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.

PPO DENTAL PLUS 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)

PPO DENTAL PLUS 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 PPO Dental Plus Plan 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.

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.

If Participants receive this document and/or any other Plan notices electronically, Participants have the right to receive paper copies of the electronic documents, including summary plan descriptions and plan amendments, upon request at no additional charge.

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 1-800-627-1188 (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 1-800-627-1188 (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 दनुिहोस्: तपाईंले नेपाली बोलनुहुन्छ भने तपाईंको नमिति 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).

PREFERRED DENTAL PLAN BENEFITS (PPO)		
For Covered Providers and Services	**In-Network**	**Out-of-Network**
Benefit Limit	$3,000 per Participant, per Benefit Period	
Orthodontic Lifetime Limit	$3,000 per Participant	
Deductible: Individual	Participant pays $50 per Benefit Period (Deductible does not apply to Preventive Dental Covered Services)	
Family	The Benefit Period Family Deductible is satisfied after three (3) Participants of the same family have met their Individual Deductible (No Participant may contribute more than the Individual Deductible amount toward the Family Deductible)	
	In-Network	**Out-of-Network**
PREFERRED DENTAL PLAN BENEFITS (PPO)	(Deductible does not apply to Preventive Dental Covered Services)	
Preventive Dental Services	Plan pays 100% of Maximum Allowance	Plan pays 90% of Maximum Allowance
Basic Dental Services	Plan pays 90% of Maximum Allowance after Deductible	Plan pays 70% of Maximum Allowance after Deductible
Major Dental Services	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible
Orthodontic Services	Plan pays 80% of Maximum Allowance after Deductible	Plan pays 50% of Maximum Allowance after Deductible

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(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

DENTAL PLAN BENEFITS SECTION

PREFERRED DENTAL PLAN *(PPO Option)*
This section specifies the benefits a Participant is entitled to receive for the Dental Covered Services described, subject to other provisions of this Summary of Health Care Benefits.

I. Benefit Period and Benefit Limits for Covered Services

The Benefit Period and the benefit limits are shown in the Benefit Summary. Please see the cover page of this Summary of Health Care Benefits for the Benefit Period.

II. Covered Providers

The following are Covered Providers under this section:

- Dentist
- Denturist

III. Deductibles

The Benefit Summary will show applicable individual and family Deductibles.

IV. Predetermination of Benefits

A recommended Dental Treatment Plan should be submitted to the Third Party Administrator for a Predetermination of Benefits before treatment begins if the Plan includes one (1) or more of the following procedures:

A.	Bridgework	**E.**	Laminate Veneers
B.	Crowns	**F.**	Periodontal Surgery
C.	Full or Partial Dentures	**G.**	Surgical Removal of Impacted Teeth
D.	Inlays/Onlays	**H.**	Implants

The Dental Treatment Plan must be accompanied by supporting the most current preoperative x-rays and any other appropriate diagnostic materials requested by the Claims Administrator or the Dental Consultant(s) to help make a benefit decision.

The Claims Administrator will notify the Participant and their Dentist of the benefits available based upon the Dental Treatment Plan. In determining the amount of benefits available, the Claims Administrator or the Dental Consultant(s) will consider whether alternate procedures would accomplish a professionally satisfactory result. If the charges or fees for the treatment chosen by the Participant and their Dentist exceed the charges or fees for the treatment the Claims Administrator has determined will accomplish a professionally satisfactory result, then the Third Party Administrator will only provide benefits based on the charges or fees for the less costly treatment.

If a Participant submits a claim for completed treatment that includes services in the above listed categories, and benefits have not been predetermined by the Claims Administrator the claim is reviewed in the same manner as if it were being submitted for a Predetermination of Benefits. The Claims Administrator or the Dental Consultant(s) will consider whether alternate procedures would have accomplished a professionally satisfactory result. If the Participant and their Dentist have chosen a more expensive method of treatment than is determined professionally satisfactory by the Claims Administrator the excess charge is solely the responsibility of the Participant, whether services are provided by a Contracting or Noncontracting Provider.

A Predetermination of Benefits is valid for six (6) months from the date it is issued. After six (6) months, a Dental Treatment Plan must be resubmitted for a new Predetermination of Benefits before treatment begins. All Predetermination of Benefits will be processed without taking into consideration dental benefits that may be paid under another certificate of insurance.

