility. Within five (5) business days after the Claims Administrator completes that review, we will notify the Participant and the Idaho Department of Insurance in writing if the request is eligible or what additional information is needed. If the Claims Administrator denies the eligibility for review, the Participant may appeal that determination to the Department.
3. If the request is eligible for review, the Idaho Department of Insurance will assign an independent review organization to your review within seven (7) days of receipt of the Claims Administrator's notice. The Idaho Department of Insurance will also notify the Participant in writing.
4. Within seven (7) days of the date you receive the Idaho Department of Insurance's notice of assignment to an independent review organization, the Participant may submit any additional information in writing to the independent review organization that they want the organization to consider in its review.
5. The independent review organization must provide written notice of its decision to the Participant, the Claims Administrator and to the Idaho Department of Insurance within forty-two (42) days after receipt of an external review request.

Expedited External Review Request: A Participant may file a written "urgent care request" with the Idaho Department of Insurance for an expedited external review of a pre-service or concurrent service denial. The Participant may file for an internal urgent appeal with the Claims Administrator and for an expedited external review with the Idaho Department of Insurance at the same time.

"Urgent care request" means a claim relating to an admission, availability of care, continued stay or health care service for which the covered person received emergency services but has not been discharged from a facility, or any Pre-Service Claim or concurrent care claim for medical care or treatment for which application of the time periods for making a regular external review determination:

1. Could seriously jeopardize the life or health of the Participant or the ability of the Participant to regain maximum function;

2. In the opinion of the Provider with knowledge of the covered person's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the disputed care or treatment; or
3. The treatment would be significantly less effective if not promptly initiated.

The Idaho Department of Insurance will send your request to us. The Claims Administrator will determine, no later than the second (2nd) full business day, if the request is eligible for review. The Claims Administrator's decision if the request is eligible. If the Claims Administrator denies the eligibility for review, the Participant may appeal that determination to the Idaho Department of Insurance.

If the request is eligible for review, the Idaho Department of Insurance will assign an independent review organization to the review upon receipt of the Claims Administrator's notice. The Idaho Department of Insurance will also notify the Participant. The independent review organization must provide notice of its decision to the Participant, the Claims Administrator and to the Idaho Department of Insurance within seventy-two (72) hours after the date of receipt of the external review request. The independent review organization must provide written confirmation of its decision within forty-eight (48) hours of notice of its decision. If the decision reverses the Claims Administrator's denial, the Claims Administrator will notify the Participant and the Idaho Department of Insurance of the Claims Administrator's intent to pay for the covered benefit as soon as reasonably practicable, but not later than one (1) business day after receiving notice of the decision.

Binding Nature of the External Review Decision:
The external review decision by the independent review organization will be final and binding on both the Plan and the Participant. **This means that if the Participant elects to request external review, the Participant will be bound by the decision of the independent review organization. The Participant will not have any further opportunity for review of the Claims Administrator's denial after the independent review organization issues its final decision.** If the Participant chooses not to use the external review process, other options for resolving a disputed claim may include mediation, arbitration or filing an action in court.

Under Idaho law, the independent review organization is immune from any claim relating to its opinion rendered or acts or omissions performed within the scope of its duties unless performed in bad faith or involving gross negligence.

XII. Reimbursement of Benefits Paid by Mistake

If the Third Party Administrator mistakenly makes payment for benefits on behalf of an Enrollee or their Eligible Dependent(s) that the Enrollee or their Eligible Dependent(s) is not entitled to under this Summary of Health Care Benefits, an equitable lien will automatically be created on any such erroneous payment and the erroneous payment will be held in trust for the benefit of the Plan. The Enrollee must reimburse the erroneous payment to the Third Party Administrator, on behalf of the Plan Administrator.

The reimbursement is due and payable as soon as the Third Party Administrator notifies the Enrollee and requests reimbursement. The Third Party Administrator may also recover such erroneous payments from any other person or Provider to whom the payments were made. If reimbursement is not made in a timely manner, the Third Party Administrator may reduce benefits or reduce an allowance for benefits as a set-off toward reimbursement.

Even though the Third Party Administrator may elect to continue to provide benefits after mistakenly paying benefits, the Third Party Administrator may still enforce this provision. This provision is in addition to, not instead of, any other remedy the Third Party Administrator may have at law or in equity.

