Participants enrolled in a High-Deductible Medical Plan are NOT eligible to participate in this Health Care Flexible Spending Account Plan. Instead, such Participants may enroll in a Health Savings Account and/or the Limited-Purpose Flexible Spending Account Plan.

Micron offers a Health Care Flexible Spending Account Plan to full-time and part-time team members pursuant to regulations issued by the IRS. Enrollment in this plan is based on your agreement to comply with the terms of the Plan as described in this Benefits Handbook, the Internal Revenue Code (IRC), and regulations issued under the IRC. The Health Care Flexible Spending Account Plan is administered by Flores & Associates.

If a Participant is enrolled in a Health Care Flexible Spending Account and subsequently enrolls in a High Deductible Medical Plan at any time during the calendar year, they are not eligible to participate in a Health Savings Account in that same calendar year. Their Health Care Flexible Spending Account will continue and will not convert to a Limited Purpose Flexible Spending Account for the remainder of the year.

The Health Care Flexible Spending Account Plan is used to pay for eligible health care expenses for you and your Eligible Dependents. You do not need to participate in Micron's medical, dental or vision plans to participate in this Plan.

The Health Care Flexible Spending Account Plan, Limited-Purpose Flexible Spending Account Plan, and Day Care Flexible Spending Account Plan are separate plans. You are not allowed to transfer unused contributions at any time from one flexible spending account plan to another.

ERISA

The Health Care Flexible Spending Account Plan is subject to ERISA. See the Additional Administrative Facts and Statement of ERISA Rights sections of this Benefits Handbook for details.

Eligibility

You are eligible to participate in this Plan if you are actively employed and classified by Micron as a regular, full-time team or part-time member of Micron Technology, Inc. ("Micron") or a wholly owned US-based Micron subsidiary and you are not enrolled in a High-Deductible Medical Plan.

Definition of a Team Member. Team members are those individuals who are considered an employee of Micron as classified by Micron under its standard personnel practices, regardless of whether or not such person may be considered a common law employee or independent contractor for purposes of federal income tax withholding or other purposes. For example, the following persons are not employees for purposes of this Plan:

- leased employees, as defined in Internal Revenue Code Section 414(n),
- individuals classified by Micron as independent contractors, temporary workers or leased employees (including those who are at any time reclassified by the Internal Revenue Service, a court of competent jurisdiction or otherwise), and
- individuals who are seconded to an employer participating in this Plan.

Ineligible Team Members. You are ineligible to participate in this Plan if:

- You are an intern,
- You are an individual whose terms and conditions of employment are governed by a collective bargaining agreement (unless the collective bargaining ageement expressly provides for this benefit),
- You are an individual who has waived participation in the Plan through any means including individuals whose employment is governed by a written agreement with Micron (including an offer letter setting forth the terms and conditions of employment) that provides that the individual is not eligible to participate in the Plan or
  you are enrolled in a High-Deductible Medical Plan.

Definition of Full-Time. A full-time team member is a team member who is actively

employed and classified as full-time by Micron.

Definition of Part-Time. A part-time team member is a team member who is actively employed and classified as part-time by Micron.

Definition of Intern. An intern is a team member who is actively employed and classified as an Intern by Micron.

Eligibility upon Re-Employment. If your employment with Micron has terminated for at least 31 days and you are later re-employed by Micron or another wholly owned or US-based Micron subsidiary that participates in this Plan, you are required to meet the applicable eligibility (described above) and enrollment (described below) requirements before coverage begins.

Eligibility During a Leave of Absence. Your participation in this Plan will automatically continue while on a Micron approved leave of absence provided you pay all of your contributions accrued during the approved leave of absence. You also have the option to stop coverage while you are on a leave of absence. See the "Leave of Absence" section for more information on stopping coverage and important implications as a result of stopping coverage.

An approved leave of absence is your absence from assigned work, which has been approved by Micron under standard human resource policies, applied in a nondiscriminatory manner to all team members, including:

- an approved leave of absence for up to 24 weeks in any 12-month period qualifying under the Family and Medical Leave Act of 1993 ("FMLA") or 26 weeks in any 12-month period under the Service Member Family Leave ("SMFL") for Caregiver Leave,
- an approved personal leave of absence,
- An approved Birth and Adoption leave of absence,
- an approved leave of absence in accordance with other state law, and
- an approved military leave of absence as a result of duty in the uniformed services including service in the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, certain types of service in the National Disaster Medical System, and any other category of persons designated by the President of the United States in time of war or emergency.

If you have not returned to full-time or part-time active employment after 24 (or 26 if SMFL for Caregiver Leave) consecutive calendar weeks of an approved leave of absence, you are no longer eligible to participate in this Plan and your participation will end on the last day of the month in which your leave reaches 24 (or 26 if SMFL for Caregiver Leave) consecutive calendar weeks. There is one exception to this rule.

- If you are on a state or federal mandated leave of absence that requires coverage to continue for a specified period of time under this Plan, your participation will continue through the time specified in that regulation. Examples of state or federal mandated leaves of absence that require coverage to continue for a specified period of time include the Uniformed Services Employment and Re-employment Act, and the Family and Medical Leave Act.