V. Amount of Payment

Except as stated elsewhere in this Summary of Health Care Benefits, the Third Party Administrator, on behalf of the Plan Administrator, will pay benefits for Preventive, Basic, and Major Dental Covered Services after a Participant has satisfied their Deductible, if applicable. The reimbursement schedule is shown in the Benefit Summary.

Benefits for Orthodontic Services are paid as follows:

1. Plan will pay benefits on the patient's initial banding.
2. Thereafter, the Third Party Administrator, on behalf of the Plan Administrator, will pay benefits up to the Orthodontic Lifetime Benefit Limit as Covered Services are performed so long as the Participant continues orthodontic treatment and remains covered under this Summary of Health Care Benefits.

A. Dental Services Outside Idaho

For Dental Covered Services furnished by a Dentist outside the state of Idaho, the Third Party Administrator, on behalf of the Plan Administrator, will provide benefit payments according to the following:

1. If the Dentist has a PPO or Traditional agreement for claims payment with the Blue Cross and/or Blue Shield plan or an affiliate in the area where the Covered Services were rendered, the Third Party Administrator will base the payment on the local plan's payment arrangement and allow In-Network benefits.
2. If the Dentist does not have a PPO or Traditional agreement for claims payment with the Blue Cross and/or Blue Shield plan or an affiliate in the area where the Covered Services are rendered, the Third Party Administrator will base the payment on the Maximum Allowance and allow Out-of-Network benefits.

The Dentist is not obligated to accept the Maximum Allowance as payment in full. Neither the Third Party Administrator or the Plan Administrator is responsible for the difference, if any, between the Third Party Administrator's payment and the actual charge, unless otherwise specified. Participants are responsible for any such difference, including Deductibles, Cost Sharing, Copayments, charges for noncovered services, and the amount charged by the Dentist in excess of the Maximum Allowance.

B. Dental Services from a Contracting Dentist

A Contracting Dentist rendering Covered Services as provided in this section shall not make an additional charge to a Participant for amounts in excess of the Maximum Allowance except for Deductible, Cost Sharing, and charges for noncovered services, if any. A Contracting Dentist is not obligated to accept the Third Party Administrator's Maximum Allowance for services provided after any Benefit Period or lifetime maximum limit or frequency limitations. In this instance, Participants are responsible for any difference between the amount charged by the Contracting Dentist and the Maximum Allowance.

C. Dental Services from a Noncontracting Dentist

A Noncontracting Dentist is not obligated to accept the Maximum Allowance as payment in full. Neither the Third Party Administrator or the Plan Administrator is responsible for the difference, if any, between the Third Party Administrator's payment and the actual charge, unless otherwise specified. Participants are responsible for any such difference, including Deductibles, Cost Sharing, Copayments, charges for noncovered services, and the amount charged by the Noncontracting Dentist that exceed the Maximum Allowance.

VI. Closed List of Dental Covered Services

The following is a complete list of Dental Covered Services for which benefits are available. Only those services included on this list are eligible for payment.

Refer to Benefit Summary for applicable Waiting Periods.

A. Type I: Preventive Dental Services

1. Oral examination—limited to two (2) per Benefit Period.
2. Emergency oral examination—limited to one (1) per Benefit Period, covered for trauma, acute infection, or acute pain.
3. Complete mouth series or panoramic x-ray—limited to one (1) time in any five (5) consecutive Benefit Period, unless requested by the Claims Administrator for verification of treatment claimed.
4. Individual periapical x-rays—limited to the same benefit as a complete mouth series or panoramic x-ray. Individual periapical x-rays are not covered when performed during or at the completion of a root canal therapy as an intra-operative procedure.
5. Occlusal l x-rays—limited to once per Benefit Period.
6. Extraoral x-rays – limited to once per Benefit Period.

7. Bitewing x-rays—limited to once per Benefit Period. Limited to the same benefit as a complete mouth series or panoramic x-ray.
8. Dental prophylaxis—limited to two (2) per Benefit Period.
9. Fluoride treatments—limited to two (2) applications per Benefit Period and limited to Participants who are under age nineteen (19).
10. Palliative treatment—paid as a separate benefit only if no other treatment is rendered during the visit.
11. Topical application of sealants per tooth—limited to permanent posterior first (1^{st}) and second (2^{nd}) molars unrestored of Participants under age nineteen (19). Also limited to one (1) time per tooth in any three (3) years.