XIII. Subrogation and Reimbursement Rights

The benefits of this Summary of Health Care Benefits, will be available to a Participant when the Participant is injured, suffers harm or incurs loss due to any act, omission, or defective or unreasonably hazardous product or service of another person, firm, corporation or entity (hereinafter referred to as a "third party"). To the extent that such benefits for Covered Services are provided or paid for by the Third Party Administrator, on behalf of the Plan Administrator under this Summary of Health Care Benefits, agreement, certificate, contract or plan, the Third Party Administrator, on behalf of the Plan Administrator shall be subrogated and succeed to the rights of the Participant or, in the event of the Participant's death, to the rights of their heirs, estate, and/or personal representative.

As a condition of receiving benefits for Covered Services in such an event, the Participant or their personal representative shall furnish the Third Party Administrator in writing with the names, addresses, and contact information of the third party or parties that caused or are responsible, or may have caused or may be responsible for such injury, harm or loss, and all facts and information known to the Participant or their personal representative concerning the injury, harm or loss. In addition, the Participant shall furnish the name and contact information of the liability insurer and its adjuster of the third party, including the policy number, of any liability insurance that covers, or may cover, such injury, harm, or loss.

The Third Party Administrator, on behalf of the Plan Administrator may at its option elect to enforce either or both of its rights of subrogation and reimbursement.

Subrogation is taking over the Participant's right to receive payments from other parties. The Participant or their legal representative will transfer to the Third Party Administrator, on behalf of the Plan Administrator any rights the Participant may have to take legal action arising from the injury, harm or loss to recover any sums paid on behalf of the Participant. Thus, the Third Party Administrator, on behalf of the Plan Administrator may initiate litigation at its sole discretion, in the name of the Participant, against any third party or parties. Additionally, the Third Party Administrator, on behalf of the Plan Administrator may at its option elect to enforce its right of reimbursement from the Participant, or their legal representative, of any benefits paid from monies recovered as a result of the injury, harm or loss.
The Participant shall fully cooperate with the Third Party Administrator in its investigation, evaluation, litigation and/or collection efforts in connection with the injury, harm or loss and shall do nothing whatsoever to prejudice the Third Party Administrator's subrogation rights and efforts. The Participant must, upon the Plan Administrator's request, provide all information and sign and return all documents necessary for the Third Party Administrator to exercise its rights under this Section on behalf of the Plan Administrator. The Third Party Administrator, on behalf of the Plan Administrator will be reimbursed in full for all benefits paid even if the Participant is not made whole or fully compensated by the recovery.

The Participant shall pay the Third Party Administrator, on behalf of the Plan Administrator as the first priority, and the Third Party Administrator shall have a constructive trust and an equitable lien on, all amounts from any recovery by suit, settlement or otherwise from any third party or parties or from any third party's or parties' insurer(s), indemnitor(s) or underwriter(s), to the extent of benefits provided by the Third Party Administrator, on behalf of the Plan Administrator under this Summary of Health Care Benefits, regardless of how the recovery is allocated *(i. e.,* pain and suffering) and whether the recovery makes the Participant whole. Thus, the Third Party Administrator will be reimbursed by the Participant, or their legal representative, from monies recovered as a result of the injury, harm or loss, for all benefits paid even if the Participant is not made whole or fully compensated by the recovery. Moreover, the Third Party Administrator and the Plan Administrator are not responsible for any attorney's fees, other expenses or costs incurred by the Participant without the prior written consent of the Third Party Administrator and, therefore, the "common fund" doctrine does not apply to any amounts recovered by any attorney the Participant hires regardless of whether amounts recovered are used to repay benefits paid by the Third Party Administrator, on behalf of the Plan Administrator.

To the extent that the Third Party Administrator, on behalf of the Plan Administrator, provides or pays benefits for Covered Services, the Third Party Administrator's rights of subrogation and reimbursement extend to any right the Participant has to recover from the Participant's insurer, or under the Participant's "Medical Payments" coverage or any "Uninsured Motorist," "Underinsured Motorist," or other similar coverage provisions, and workers' compensation benefits.

The Third Party Administrator, on behalf of the Plan Administrator, shall have the right, at its option, to seek reimbursement from, or enforce its right of subrogation against, the Participant, the Participant's personal representative, a special needs trust, or any trust, person or vehicle that holds any payment or recovery from or on behalf of the Participant including the Participant's attorney. The Third Party Administrator, on behalf of the Plan Administrator, will also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds.