If you return to full-time or part-time active employment after being gone for 24 (or 26 if SMFL for Caregiver Leave) consecutive calendar weeks on an approved personal leave of absence, an approved leave of absence in accordance with state law, a FMLA leave of absence, or an approved military leave of absence within the guidelines outlined in the Uniformed Services Employment and Reemployment Act, you are eligible to re-enroll.

Benefits Enrollment System

You must use the Benefits Enrollment System: enrollnow.micron.com from outside Micron (using DUO Authenticator), or type ENROLLNOW/ in your browser's address bar.

Initial Enrollment

You are not automatically enrolled in this Plan. You may enroll by using the Benefits Enrollment System: enrollnow.micron.com from outside Micron (using DUO Authenticator), or type ENROLLNOW in your

Micron web browser address bar within 30 days of your hire date to have coverage.

How to Enroll. You enroll by using the Benefits Enrollment System: enrollnow.micron.com from outside Micron (using DUO Authenticator), or type ENROLLNOW in your Micron web browser address bar within 30 days of your hire date.

When to Enroll. You may only enroll in this Plan within 30 days of your hire date.

Changing your Enrollment. Subject to the provisions described in the "Midyear Enrollment Changes" section, once you have submitted your enrollment, you will not be able to change the coverage until the next Annual Enrollment.

Enrollment Effective Date. If you enroll timely, the Effective Date of coverage is the first day of the calendar month following your date of hire. This may result in retroactive coverage, depending on when you enroll. As a result, your first paycheck after enrollment could have multiple deductions to cover the retroactive period and the current period. Your FSA annual election will be divided evenly over the remaining paychecks in the year.

Enrollment Effective Date for Transfers. If you transfer from a wholly owned US-based Micron subsidiary, the Effective Date of coverage is the first day of the calendar month following your date of hire or your transfer date. This may result in retroactive coverage, depending on when you enroll. As a result, your first paycheck after enrollment could have multiple deductions to cover the retroactive period and the current period. Your FSA annual election will be divided evenly over the remaining paychecks in the year.

If you are transferring to Micron or another wholly owned US-based Micron subsidiary directly into an eligible position (as described above) from a wholly owned foreign Micron subsidiary, the Effective Date of coverage is the first day of the calendar month following the date of your transfer.

Confirmation of Enrollment. It is your responsibility to print and review your enrollment benefit confirmation statement. You can access a benefit summary or benefit confirmation at any time on-line using the enrollment system by accessing ENROLLNOW.micron.com from outside Micron (using DUO Authenticator), or type ENROLLNOW/ in your browser's address bar. Your benefit summary or benefit confirmation may be requested in the event of a dispute.

Contributions. By enrolling in the Plan you authorize Micron to collect the required contributions through payroll deduction.

Annual Enrollment

Micron's Annual Enrollment usually takes place each year in the fall. Unlike most other benefits, your enrollment in this plan does not carry over to the next plan year. You must re-enroll in this Plan during Annual Enrollment to continue your participation. You may also enroll in this plan for the first time.

Micron will notify you before the start of Annual Enrollment. You must make your enrollment change using Micron's online enrollment system.

If you are on an approved leave of absence under FMLA, the Effective Date of coverage will not be delayed.

Midyear Enrollment Changes

Your enrollment in this Plan may not be changed during the Plan Year unless you experience one of the events outlined below.

- Change in Status
- Certain Judgments, Decrees and Orders
- Entitlement to Medicare or Medicaid
- Qualifying Leave of Absence

How to Make an Enrollment Change. If one of these events occurs and you want to change your enrollment in this Plan, you must complete your enrollment change on enrollnow.micron.com from outside Micron (using DUO Authenticator), or type ENROLLNOW in your web browser address bar within 60 days of the event. You are required to provide supporting documentation for certain midyear events ("Event Documentation"). If you fail to provide proof of eligibility and/or supporting Event Documentation within the time limit specified, the change will be denied. If you are experiencing a delay or difficulty in obtaining documentation and feel you need additional

time, you may request an extension by contacting the Micron Global People Services PRIOR to the deadline. Extensions are not permitted once you have exceeded 60 days beyond the event date. You must always timely complete the enrollment process within the applicable enrollment period even if you receive an extension to provide documentation.

Effective Date of Midyear Enrollment Change. All changes are effective the first day of the month after you complete your enrollment election on ENROLLNOW, as long as the enrollment is completed within the appropriate time period. Expenses incurred prior to the effective date are not reimbursable.

- Any change in contribution is effective on the date the enrollment change takes effect and eligible expenses must be incurred after the date the enrollment change takes effect. For example, if you have a birth of a child on July 15 and choose to participate in this Plan by completing your enrollment election on July 20, your participation in this Plan will begin on August 1. This means medical costs connected with the birth of the child on July 15 cannot be reimbursed through this Plan.
- Please review your Benefits Confirmation Statement carefully to validate the contribution and effective date.