B. Type II: Basic Dental Services

1. Amalgam restorations—posterior restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of unique surfaces treated. Same tooth surface restoration is covered once in a two (2) year period.
2. Pin retention.
3. Resin-Composite restorations—posterior restorations involving multiple surfaces will be combined for benefit purposes and paid according to the number of unique surfaces treated. Same tooth surface restoration is covered once in a two (2) year period.
4. Simple extractions.
5. Surgical removal of an erupted or partially erupted tooth or mucoperiosteal flap or incision of soft tissue.
6. Alveoloplasty and alveolectomy—not separately payable if performed on the same date as an extraction.
7. General anesthesia.
8. I.V. sedation.
9. Pulp cap (direct or indirect).
10. Pulpotomy.
11. Root canal therapy—multiple endodontic treatments, on the same tooth within a period of one (1) year, are subject to review and approval by the Claims Administrator.
12. Scaling and root planing—limited to once per area of the mouth, every two (2) years.
13. Periodontal maintenance—limited to four (4) per Benefit Period. Requires prior periodontal treatment.
14. Gingivectomy—one (1) such surgical procedure per area, once every three (3) years.
15. Osseous Surgery—one (1) such surgical procedure per area, once every three (3) years.
16. Osseous grafts—only autogenous grafts are covered every three (3) years per area. Synthetic grafting techniques are not covered.
17. Pedicle grafts—once every three (3) years per area.
18. Free soft tissue grafts—once every three (3) years per area.
19. Occlusal guard—covered for erosion or abrasion for one (1) appliance every two (2) years.
20. Space maintainers—limited to Participants who are under age sixteen (16). Benefits limited to deciduous teeth. Includes all adjustments made within six (6) months of installation.
21. Full Mouth Debridement—limited to one time in a three (3) year period.
22. Sedative Fillings.
23. Localized delivery of chemotherapeutic/antimicrobial agents—up to a maximum of four (4) teeth at once per visit. Not allowed on the initial scaling and root planing visit.

C. Type III: Major Dental Services

Benefits for the services listed below include an allowance for all temporary restorations and appliances and for one (1) year follow-up care:

1. Synthetic bone grafting procedures.
2. Periodontal splinting procedures.
3. Recement inlays; recement crowns; recement bridges.
4 Crown build-up—cover to support and retain a crown.
5. Tissue conditioning—limited to repairs or adjustments performed more than twelve (12) months after the initial insertion of prosthesis.
6. Repairs to full dentures, repairs to partial dentures, and/or repairs to bridges—limited to repairs performed more than twelve (12) months after the initial insertion of prosthesis.
7. Repairs to crowns.

8. Inlays and onlays—covered only when the teeth cannot be restored by a filling, and only if more than seven (7) years have elapsed since the last placement. If a tooth can be restored with a filling, the benefit will be limited to the allowable benefit for an amalgam or composite restoration.
9. Crowns and laminate veneers—covered only when the tooth has visible destruction of tooth surface from decay and the tooth cannot be restored by a filling. Benefits will not be allowed when placement of the crown or veneer is for micro fractures, stress fractures, or craze lines. Coverage is available if more than one-third (1/3) of the tooth is missing due to accident or erosion. Coverage is allowed if more than seven (7) years have elapsed since the last placement. For Participants under age sixteen (16), benefits are limited to plastic/resin-based or stainless steel crowns.
10. Stainless steel crowns—covered only when the tooth has visible destruction of tooth surface from decay and the tooth cannot be restored by a filling. Benefits will not be allowed when placement of the crown or veneer is for micro fractures, stress fractures, or craze lines. Coverage is available if more than one-third (1/3) of the tooth is missing due to accident. Coverage is allowed if more than seven (7) years have elapsed since the last placement.
11. Post and core.
12. Full dentures—includes all adjustments within six (6) months of installation. Replacement of a denture is covered only if the existing denture is more than seven (7) years old and cannot be repaired. There are no additional benefits for overdentures or customized dentures.
13. Partial dentures—includes all clasps and rests, all teeth, and all adjustments within six (6) months of installation. Replacement of a partial denture with another denture is eligible for benefits only if the existing denture is more than seven (7) years old and cannot be repaired.
14. Denture adjustments—one (1) adjustment per Benefit Period and only if performed more than six (6) months after the insertion of the denture.
15. Relining dentures—Relines performed twelve (12) months after initial placement and no more than once in two (2) years.
16. Fixed bridges—upgrading from a partial denture to fixed bridgework is covered only if the patient's arch cannot be adequately restored with a partial denture. Replacement of an existing fixed bridge or partial denture is eligible only if the existing appliance is more than seven (7) years old and cannot be repaired.
17. Implants, including the implant body, implant abutment and implant crown.