The Third Party Administrator's subrogation and reimbursement rights shall take priority over the Participant's rights both for benefits provided and payments made by the Third Party Administrator, and for benefits to be provided or payments to be made by the Third Party Administrator in the future on account of the injury, harm or loss giving rise to the Third Party Administrator's subrogation and reimbursement rights. Further, the Plan Administrator's subrogation and reimbursement rights for such benefits and payments provided or to be provided are primary and take precedence over the rights of the Participant, even if there are deficiencies in any recovery or insufficient financial resources available to the third party or parties to totally satisfy all of the claims and judgments of the Participant and the Third Party Administrator.

Collections or recoveries made by a Participant for such injury, harm or loss in excess of such benefits provided and payments made shall first be allocated to such future benefits and payments that would otherwise be owed by the Plan on account of the injury, harm or loss giving rise to the Third Party Administrator's subrogation and reimbursement rights, and shall constitute a Special Credit applicable to such future benefits and payments that would otherwise be owed by the Plan, or any subsequent group health plan provided by the Plan Sponsor. Thereafter, the Third Party Administrator, on behalf of the Plan Administrator, shall have no obligation to provide any further benefits or make any further payment until the Participant has incurred medical expenses in treatment of such injury, harm or loss equal to such Special Credit.

A Participant has a duty to notify the Plan within 10 days of the date when any notice is given to any party (including an insurance company or attorney) of the Participant's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition for which the Plan has paid benefits or has agreed to pay benefits. The Participant must also provide notice to the Plan of any recovery the Participant (or the Participant's agent) obtains prior to receipt of such recovery or within five days if no notice was given prior to receipt. Further, the Participant agrees to provide notice prior to any disbursement of settlement or any other recovery funds obtained.

If a Participant makes a recovery from a third party and does not reimburse the Plan for benefits that arise from the illness or injury, the Participant will be personally liable to the Plan for the amount of benefits paid under the Plan, and the Plan may reduce future benefits payable for any illness or injury by the amount of the payment that the Participant received from the third party.

XIV. Statements

In the absence of fraud, all statements made by an Eligible Employee or Participant shall be deemed representations and not warranties, and no statement made for the purpose of acquiring coverage under the Plan shall void such coverage under this Summary of Health Care Benefits or reduce benefits unless contained in a written instrument signed by the Plan Sponsor or the enrolled person.

XV. Out-of-Area Services

Overview

The Third Party Administrator has a variety of relationships with other Blue Cross and/or Blue Shield Licensees referred to generally as "Inter-Plan Arrangements." These Inter-Plan Arrangements operate under rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever Participants access healthcare services outside the geographic area served by the Third Party Administrator, the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described generally below.

Typically, when accessing care outside the geographic area served by the Third Party Administrator, Participants obtain care from healthcare Providers that have a contractual agreement ("participating Providers") with the local Blue Cross and/or Blue Shield Licensee in that other geographic area ("Host Blue"). In some instances, Participants may obtain care from healthcare Providers in the Host Blue geographic area that do not have a contractual agreement ("nonparticipating Providers") with the Host Blue. The Third Party Administrator remains responsible for fulfilling its contractual obligations. The Third Party Administrator's payment practices in both instances are described below.

This disclosure describes how claims are administered for Inter-Plan Arrangements and the fees that are charged in connection with Inter-Plan Arrangements. Note that Dental Care Benefits, except when not paid as medical claims/benefits, and those Prescription Drug Benefits or Vision Care Benefits that may be administered by a third party contracted by the Third Party Administrator to provide the specific service or services are not processed through Inter-Plan Arrangements.

A. BlueCard® Program

The BlueCard® Program is an Inter-Plan Arrangement. Under this Arrangement, when Participants access Covered Services within the geographic area served by a Host Blue/outside the geographic area served by the Third Party Administrator, the Host Blue will be responsible for contracting and handling all interactions with its participating healthcare Providers. The financial terms of the BlueCard Program are described generally below.