Changing to a High Deductible Medical Plan. If midyear, you change your work location from in or out of California, Virginia or Idaho and you change your medical plan to a High Deductible Medical Plan, you are not eligible to participate in a Health Savings Account. Your Health Care Flexible Spending Account will remain a General Purpose Health Care Flexible Spending Account for the remainder of the year***.***

Documentation Requirements

Documentation is required for all Midyear Enrollment Changes initiated by the Micron Team Member. Documentation requirements and instructions are provided on enrollnow.micron.com (using DUO Authenticator) or type ENROLLNOW in your Micron web browser. If your Midyear Enrollment Change was made within the deadline and supporting Event Documentation is provided after the deadline (but within 60 days of the event), the enrollment change will be effective as indicated in the "Change in Status Chart". The Event Documentation you provide must be consistent with and support the occurrence of the midyear event (as determined by Micron).

If you fail to provide required Event Documentation, the Midyear Enrollment Change will not be permitted. If you fail to provide proof of eligibility and/or supporting Event Documentation within the time limit specified, the change will be denied. If you are experiencing a delay or difficulty in obtaining documentation and feel you need additional time, you may request an extension by contacting the Micron Global People Services PRIOR to the deadline. Extension requests must be made prior to the applicable enrollment deadline.

Confirmation of Enrollment. It is your responsibility to print and review your enrollment benefit confirmation statement. You can access a benefit summary or benefit confirmation at any time on-line using the enrollment system by accessing ENROLLNOW.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar. Your benefit summary or benefit confirmation may be requested in the event of a dispute.

Important Information when Changing Coverage Level.

If you change your coverage level, then the amount of reimbursement available will be different for the periods of coverage before and after the change. Your elected amount prior to the change will be the maximum amount of reimbursement available for that time period. Your elected amount after the change will be the maximum amount of reimbursement available for the time period after the change. However, the total amount reimbursable for the Plan Year cannot exceed your highest level of coverage during the Plan Year.

- For example, you elect $1,000 in coverage during Annual Enrollment. Then, on June 1, you experience a midyear event that allows you to increase your coverage level and you immediately elect a new coverage level of $2,850. This change will go into effect on July 1, which is the first day of the month after you completed your enrollment. You may be reimbursed for up to $1,000 in claims for the period from January 1 to June 30 and you may be reimbursed for up to $2,850 in claims for the period from July 1 to December 31, but in no case will you be reimbursed for a total amount in excess of $2,850.

Important Information when Reducing Coverage Level. You may not choose to reduce your coverage level below the amount of contributions you have previously paid, although in certain circumstances you may stop participating in the Plan. The Plan will not refund any contributions that have been paid.

Change in Status

Micron's change in status rules are written to comply with Internal Revenue Code Section 125 and regulations issued under Code Section 125. Your enrollment in this Plan may only be changed during the Plan Year due to a change in status if:

- you experience one of the events listed in the Change in Status Chart,
- the event causes a gain or loss of eligibility under an employer's health care flexible spending account plan, and
- the enrollment change is consistent with the event as outlined in the Change in Status Chart.

Change in Status

HEALTH CARE FSA enrollment changes are effective the first of the month following your enrollment election on ENROLLNOW

Event	Change Allowed	Documentation Required
Marriage	You may enroll or increase your contributions or you may decrease your contributions if you become covered on your spouse's health plan, health care flexible spending account or limited-purpose flexible spending account plan.	* Marriage license * Birth or adoption certificate for each child you are adding to coverage, showing either your name or that of your spouse as parent.
Establishment of Domestic Partnership	You may enroll or increase your contributions to accommodate newly eligible dependents (but only to the extent the newly eligible dependents qualify as your tax dependents).	* Micron Domestic Partner Affidavit * Birth or adoption certificate for each child you are adding to coverage, showing your domestic partner as parent.
Divorce, termination of domestic partnership, Legal Separation, Annulment, (as defined by state family law principles) or Death of a Spouse or domestic partner	You may decrease your contributions or you may increase your contributions if coverage is lost under your spouse/domestic partner's health plan, health care flexible spending account or limited-purpose flexible spending account plan.	*Legally executed separation agreement *Divorce decree *Finalized annulment *Death Certificate *Micron Termination of Domestic Partner Affidavit

Birth, Legal Guardianship, Adoption or Placement for Adoption	You may enroll or increase your contributions. Increase or enrollment is effective the first day of the month following your enrollment on ENROLLNOW. Coverage is not retroactive to date of birth, legal guardianship or placement for Adoption.	*Application for Birth Certificate on an official state form or Hospital Birth Certificate or Legal Birth Certificate *Legally executed paperwork showing legal ward, in your custody, or placed with you for adoption, or legally executed final adoption papers
Change in your employment status that triggers eligibility in this Plan such as a return from an unpaid leave of absence longer than 24 consecutive calendar weeks.	You may enroll in this plan.	No Documentation needed
Change in your Eligible Dependent's employment status that triggers eligibility and enrollment under another employer's health care FSA Plan such as commencement of employment, return from an unpaid leave of absence, change in worksite, switching from salaried to hourly-paid or union to non-union or vice versa, incurring an increase in hours (for example your Eligible Dependent goes from part-time to full-time), or any other similar change which makes your Eligible Dependent eligible for another employer's health plan or health care FSA plan.	You may decrease or stop your contributions.	*Proof of your dependent's new coverage, such as a confirmation statement from his/her employer, or a copy of his/her new health insurance card showing the effective date of coverage
Change in your Eligible Dependent's employment status that results in a loss of eligibility and enrollment in his/her employer's health plan or health care FSA Plan such as termination, strike or lockout, commencement of an unpaid leave of absence, change in worksite, switching from salaried to hourly-paid or union to non-union or vice versa, incurring a reduction in hours (for example your Eligible Dependent goes from full-time to part-time), or any other similar change which makes the individual ineligible for another employer's health plan or health care FSA plan.	You may enroll or increase your contributions.	*Copy of the confirmation statement showing dependent's (or dependents') other coverage through another employer *Copy of letter or documentation describing the significant change in coverage or coverage costs (for example, large increase in employee contributions, elimination of the dependent's existing plan)
Eligible Dependent no longer meets eligibility requirements.	You may decrease or stop your contributions.	No Documentation needed