    Implant body—limited to once per tooth, per seven (7) years. Coverage is allowed if more than seven (7) years has elapsed since the last placement of a prosthetic of any type on the tooth.

    Implant abutment—limited to once per tooth, per seven (7) years. Coverage is allowed if more than seven (7) years has elapsed since the last placement of a prosthetic of any type on the tooth.

    Implant Crown – Coverage is allowed if more than seven (7) years has elapsed since the last placement of a prosthetic of any type on the tooth.
18. Biopsy of soft or hard oral tissue (for removal of specimen only).
19. Impaction that requires incision of overlying soft tissue, elevation of a flap and either removal of bone and tooth or sectioning and removal of the tooth (extraction of tooth, partial bony impaction).
20. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, and sectioning of the tooth for removal (extraction of tooth, complete bony extraction).
21. Impaction that requires incision of overlying soft tissue, elevation of a flap, removal of bone, sectioning of the tooth for removal, and/or presents unusual difficulties and circumstances (including report).
22. Root recovery.
23. Excision of pericoronal tissues.
24. Tooth reimplantation.
25. Tooth transplantation—separate benefits are not payable for donor site charges.
26. Removal of exostosis.
27. Frenectomy (frenulectomy).
28. Excision of hyperplastic tissue.
29. Incision and drainage.
30. Radical excision (lesion diameter up to or greater than 1.25 cm)—not payable in addition to extraction performed in same site on same date.
31. Excision pericoronal gingiva (operculectomy).
32. Excision of benign tumor (lesion diameter up to or greater than 1.25 cm) —not payable in addition to extraction performed in same site on same date.

33. Removal of odontogenic cyst or tumor (diameter up to or greater than 1.25 cm)—not payable in addition to extraction performed in same site on same date.
34. Suture of small wounds.
35. Apicoectomy and retrograde filling.
36. Hemisection.
37. Ridge augmentation.
38. Bone graft.
39. Cone beam image.

D. Type IV: Orthodontic Services

1. Orthodontia or Orthodontic Treatment.

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. 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. 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.

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

Amendment (Amend)—a formal document signed by the Plan Sponsor. The Amendment adds, deletes or changes the provisions of the Plan.

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

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

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 final authority to approve or deny a claim rests with the Claims Administrator and not any Dental Consultant. 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.

Closed List of Dental Covered Services—the list of Covered Dental Services in the Dental Benefits Section for which benefits are available under this Summary of Health Care Benefits.

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.

Contracting Dentist—a Dentist who has entered into a written agreement with the Third Party Administrator regarding payment for Dental Covered Services rendered to a Participant under a PPO Dental Option. To find Contracting Dentist 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 Covered 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 Provider—a Provider specified in this Summary of Health Care Benefits from whom a Participant must receive Covered Services in order to be eligible to receive benefits.

Covered Services—services listed in the Closed List of Dental Covered Services.

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

Dental Consultant—a duly licensed dentist retained by the Claims Administrator for the purpose of advising and performing any and all services requested in connection with review of dental claims, as well as consulting and advising in the area of dentistry.

Dental Hygienist—a person licensed to practice dental hygiene who is acting under the supervision and direction of a Dentist. For the Third Party Administrator to provide benefits, the Dental Hygienist must be licensed in the state where service is rendered and the hygienist must be performing within the scope of their license.

Dental Treatment Plan—the Dentist's report of recommended treatment on a form satisfactory to the Third Party Administrator that:
1. Itemizes dental procedures by American Dental Association (ADA) code and description for the care of a Participant.
2. Lists the charges for each procedure.
3. Is accompanied by supporting most current preoperative x-rays and any other appropriate diagnostic materials reasonably required by the Claims Administrator to help make a benefit decision.