1. Liability Calculation Method Per Claim – In General

a. Participant Liability Calculation

Unless subject to a fixed dollar copayment, the calculation of the Participant liability on claims for Covered Services will be based on the lower of the participating Provider's billed charges for Covered Services or the negotiated price made available to the Third Party Administrator by the Host Blue.

b. The Plan Sponsor Liability Calculation

The calculation of the Plan Sponsor liability on claims for Covered Services processed through the BlueCard Program will be based on the negotiated price made available to the Third Party Administrator by the Host Blue under the contract between the Host Blue and the Provider. Sometimes, this negotiated price may be greater for a given service or services than the billed charge in accordance with how the Host Blue has negotiated with its participating healthcare Provider(s) for specific healthcare services. In cases where the negotiated price exceeds the billed charge, the Plan Sponsor may be liable for the excess amount even when the Participant's deductible has not been satisfied. This excess amount reflects an amount that may be necessary to secure (a) the Provider's participation in the network and/or (b) the overall discount negotiated by the Host Blue. In such a case, the entire contracted price is paid to the Provider, even when the contracted price is greater than the billed charge.

2. Claims Pricing

Host Blues determine a negotiated price, which is reflected in the terms of each Host Blue's Provider contracts. The negotiated price made available to the Third Party Administrator by the Host Blue may be represented by one of the following:

(i) An actual price. An actual price is a negotiated rate of payment in effect at the time a claim is processed without any other increases or decreases; or

(ii) An estimated price. An estimated price is a negotiated rate of payment in effect at the time a claim is processed, reduced or increased by a percentage to take into account certain payments negotiated with the Provider and other claim- and non-claim-related transactions. Such transactions may include, but are not limited to, anti-fraud and abuse recoveries, Provider refunds not applied on a claim-specific basis, retrospective settlements and performance-related bonuses or incentives; or

(iii) An average price. An average price is a percentage of billed charges for Covered Services in effect at the time a claim is processed representing the aggregate payments negotiated by the Host Blue with all of its healthcare Providers or a similar classification of its Providers and other claim- and non-claim-related transactions. Such transactions may include the same ones as noted above for an estimated price.

The Host Blue determines whether it will use an actual, estimated or average price. The use of estimated or average pricing may result in a difference (positive or negative) between the price the Plan Sponsor pay on a specific claim and the actual amount the Host Blue pays to the Provider. However, the BlueCard Program requires that the amount paid by the Participant and the Plan Sponsor is a final price; no future price adjustment will result in increases or decreases to the pricing of past claims.

Any positive or negative differences in estimated or average pricing are accounted for through variance accounts maintained by the Host Blue and are incorporated into future claim prices. As a result, the amounts charged to the Plan Sponsor will be adjusted in a following year, as necessary, to account for over- or underestimation of the past years' prices. The Host Blue will not receive compensation from how the estimated price or average price methods, described above, are calculated. Because all amounts paid are final, neither positive variance account amounts (funds available to be paid in the following year), nor negative variance amounts (the funds needed to be received in the following year), are due to or from the Plan Sponsor. If the Plan Sponsor terminates, you will not receive a refund or charge from the variance account.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated/drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

3. BlueCard Program Fees and Compensation

The Plan Sponsor understands and agrees to reimburse the Third Party Administrator for certain fees and compensation which the Third Party Administrator are obligated under the BlueCard Program to pay to the Host Blues, to the Association and/or to vendors of BlueCard Program-related services. The specific BlueCard Program fees and compensation that are charged to the Plan Sponsor are set forth in Appendix A. BlueCard Program Fees and compensation may be revised from time to time as described in section G. below.

B. Special Cases: Value-Based Programs

Value-Based Programs Overview

The Plan Sponsor's Participants may access Covered Services from Providers that participate in a Host Blue's Value-Based Program. Value-Based Programs may be delivered either through the BlueCard Program or a Negotiated Arrangement. These Value-Based Programs may include, but are not limited to, Accountable Care Organizations, Global Payment/Total Cost of Care arrangements, Patient Centered Medical Homes and Shared Savings arrangements.

Value-Based Programs under the BlueCard Program
Value-Based Programs Administration

Under Value-Based Programs, a Host Blue may pay Providers for reaching agreed-upon cost/quality goals in the following ways:

The Host Blue may pass these Provider payments to the Third Party Administrator, which the Third Party Administrator will pass directly on to the Plan Sponsor as either an amount included in the price of the claim or an amount charged separately in addition to the claim.