Eligible Dependent first meets eligibility requirements.	You may enroll or increase your contributions.	* Marriage license * Birth or adoption certificate for each child you are adding to coverage, showing either your name or that of your spouse / domestic partner as parent. *Completed, notarized Micron Affidavit of Domestic Partnership
Termination and Rehire within 30 days	Your enrollment at termination is reinstated unless another event has occurred that allows a change.	No Documentation needed
Death of a Dependent Child	You may decrease or stop your contributions.	Death Certificate
Commencement or Termination of a Qualified Medical Child Support Order (QMCSO)	You may increase, decrease or stop your contributions.	Copy of Qualified Medical Child Support Order

Judgments, Decrees and Orders

You may change your enrollment in this Plan if a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including a National Medical Support Notice) requires you to provide coverage on this Plan for your Eligible Dependent child or requires another individual to provide coverage under a similar plan. If the judgment, decree or order requires you to provide coverage through a health care flexible spending account, you may change your enrollment to provide coverage for the child. If the judgment, decree or order requires someone else to provide coverage through a health care flexible spending account, you may change your enrollment to drop coverage for the child.

This Plan complies with all Qualified Medical Child Support Orders ("QMCSO"), including National Medical Support Notices. A QMCSO requires a Participant to provide health coverage to a dependent child in accordance with a court order despite certain Plan rules that might otherwise exclude these children. A QMCSO must include certain information to be considered qualified. When a QMCSO is received by the Global People Services, it is reviewed to determine if it is qualified. A determination will be made within 30 days of receipt and you and the affected child will then be notified of the determination. A change due to a QMCSO is effective the first of the month after the determination.

Entitlement to Medicare or Medicaid

If you or your Eligible Dependent who is enrolled in this Plan becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), you may cancel Micron's coverage for the person becoming entitled to Medicare or Medicaid.

Further, if you or your Eligible Dependent that has been entitled to Medicare or Medicaid loses eligibility for such coverage, then you may choose to enroll that dependent under this Plan.

Leave of Absence

Continuing Coverage. Your participation in this Plan will automatically continue while on:

- an approved leave of absence qualifying under the FMLA,
- an approved military leave as a result of duty in the uniformed services including the Armed Forces, the Army National Guard, and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, certain types of service in the National Disaster Medical System, and any other category of persons designated by the President of the United States in time of war or emergency,
- an approved personal leave,
- an approved state mandated leave of absence, or

- an approved Birth and Adoption leave of absence.

If you are receiving pay during the approved leave of absence, including regular pay, TOP pay, Birth and Adoption Leave pay or short-term disability pay, your contributions will be deducted from your pay. If you are not receiving pay during the approved leave of absence, any missed contributions will be deducted from your pay in one lump sum upon your return.

If you have not returned to active employment within 24 (or 26 if SMFL for Caregiver Leave) consecutive calendar weeks of an approved leave of absence you will no longer be eligible to participate in this Plan and your participation in this Plan will end on the last day of the month in which your leave reaches 24 (or 26 if SMFL for Caregiver Leave) consecutive calendar weeks. There is one exception to this rule.

- If you are on a state mandated leave of absence that requires coverage to continue for a longer period of time under this Plan, your participation will continue through the time specified in that regulation, but in no case will it continue past the end of the Plan Year unless you re-enroll during Annual Enrollment.

If you return to full-time active employment after being absent for 24 (or 26 if SMFL for Caregiver Leave) consecutive calendar weeks, you may enroll yourself and your Eligible Dependents in this Plan only if you complete your enrollment election on ENROLLNOW within 60 days of your return from the approved leave of absence. You must complete your election within the deadline. Upon return from a personal leave, your coverage will go into effect the first day of the month after the month you returned from leave. Upon return from an approved military or FMLA leave, your coverage will go into effect on the date you return to work.

If you choose to end your employment with Micron while on an approved leave of absence, any missed contributions will be deducted from your final paycheck.

Stopping Coverage. You also have the right to stop your coverage under this Plan while on an approved leave of absence. If you decide to stop your coverage, you must complete an enrollment election on ENROLLNOW within 60 days of the start of your leave. The change will be effective the first of the month following your enrollment change on ENROLLNOW. You are not eligible to have your claims reimbursed for expenses incurred during the period in which coverage was not in effect.

Upon return to full-time active employment, you may enroll in this Plan only if you complete your enrollment election on ENROLLNOW within 60 days of your return from the approved leave of absence.