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.

Denturist—a person licensed in the state where service is rendered to engage in the practice of denturism. For the Third Party Administrator to provide benefits, the Denturist must be performing within the scope of their license.

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).

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

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.

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.

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).

Implant—a device specifically designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental tooth replacement.

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

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.

Investigational—the use of any treatment, procedure, facility, equipment, drug, device or supply that:

1. Is not yet generally recognized by Dentists practicing within the state of Idaho as accepted dental practice, or
2. Requires federal or other governmental approval, for other than Investigational purposes, and such approval has not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply is used.

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 Dentist 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.

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. Moreover, Maximum Allowance may differ depending on whether the Provider is Contracting or Noncontracting.

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

Medically Necessary (or Medical Necessity)—the Covered Service or supply recommended by the treating Covered 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 Covered Provider.
4. Cost Effective for this condition.

The fact that a Covered 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.

Noncontracting Dentist—a Dentist who has not entered into a written agreement with the Third Party Administrator regarding payment for Dental Covered Services rendered to a Participant under a PPO Dental Option. 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.

Orthodontia or Orthodontic Treatment—the movement of teeth through bone by means of active orthodontic appliances in order to correct a patient's malocclusion (misalignment of the teeth) and improve function.

Out-of-Network Services—Covered Services that are not rendered by a Contracting Dentist.

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

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

Physician—a doctor of medicine (M.D.) or doctor of osteopathy (D.O.) licensed to practice medicine by the state where services are rendered.

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.

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

PPO Dental Option—a Preferred Provider Organization (PPO) Dental Option in which a Participant receives the highest level of benefits for In-Network Services.

Predetermination of Benefits—a proposed Dental Treatment Plan and anticipated benefits for the Participant should the proposed Dental Treatment Plan be completed.

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

Provider—a Dentist, Dental Hygienist or Denturist who provides services under this Summary of Health Care Benefits and is acting within the scope of their license.

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.

Waiting Period—a specified period of enrollment that must be completed before benefits are available for certain Covered Services.

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 to the entire Summary of Health Care Benefits, unless otherwise specified.

I. General Exclusions and Limitations

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

A. Procedures that are not included in the Closed List of Dental Covered Services; or that are not Medically Necessary for the care of a Participant's covered dental condition; or that do not have uniform professional endorsement.

B. Charges for services that were started prior to the Participant's Effective Date. The following guidelines will be used to determine the date when a service is deemed to have been started:

1. For full dentures or partial dentures: on the date the final impression is taken.
2. For fixed bridges, crowns, inlays or onlays: on the date the teeth are first prepared and a final impression taken.
3. For root canal therapy: on the date the pulp chamber is opened and the canals are explored to the apex.
4. For periodontal Surgery: on the date the Surgery is actually performed.
5. For all other services: on the date the service is performed.
6. For orthodontic services, if benefits are available under this Summary of Health Care Benefits: on the date any bands or other appliances are first inserted.

C. Cast restorations (crowns, inlays or onlays) for teeth that are restorable by other means (i.e., by amalgam or composite fillings).

D. Replacement of an existing crown, inlay or onlay that was installed within the preceding seven (7) years or replacement of an existing crown, inlay or onlay that can be repaired.

E. Appliances, restorations or other services provided or performed solely to change, maintain or restore vertical dimension or occlusion.

F. A service for cosmetic purposes.

G. In excess of the Maximum Allowance.

H. A replacement of a partial or full removable denture for fixed bridgework, or the addition of teeth thereto, if involving a replacement or modification of a denture or bridgework that was installed during the preceding seven (7) years.

I. Orthodontic services and supplies unless otherwise specifically listed in the Closed List of Dental Covered Services.

J. Replacement of lost or stolen appliances.

K. Ridge augmentation procedures, unless otherwise specifically listed in the Closed List of Dental Covered Services.

L. Any procedure, service or supply other than alveoloplasty or alveolectomy required to prepare the alveolus, maxilla or mandible for a prosthetic appliance. Excluded services include, but are not limited to, vestibuloplasty, stomatoplasty and bone grafts (either synthetic or autogenous) to the alveolars, maxilla or mandible, unless otherwise specifically listed in the Closed List of Dental Covered Services.