When such amounts are included in the price of the claim, the claim may be billed using one of the following pricing methods, as determined by the Host Blue:

(i) Actual Pricing: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is part of the claim. These charges are passed to the Plan Sponsor via an enhanced Provider fee schedule.
(ii) Supplemental Factor: The charge to accounts for Value-Based Programs incentives/Shared Savings settlements is a supplemental amount that is included in the claim as an amount based on a specified supplemental factor (e.g., a small percentage increase in the claim amount). The supplemental factor may be adjusted from time to time.

When such amounts are billed separately from the price of the claim, they may be billed as follows:

- Per Member Per Month (PMPM) Billings: Per Member Per Month billings for Value-Based Programs incentives/Shared Savings settlements to accounts are outside of the claim system. The Third Party Administrator will pass these Host Blue charges directly through to the Plan Sponsor as a separately identified amount on the group billings.

The amounts used to calculate either the supplemental factors for estimated pricing or PMPM billings are fixed amounts that are estimated to be necessary to finance the cost of a particular Value-Based Program. Because amounts are estimates, there may be positive or negative differences based on actual experience, and such differences will be accounted for in a variance account maintained by the Host Blue (in the same manner as described in the BlueCard claim pricing section above) until the end of the applicable Value-Based Program payment and/or reconciliation measurement period. The amounts needed to fund a Value-Based Program may be changed before the end of the measurement period if it is determined that amounts being collected are projected to exceed the amount necessary to fund the program or if they are projected to be insufficient to fund the program.

At the end of the Value-Based Program payment and/or reconciliation measurement period for these arrangements, Host Blues will take one of the following actions:

- Use any surplus in funds in the variance account to fund Value-Based Program payments or reconciliation amounts in the next measurement period.
- Address any deficit in funds in the variance account through an adjustment to the PMPM billing amount or the reconciliation billing amount for the next measurement period.

The Host Blue will not receive compensation resulting from how estimated, average or PMPM price methods, described above, are calculated. If the Plan Sponsor terminates, you will not receive a refund or charge from the variance account. This is because any resulting surpluses or deficits would be eventually exhausted through prospective adjustment to the settlement billings in the case of Value-Based Programs. The measurement period for determining these surpluses or deficits may differ from the term of the Plan.

Variance account balances are small amounts relative to the overall paid claims amounts and will be liquidated/drawn down over time. The timeframe for their liquidation depends on variables, including, but not limited to, overall volume/number of claims processed and variance account balance. Variance account balances may earn interest, and interest is earned at the federal funds or similar rate. Host Blues may retain interest earned on funds held in variance accounts.

Note: Participants will not bear any portion of the cost of Value-Based Programs except when a Host Blue uses either average pricing or actual pricing to pay Providers under Value-Based Programs.

Care Coordinator Fees

Host Blues may also bill the Third Party Administrator for Care Coordinator Fees for Provider services which we will pass on to the Plan Sponsor as follows:

1. PMPM billings; or
2. Individual claim billings through applicable care coordination codes from the most current editions of either Current Procedural Terminology (CPT) published by the American Medical Association (AMA) or Healthcare Common Procedure Coding System (HCPCS) published by the U.S. Centers for Medicare and Medicaid Services (CMS).

As part of the Plan, the Third Party Administrator and the Plan Sponsor will not impose Participant Cost Sharing for Care Coordinator Fees.

Value-Based Programs under Negotiated Arrangements

If the Third Party Administrator has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to the Plan Sponsor's Participants, the Third Party Administrator will follow the same procedures for Value-Based Programs administration and Care Coordination Fees as noted in the BlueCard Program section.

Exception: For negotiated arrangements, when Control/Home Licensees have negotiated with accounts to waive member Cost Sharing for care coordinator fees, the following provision will apply: As part of the Plan, the Third Party Administrator and the Plan Sponsor have agreed to waive Participant Cost Sharing for care coordinator fees.

C. Prepayment Review and Return of Overpayments

If a Host Blue conducts prepayment review activities including, but not limited to, data mining, itemized bill reviews, secondary claim code editing, and DRG audits, the Host Blue may bill the Third Party Administrator up to a maximum of 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by the Third Party Administrator and the Host Blue. If a Host Blue engages a third party to perform these activities on its behalf, the Host Blue may bill the Third Party Administrator the lesser of the full amount of the third-party fees or up to 16 percent of the savings identified, unless an alternative reimbursement arrangement is agreed upon by the Third Party Administrator and the Host Blue.