In this circumstance, you will have no greater right to benefits for the remainder of the Plan Year than a Participant who worked continually during the Plan Year. Therefore, your contribution will be limited to the coverage you selected prior to your approved leave of absence. Your contribution may only be changed if you experience another event that allows a midyear enrollment change.

How This Plan Works

Throughout the year, you contribute to your Health Care Flexible Spending Account each pay date through a payroll deduction. The contribution is taken before taxes are calculated. This means you do not have to pay most federal, state and local taxes on contributions made to your account.

After you pay for eligible health care expenses, you can submit a claim for reimbursement from your Health Care Flexible Spending Account. The money you receive from your account is paid directly to you. There are no taxes taken on this amount.

In other words, the money you contribute to and receive from your Health Care Flexible Spending Account is generally not taxed. How does this help you? Assume your eligible health care expenses cost $500. If you contribute $500 to this Plan, you can receive reimbursement of up to $500 from your Health Care Flexible Spending Account to cover the cost of your health care expenses. If you did not participate in this Plan, to pay for $500 worth of health care expenses using after-tax dollars, you would have to earn more than $500 to have $500 left over after payroll taxes are deducted.

How This Plan Affects Social Security. Because you may pay less in social security tax as a result of your participation in this Plan, your social security benefits may be slightly less when you retire or if you become disabled, due to federal regulations. Check with your tax consultant for personal tax advice on how this impacts you.

How This Plan Affects Federal Tax Credits. Amounts reimbursed from this Plan cannot be taken as federal or state income tax deductions or credits. This is because these amounts are already being paid for with tax-free income dollars. Check with your tax consultant for personal tax advice on how this impacts you.

Annual Contributions

The minimum annual contribution amount is $100 and the maximum annual contribution amount is $2,850.

Eligible Expenses

Health care expenses are eligible for reimbursement through this Plan if they meet all of the following criteria:

- Expenses must be for expenses as defined in section 213(d) of the Internal Revenue Code,
- Expenses must be for expenses not reimbursed or entitled to reimbursement through insurance or any other source,
- Expenses must be incurred during the Plan Year, and
- Expenses must be incurred while you are participating in this Plan.

Incurred means when the health care services were provided, not when services are billed or when you pay for the services.

Eligible Health Care Expenses. As a general rule, eligible health care expenses include many of the out-of-pocket expenses you pay toward medical care for you and your eligible dependent's health and well-being such as deductibles and coinsurance expenses not covered by your health plans (for example, the medical, dental and/or vision plans offered by Micron).

- Eligible dependents generally include your legal spouse and any natural born, adopted or step-children who are considered your dependent under Section 152 of the Internal Revenue Code, as amended under the Working Families Tax Relief Act of 2005.
- Health care expenses incurred by your domesticpartner or his or her children are not considered eligible health care expenses unless your domestic partner and/or their children are considered your dependent(s) under Section 152 of the Internal Revenue Code, as amended under the Working Families Tax Relief Act of 2005.

The following list identifies some of the common medical and health-related expenses that the Internal Revenue Service (IRS) has considered in the past to be Eligible Expenses. These expenses may be eligible provided that you have not been reimbursed for them through any other benefit plan:

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limbs and teeth
- Birth control pills
- Braille books and magazines (to the extent prices exceed prices for regular books and magazines)
- Car (special hand controls or other special equipment installed for the use of a person with a disability)
- Chiropractor
- Christian science practitioner
- Contact lenses (includes equipment and materials required for using contact lenses such as saline solution and enzyme cleaner)
- Crutches
- Dental treatment (including x-rays, fillings, braces, dentures and extractions)
- Drug addiction treatment
- Eye examinations and eyeglasses (must be required for medical reasons)
- Fertility enhancement surgery (including reversal of prior surgery to prevent children)
- Guide dog and its upkeep
- Hearing aids and batteries
- Hospital services
- In vitro fertilization
- Insulin
- Laboratory fees
- Laser eye surgery
- Lead-based paint removal to prevent lead poisoning
- Legal fees you paid that are necessary to authorize treatment for mental illness
- Lodging for medical care

- Medical conference which concerns a chronic illness of you, your spouse, or your dependent
- Medical information plan
- Medical services provided by physicians, surgeons, specialists, or other medical practitioners
- Menstrual products
- Prescribed medicines and drugs
- Nursing care or nursing home (if for medical reasons)
- Operations that are not for cosmetic surgery
- Osteopath
- Over the counter medication such as antacid, allergy medicine, pain reliever and cold medications.
- Oxygen equipment
- Psychiatric care
- Psychoanalysis
- Psychologist
- Sterilization
- Stop smoking programs for general well-being
- Telephone for the hearing impaired
- Television equipment that displays the audio part of television programs as subtitles for hearing impaired persons
- Therapy
- Transplants
- Tuition fees you pay to a special school for a child who has severe learning disabilities caused by mental or physical impairments
- Vasectomy
- Weight loss program (only if undertaken at a physician's direction to treat an existing disease such as heart disease)
- Wheelchair
- X-Ray

Ineligible Expenses. Examples of health care expenses that cannot be reimbursed through this Plan include the following:

- Any illegal treatment
- Cosmetic surgery
- Dancing or ballet
- Dietary supplements such as vitamins
- Expenses for long-term care
- Expenses incurred prior to the plan year
- Expenses provided before you are a participant in the Health Care Flexible Spending Account Plan
- Fee for exercise, athletic, or health club membership
- Marriage counseling
- Premiums paid for health insurance coverage
- Remedial reading class for non-handicapped child
- Weight reduction programs for general well-being
- Health care expenses incurred by your domesticpartner or his or her children are not considered eligible health care expenses unless your domestic partner and/or their children are considered your dependent(s) under Section 152 of the Internal Revenue Code, as amended under the Working Families Tax Relief Act of 2005.