M. Any procedure, service or supply required directly or indirectly to treat or diagnose a muscular, neural, orthopedic or skeletal disorder, dysfunction or Disease of the temporomandibular joint (jaw hinge) and its associated structures including, but not limited to, myofascial pain dysfunction syndrome.

N. Orthognathic Surgery, including, but not limited to, osteotomy, ostectomy and other services or supplies to augment or reduce the upper or lower jaw.

O. Temporary dental services. Charges for temporary services are considered an integral part of the final dental services and are not separately payable. Provisional services will be considered permanent and will have standard replacement frequencies applied.

P. Any service, procedure or supply for which the prognosis for success is not reasonably favorable as determined by the Claims Administrator at least three (3) years.

Q. Myofunctional therapy and biofeedback procedures.

R. For hospital Inpatient or Outpatient care for extraction of teeth or other dental procedures.

S. Diagnostic casts.

T. Occlusal adjustments.

U. Not prescribed by or upon the direction of a Provider.

V. Investigational in nature.

W. 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.

X. 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.

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

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

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

AB. For personal hygiene, comfort, beautification or convenience items even if prescribed by a Dentist, including but not limited to, air conditioners, air purifiers, humidifiers, physical fitness equipment or programs.

AC. For telephone consultations; 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 Third Party Administrator); or for personal mileage, transportation, food or lodging expenses or for mileage, transportation, food or lodging expenses billed by a Dentist or other Provider.

AD. For Congenital Anomalies, or for developmental malformations, unless the patient is an Eligible Dependent child.

AE. 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.

AF. 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 this provision, 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.

AG. 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.

AH. Provided to persons who were enrolled as Eligible Dependents after they cease to qualify as Eligible Dependents due to a change in Eligibility status which occurs during the Plan term.

AI. Provided outside the United States, which if had been provided in the United States, would not be Covered Services.

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

AK. For acupuncture or hypnosis.

AL. Repair, removal, cleansing or reinsertion of Implants, unless otherwise specifically listed in the Closed List of Dental Covered Services.

AM. Denture duplication.

AN. Oral hygiene instruction.

AO. Treatment of jaw fractures.

AP. Charges for acid etching.

AQ. Charges for oral cancer screening which are included in a regular oral examination.

AR. No benefits are available for replacement and/or repair of orthodontic appliances. This includes removable and/or fixed retainers.

AS. Support service(s) provided for a non-Covered Service.

II. Conditions

A. Right to Review Dental Work

Before providing benefits for Covered Services, the Third Party Administrator has the right to refer the Participant to a Dentist of its choice and at its expense to verify the need, quantity, and quality of dental work claimed as a benefit.

B. Care Rendered by More Than One (1) Dentist

If a Participant transfers from the care of one (1) Dentist during a Dental Treatment Plan, or if more than one (1) Dentist renders services for one (1) dental procedure, the Third Party Administrator will pay no more than the amount that it would have paid if only one (1) Dentist had rendered the service.

C. Alternate Treatment Plan

If a Dentist and a Participant select a Dental Treatment Plan other than that which is customarily provided by the dental profession, payments of benefits available under this section shall be limited to the Dental Treatment Plan that is the standard and most economical, according to generally accepted dental practices.

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 Covered Provider and are regularly and customarily included in such Covered Providers' charges.

C. Covered Services are subject to the availability of 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. 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. 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.

X. 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. External Review

At the Claims Administrator's discretion an additional review is available for Adverse Benefit Determinations based upon medical issues including Medical Necessity and Investigational treatment. A Participant must first exhaust both levels of the formal appeals process before submitting a request for External Review to the Appeals and Grievance Coordinator. A request for External Review must be sent within sixty (60) days of the date of the Claims Administrator's second formal written appeal decision. External Review will be made by an impartial provider, associated with an independent review organization, who practices in the same or a similar specialty as the one involved in the review. The Independent Review Organization will issue a determination within sixty (60) days of receipt of the request for External Review.

Submission of an appeal for External Review is voluntary and does not affect a Participant's right to file a civil action under section 502(a) of ERISA following the exhaustion of the formal appeals process, except that the time to file such action shall be tolled while the External Review is pending.

XI. 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.

XII . 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.

XIII. 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.

XIV. 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.

XV. 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.

XVI. 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. Reimbursement for Covered Services will be made directly to the Participant. 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.

XVII. 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.

XVIII. 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.