Recoveries from a Host Blue or its participating and nonparticipating Providers can arise in several ways, including, but not limited to, anti-fraud and abuse recoveries, audits/healthcare Provider/hospital bill audits, credit balance audits, utilization review refunds and unsolicited refunds. Recoveries will be applied so that corrections will be made, in general, on either a claim-by-claim or prospective basis. If recovery amounts are passed on a claim-by-claim basis from a Host Blue to the Third Party Administrator they will be credited to the Plan Sponsor's account. In some cases, the Host Blue will engage a third party to assist in identification or collection of recovery amounts.

Unless otherwise agreed to by the Host Blue, for retroactive cancellations of membership, the Third Party Administrator will request the Host Blue to provide full refunds from participating healthcare Providers for a period of only one year after the date of the Inter-Plan financial settlement process for the original claim. For Care Coordinator Fees associated with Value-Based Programs, the Third Party Administrator will request such refunds for a period of only up to ninety (90) days from the termination notice transaction on the payment innovations delivery platform. In some cases, recovery of claim payments associated with a retroactive cancellation may not be possible if, as an example, the recovery (a) conflicts with the Host Blue's state law or healthcare Provider contracts, (b) would result from Shared Savings and/or Provider Incentive arrangements or (c) would jeopardize the Host Blue's relationship with its participating healthcare Providers, notwithstanding to the contrary any other provision of the Plan.

D. Inter-Plan Programs: Federal/State Taxes/Surcharges/Fees

In some instances, federal or state laws or regulations may impose a surcharge, tax or other fee that applies to self-funded accounts. If applicable, the Third Party Administrator will disclose any such surcharge, tax or other fee to the Plan Sponsor.

E. Nonparticipating Providers Outside the Third Party Administrator's Service Area

Please refer to the Additional Amount of Payment Provisions section in this Summary of Health Care Benefits.

F. Blue Cross Blue Shield Global Core

1. General Information

If Participants are outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands (hereinafter: "BlueCard service area"), they may be able to take advantage of BCBS Global Core when accessing Covered Services. BCBS Global Core is unlike the BlueCard Program available in the BlueCard service area in certain ways. For instance, although BCBS Global Core assists Participants with accessing a network of Inpatient, outpatient and professional Providers, the network is not served by a Host Blue. As such, when Participants receive care from Providers outside the BlueCard service area, the Participants will typically have to pay the Providers and submit the claims themselves to obtain reimbursement for these services.

- **Inpatient Services**

  In most cases, if Participants contact the BCBS Global Core Service Center for assistance, hospitals will not require Participants to pay for covered Inpatient services, except for their deductibles, Cost Sharing, etc. In such cases, the hospital will submit Participant claims to the BCBS Global Core service center to initiate claims processing. However, if the Participant paid in full at the time of service, the Participant must submit a claim to obtain reimbursement for Covered Services. **Participants must contact Blue Cross of Idaho to obtain precertification for non-emergency Inpatient services.**

- **Outpatient Services**

  Physicians, urgent care centers and other outpatient Providers located outside the BlueCard service area will typically require Participants to pay in full at the time of service. Participants must submit a claim to obtain reimbursement for Covered Services.

- **Submitting a BCBS Global Core Claim**

When Participants pay for Covered Services outside the BlueCard service area, they must submit a claim to obtain reimbursement. For institutional and professional claims, Participants should complete a BCBS Global Core claim form and send the claim form with the Provider's itemized bill(s) to the BCBS Global Core service center address on the form to initiate claims processing. The claim form is available from Blue Cross of Idaho, the BCBS Global Core service center, or online at www.bcbsglobalcore.com. If Participants need assistance with their claim submissions, they should call the BCBS Global Core service center at 1.800.810.BLUE (2583) or call collect at 1.804.673.1177, 24 hours a day, seven days a week.

2. BCBS Global Core-Related Fees

The Employer understands and agrees to reimburse Blue Cross of Idaho for certain fees and compensation which we are obligated under applicable Inter-Plan Arrangement requirements to pay to the Host Blues, to the Association and/or to vendors of Inter-Plan Arrangement-related services. The specific fees and compensation that are charged to the Employer under BCBS Global Core are set forth in Appendix A. Fees and compensation under applicable Inter-Plan Arrangements may be revised from time to time as provided for in section G. below.