A list of health-related expenses that the IRS has considered in the past to be eligible or ineligible expenses can also be found by going to the Flores & Associates Web site (Flores247.com).

Plan Year. The Plan Year for this Plan is January 1 through December 31.

Carryover. A Participant in the Health Care Flexible Spending Account may roll over up to $570.00 of unused amounts in the Health Care Flexible Spending Account remaining at the end of one Plan Year to the immediately following Plan Year if the participant remains eligible in the following year to participate in this Plan.

Amounts carried over do not affect the maximum amount of salary redirection contributions for the Plan Year to which they are carried over. Unused amounts are those remaining after expenses have been reimbursed during the runout period. These amounts may not be cashed out or converted to any other taxable or nontaxable benefit. Amounts in excess of $570.00 will be forfeited.

The Plan is allowed, but not required, to treat claims as being paid first from the current year amounts, then from the carryover amounts.

Important Timing Consideration. Expenses must be incurred during the Plan Year while you are participating in the Plan to be eligible for reimbursement.

For example, if your participation in the Health Care Flexible Spending Account Plan

begins on May 1 and ends on December 31, you will be eligible for reimbursement of Eligible Health Care Services provided between May 1 and December 31, but you will not be eligible for reimbursement for Eligible Health Care Services provided prior to May 1.

If you enroll in a High Deductible Medical Plan for 2023 ***AND*** have a 2022 Health Care Flexible Spending Account balance of $570 or less, that will automatically carry over from the previous year; the carry over amount will roll over into a Limited Purpose Flexible Spending Account for 2023.

The Limited Purpose Flexible Spending Account will be available for 2022 medical, dental, vision and pharmacy claims, but limited to only dental and vision services in 2023.

The IRS does not permit a participant to have access to a General Purpose Health Care Flexible Spending Account and a Health Savings Account at the same time.

How Claims are Processed

How to File a Claim. To be reimbursed for your Eligible Expenses, use your debit card or submit a Health Care Reimbursement request with proof of expenses at flores247.com.

You may submit a claim form at any time during the Plan Year, for the full amount of reimbursement you are entitled to receive. You do not have to wait until your contributions equal the amount of reimbursement. The claims submission deadline for this Plan is 90 days after the end of the Plan Year, or until March 31 of the year following the Plan Year.

- Claims filed against contributions made in the previous Plan Year must be postmarked by March 31 of the following year or faxed by 11:59 pm Eastern Time on March 31 in order to be processed for payment.

Provided, however, for the period beginning March 1, 2020 and ending 60 days after the US President declares an end to the COVID-19 national emergency, the claims submission deadline will be extended for up to 12 months or until such time that the national emergency ends (if sooner than 12 months).

Claims submitted after the deadline will be denied and unused funds will be forfeited.

DEBIT AND CREDIT CARDS
Participants may, subject to a procedure established by the Administrator and applied in a uniform nondiscriminatory manner, use debit and/or credit (stored value) cards ("cards") provided by the Administrator and the Plan for payment of eligible expenses, subject to the following terms:

(a) **Card only for eligible expenses.** Each Participant issued a card shall certify that such card shall only be used for eligible expenses. The Participant shall also certify that any eligible expense paid with the card has not already been reimbursed by any other plan covering health benefits and that the Participant will not seek reimbursement from any other plan covering health benefits.

(b) **Card issuance.** Such card shall be issued upon the Participant's Effective Date of Participation and will remain valid for each Plan Year the Participant remains a Participant in the Health Care Flexible Spending Account. Such card shall be automatically cancelled upon the Participant's death or termination of employment, or if such Participant has a change in status that results in the Participant's withdrawal from the Health Flexible Spending Account.

(c) **Maximum dollar amount available.** The dollar amount of coverage available on the card shall be the amount elected by the Participant for the Plan Year.

(d) **Only available for use with certain service providers.** The cards shall only be accepted by such merchants and service providers as have been approved by the Administrator following IRS guidelines.

(e) **Card use.** The cards shall only be used for eligible expenses purchases at these providers, including, but not limited to, the following:

(1) Co-payments for doctor and other medical care;
(2) Purchase of drugs prescribed by a health care provider, including, if

permitted by the Administrator, over-the-counter medications as allowed under IRS regulations;
(3) Purchase of medical items such as eyeglasses, syringes, crutches, etc.

(f) **Substantiation.** Such purchases by the cards shall be subject to substantiation by the Administrator, usually by submission of a receipt from a service provider describing the service, the date and the amount. The Administrator shall also follow the requirements set forth in Revenue Ruling 2003-43 and Notice 2006-69. All charges shall be conditional pending confirmation and substantiation.