G. Modifications or Changes to Inter-Plan Arrangement Fees or Compensation

Modifications or changes to Inter-Plan Arrangement fees are generally made effective Jan. 1 of the calendar year, but they may occur at any time during the year.

XVI. Individual Benefits Management

Individual Benefits Management allows the Third Party Administrator to provide alternative benefits in place of specified Covered Services when alternative benefits allow the Participant to achieve optimum health care in the most cost-effective way.

The decision to allow alternative benefits will be made by the Third Party Administrator in its sole and absolute discretion on a case-by-case basis. The Third Party Administrator may allow alternative benefits in place of specified Covered Services when a Participant, or the Participant's legal guardian and their Physician concur in the request for and the advisability of alternative benefits. The Third Party Administrator reserves the right to modify, limit, or cease providing alternative benefits at any time.

A determination to cover alternative benefits for a Participant shall not be deemed to waive, alter, or affect the Third Party Administrator's right to reject any other requests or recommendations for alternative benefits.

XVII. Coverage and Benefits Determination

The Plan Sponsor has the authority and fiduciary discretion to determine eligibility for participation in the Plan in accordance with the terms of the Plan. The Claims Administrator is vested with authority and fiduciary discretion to determine whether a claim for benefits is covered under the terms of this Summary of Health Care Benefits, based on all the terms and provisions set forth in this Summary of Health Care Benefits, and also to determine the amount of benefits owed on claims which are covered.

XVIII. Health Care Providers Outside the United States

The benefits available under the Plan are also available to Participants traveling or living outside the United States. The Inpatient Notification and Prior Authorization requirements will apply. If the Provider is a Contracting Provider with BlueCard, the Contracting Provider will submit claims for reimbursement on behalf of the Participant. Reimbursement for Covered Services will be made directly to the Contracting Provider. If the Health Care Provider does not participate with BlueCard, the Participant will be responsible for payment of services and submitting a claim for reimbursement to the Third Party Administrator. The Third Party Administrator will require the original claim along with an English translation. It is the Participant's responsibility to provide this information.

The Third Party Administrator will reimburse covered Prescription Drugs purchased outside the United States by Participants who live outside the United States where no suitable alternative exists. Reimbursement will also be made in instances where Participants are traveling and new drug therapy is initiated for acute conditions or where emergency replacement of drugs originally prescribed and purchased in the United States is necessary. The reimbursable supply of drugs in travel situations will be limited to an amount necessary to assure continuation of therapy during the travel period and for a reasonable period thereafter.

Finally, there are no benefits for services, supplies, drugs or other charges that are provided outside the United States, which if had been provided in the United States, would not be a Covered Service under this Summary of Health Care Benefits.

XIX. Refunds, Settlements and Other Payments

If the Plan receives any refund, settlement or other payment related to Plan activities, the payment will first be paid over to Micron Technology, Inc. until all amounts Micron Technology, Inc. has paid toward Plan expenses out of the general assets of Micron Technology, Inc. have been repaid. Further payments will then be paid to the Participants in a pro-rata manner or such other manner as is deemed equitable under the circumstances by the Plan Administrator in its sole and absolute discretion.

XX. Electronic Delivery

Any reference in the Plan to a "written" agreement or document will include any agreement or document delivered electronically or posted on the Third Party Administrator's website or Plan Administrator's intranet (or other shared electronic medium controlled by the Third Party Administrator or the Plan Administrator to which the Participant has access). Any such agreements or documents signed by electronic signature will be treated by the Plan in the same manner as if such signature was made by hand.

XXI. Newborns' and Mothers' Health Protection Act of 1996

Employer health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). The Medical Plans comply with this law.

XXII. Women's Health and Cancer Rights Act of 1998

The Medical Plans, as required by the Women's Health and Cancer Rights Act of 1998, provide benefits for mastectomy-related services including all stages of reconstruction of the breast on which the mastectomy was performed as well as reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from a mastectomy including lymphedema. Keep this notice for your records and call Micron's HR Customer Service Center at (800) 336-8918 or (208) 368-4748 for more information.