(g) **Correction methods.** If such purchase is later determined by the Administrator to not qualify as an eligible expense, the Administrator, in its discretion, shall use one of the following correction methods to make the Plan whole. Until the amount is repaid, the Administrator shall take further action to ensure that further violations of the terms of the card do not occur, up to and including denial of access to the card.

(1) Repayment of the improper amount by the Participant;
(2) Withholding the improper payment from the Participant's wages or other compensation to the extent consistent with applicable federal or state law;
(3) Claims substitution or offset of future claims until the amount is repaid; and
(4) if subsections (1) through (3) fail to recover the amount, consistent with Micron's business practices, Micron may treat the amount as any other business indebtedness.

Determination of a Claim. Flores & Associates will process the claim based on Plan provisions. You will be notified about the status of your claim within a reasonable period of time, but not usually longer than 30 days after your claim is received.

This 30 day period may be extended for an additional 15 days if more time is required due to matters beyond the control of the Plan; for example, if you did not provide all the information required to make a claim. You will receive a written notice indicating the reason for the extension if this happens.

If you are asked to provide additional information, you will have at least 45 days to do so. You must provide any requested information within the time period required or a decision will be made without considering any additional information.

If your claim is denied, you will receive a written notice of the denial containing the following information:

- The reason for the denial,
- A reference to and a description of the plan provision(s) on which the denial is based,
- Information on how to request a review of the denial, and
- Other information about the reason for the denial and your options.

You may review your account balance, pending claims or paid claim history by calling Flores & Associates at 800-532-3327 or accessing your account online at Flores & Associates at Flores247.com. FSA Claim forms are located on the Flores & Associates website.

Payment to You. You will receive an explanation of benefits with either a reimbursement check or direct deposit confirmation as soon as your reimbursement is processed.

The explanation of benefits will show all the payments. It will also explain any services not reimbursable through this Plan and will include your current account balance. Keep this explanation for your records. You can choose to receive your explanation of benefits by e-mail.

In the event of your death, Flores & Associates will pay your spouse, if married, or your estate, if not married, any outstanding payments owed to you.

Assignment of Benefits. Except as required by law, the Plan's right to pay a Participant directly is not assignable and cannot be waived or transferred.

Mental or Physical Incompetence. If the Plan determines that a Participant who is entitled to payments under the Plan is incompetent by reason of mental disability or other cause, the Plan can choose to make payments to another person, including a spouse. Payments made in this situation shall completely discharge the Plan, Flores &

Associates and Micron of any further responsibility for payment to the Participant.

Important Information About the Availability of Reimbursement from Your Account. Eligible Health Care Expenses are reimbursed up to your total enrollment, regardless of the amount you have contributed to your account.

For example, if your annual contribution is $1,000 but only $200 has been contributed to your account, you can be reimbursed up to $1,000. Please refer to the "Midyear Enrollment Changes" section for how a midyear enrollment change can affect this rule.

Important Information About Contributions Not Spent. Calculate your health care expenses carefully before you decide how much to contribute to this Plan. If your Eligible Expenses turn out to be less than the amount contributed to your account, federal law requires that the unused balance be forfeited. This rule is to prevent participants from using the plans solely as an income tax shelter.

To estimate what you will likely spend, review your family's recent health care expenses. Review the list of eligible expenses and consider any anticipated increase or decrease in your health care needs for the coming year. Review your medical, dental, and vision plans to determine what will be covered and what you might expect to pay.

Remember, this Plan will not cover day care expenses for your children. It only covers health care expenses for you and your eligible dependents.

Important Notice About Submitting Claims After Coverage Ends. You are eligible to submit a claim through the last day of the month in which your employment with Micron ends for previously incurred expenses, or through the last day of the regular claims filing period for that Plan Year if your employment ends in December.

If you have not incurred expenses up to the amount contributed to this Plan at the time your employment with Micron ends, or by the end of the claims filing period for that Plan Year if your employment ends in December, the balance will be forfeited.

Appeals

There are two different types of appeals allowed under this Plan:

- First Level Appeal, and
- Second Level Appeal

The appeals process varies depending on the type of appeal.

First Level Appeal

Eligibility and Enrollment Processing Appeal. If you disagree with the decision regarding your eligibility or enrollment, you have 180 days from the date of the original notice of the denial in which to file a written request for review.

You or your authorized representative must send or fax your written request for review to:

First Level Appeal, MS 01-727
Global People Services
Micron Technology, Inc.
8000 South Federal Way
P.O. Box 6
Boise, Idaho 83707-0006
Fax (208) 368-1553
e-mail: first_level@micron.com

Claim Processing Appeal. If you or your enrolled dependents disagree with the decision regarding a claim for benefits, you have 180 days from the date of the original notice of the denial in which to file a written request for review.

You, your enrolled dependent, or an authorized representative must send or fax a written request for review to the address below.

First Level Appeal
Flores & Associates
PO Box 31397
Charlotte, NC 28231

Authorized Representative. If you are physically or mentally incapacitated (for example, you are in a coma), your spouse, parent or other individual designated by a court shall be deemed to be an authorized

representative.

Appeal Review Process. The First Level Appeals Committee will review your appeal and a decision will be made consistent with the terms of the Plan and applicable law. The persons who made the initial decision will not decide the first level appeal.

The First Level Appeals Committee has full discretionary power to interpret the Plan and decide all questions concerning the Plan and the eligibility of any person to participate in the Plan, with such interpretation and decisions to be final and conclusive on all persons claiming benefits under the Plan subject only to the decision of the Second Level Appeals Committee, if applicable.

You will receive a written decision regarding your written appeal within a reasonable period of time, but not usually longer than 30 days after your appeal is received.

The notice will include the following information:

- The results of the request for review,
- The reason(s) for the decision,
- A reference to and description of the plan provision(s) on which the decision is based, and
- Other information about the review and your options to make a second level appeal.

Second Level Appeal

Eligibility and Enrollment Processing Appeal. If you disagree with the result of the eligibility and enrollment first appeal, you may file a second written request for review. You have 180 days from the date you receive the outcome of the first appeal in which to file the written request for a second review.

You or your authorized representative must send your written request for review to:

Second Level Appeal, MS 01-727
Global People Services
Micron Technology, Inc.
8000 South Federal Way
P.O. Box 6
Boise, Idaho 83707-0006
Fax (208) 368-1553
e-mail: second_level@micron.com

Claim Processing Appeal. If you disagree with the result of the claims processing first appeal, you may file a second written request for review. You have 60 days from the date you receive the outcome of the first appeal in which to file the written request for a second review.

You or your authorized representative must send your written request for review to:

FSA Claim Second Level Appeal
Flores & Associates
PO Box 31397
Charlotte, NC 28231

Appeal Review Process. The Second Level Appeals Committee will review your appeal and will make a decision consistent with the terms of the Plan and applicable law. The persons who decided the first level appeal will not decide the second level appeal.

The Second Level Appeals Committee has full discretionary power to interpret the Plan and decide all questions concerning the Plan and the eligibility of any person to participate in the Plan, with such interpretation and decisions to be final and conclusive on all persons claiming benefits under the Plan.

You will receive a written decision regarding your appeal within a reasonable period of time, but not usually longer than 30 days after your request is received.

The notice will include the following information:

- The results of the request for review,
- The reason(s) for the decision,
- A reference to and description of the Plan provision(s) on which the decision is based, and
- Other information about the review and your options as required by federal law.

Your Appeal Rights

You have the following rights for all appeals.

- You have the right to receive, upon written request, copies of all documents, records, and other information used in the review of your claim at no cost. A document, record or other information is considered related to your claim if it was relied on in making the benefit determination; was submitted,

considered, or generated in the course of making the benefit determination; or demonstrates compliance with the Plan's administrative processes and consistency safeguards required in making the benefit determination or constitutes a statement of policy or guidance with respect to the Plan concerning the benefit for your diagnosis.

- You have the right, within the specified time limits, to submit written comments, documents, records, and other information relating to your claim.

Appeals Committee Membership. Micron's Senior Vice President of People Services may appoint and remove members of the First and Second Level Enrollment and Eligibility Appeals Committees.

Lawsuits. The Plan requires that the claims and appeals processes must be exhausted before bringing any suit in court. The Plan also requires any suit must be brought within the earlier of one year after the date the Second Level Appeals Committee has made a final denial of the claim or two years after the date service or treatment was rendered.

Exclusion of General Damages

Liability under this Plan for benefits, including recovery under any claim or breach of this Plan, shall be limited to the actual benefits available under this Plan and shall specifically exclude any claim for general damages, including but not limited to alleged pain, suffering or mental anguish, or for economic loss, consequential loss or punitive damages.

Termination of Coverage

Enrollment in this Plan ends on the earlier of the following dates:

- the date this Plan terminates,
- the last day of the month after a Participant who is a team member dies,
- the last day of the month during which a Participant who is a team member loses eligibility under this Plan due to a job status change including any approved leave of absence greater than 24 (or 26 if SMFL for Caregiver Leave) weeks, or
- when a Participant's employment with Micron ends.

This Plan may also terminate a Participant's coverage for any fraud, misrepresentation, omission or concealment of facts that could have impacted eligibility for coverage under this Plan.

Under certain circumstances, you may continue to participate on an after-tax basis provided you elect to continue participation in this Plan pursuant to your rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and you make the required monthly contribution payments to Micron. See the Health Care Continuation Coverage Notice (found in the Benefits Handbook) for more information about your rights and responsibilities.

- You may choose to continue your participation in this Plan under COBRA only if you have a positive account balance after taking into account all claims submitted on the day before the date of the qualifying event (for example, year-to- date contributions exceed year-to-date claims).

- If you are eligible for COBRA coverage under this Plan and continue to make the required monthly contribution payments, COBRA coverage will continue only for the remainder of the plan year in which your qualifying event occurred. Any amount remaining that is avaible for reimbursement at the end of the plan year in which the qualifying event occurred will be subject to the Plan's carryover rules as described herein subject to the applicable COBRA continuation period. You will not be required to make monthly contribution payments for any carryover; however, in no event will you be permitted to elect additional contribution amounts for the following plan year.