The Micron Vision Plan offers vision coverage for you and your family. This Plan is administered by Vision Service Plan (VSP). The group number is ***30021795.***

ERISA

This Vision 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 the Vision Plan if you are actively employed and classified by Micron as a regular, full-time or part-time team member of Micron Technology, Inc. ("Micron") or a wholly owned US-based Micron subsidiary.

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 the Vision 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 the Vision Plan.

Ineligible Team Members**.** You are ineligible to participate in the Vision Plan if:

- You are an individual whose terms and conditions of employment are governed by a collective bargaining agreement (unless the collective bargaining agreement expressly provides for this benefit), or
- You are an individual who has waived/declined 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 an Intern.

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 team member 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 US-based Micron subsidiary that participates in the Vision 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 the Vision Plan will automatically continue while on a Micron approved leave of absence provided you pay all of your share of premiums 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 Micron Paid Family Leave of absence,
- an approved personal leave of absence,
- an approved leave of absence in accordance with other state law, and
- an approved military leave 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 Vision 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 qualifying 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 the Vision 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 the Vision 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 qualifying active employment after being absent for 24 (or 26 if SMFL for Caregiver Leave) consecutive calendar weeks on an approved personal leave of absence, an approved Micron Paid Family 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. If you return to active employment following an approved Micron Paid Family Leave of absence, your return will be considered a return to qualifying active employment for a parental integration period of up to 8 weeks regardless of hours actually worked during such period.

Your Dependent's Eligibility

You may enroll the following Eligible Dependents in the Vision Plan.

- Spouse or Domestic Partner
- Child under age 26
- Child age 26 or older with Mental or Physical Disabilities

***Spouse or Domestic Partner*.** Your spouse by a marriage that occurred in any state or foreign jurisdiction in accordance with the applicable law of such state or foreign jurisdiction (regardless of the marital laws where you currently live) is eligible to participate in the Vision Plan. Your domestic partner, as defined by the Micron Domestic Partner Affidavit, is eligible to participate in the Vision Plan.

Child Under Age 26. Your, or your domestic partner's child who is under age 26 is eligible to participate in the Vision Plan if they meet the following criteria:

- A son, daughter, stepson, stepdaughter, or child placed with you or your domestic partner by judgement decree or other order of any court of competent jurisdiction, including guardianship of a minor child.
- A legally adopted child or child placed with you or your domestic partner for adoption through a legally enforceable agreement under applicable state law is considered your son or daughter.

Child with Mental or Physical Disability. Your, or your domestic partner's child who, except with respect to the age 26 restriction, meets the "child under age 26" eligibility requirements listed above is still eligible to participate in the Vision Plan if they meet all of the following criteria:

- The child has a permanent mental or

physical disability;
- The child is incapable of self-sustaining employment because of the disability;
- The child became incapacitated prior to reaching age 26; and
- The child is your tax dependent.

Special Rule for a Child of Divorced or Separated Parents. For purposes of the Vision Plan, if you are divorced or legally separated, your son and/or daughter is considered to be a dependent of both you and your divorced or legally separated spouse.

Dependents That are Not Eligible. You may not enroll any individual who does not meet the definition of an Eligible Dependent. Ineligible dependents include but are not limited to the following:

- An ex-spouse from whom you have obtained a legal divorce, legal separation, termination of domestic partnership, or an annulment of the marriage.
- A child who has reached age 26, unless disabled as described above.
- A child of a common law spouse (unless such spouse is your domestic partner).
- A child for whom a court ordered custodial arrangement or guardianship as described above is terminated or superseded, for example, because the child turns 18.
- A stepchild if your marriage with the natural parent terminates.
- Your domestic partner or your domestic partner's child if your domestic partnership terminates.
- Your parent, your spouse's parent, or your domestic partner's parent. Your Eligible Dependent's spouse.
- Your grandchild, or your domestic partner's grandchild.
- Individuals under your care or living in your home that do not meet the requirements of Eligible Dependent.

In some cases an individual described above may separately satisfy the definition of an Eligible Dependent. In that case, such individual will be an Eligible Dependent for purposes of the Vision Plan. For example, among other situations, a step child or the child of your common law spouse may be eligible as your adopted child or a child for whom you have court ordered custody.

Premium for Eligible Dependents.

Except with respect to certain domestic partners and their children, the Vision Plan is written to comply with the definition of dependent in Section 152 of the Internal Revenue Code, as amended under the Working Families Tax Relief Act of 2005. This generally allows the premium for Eligible Dependents that you enroll in the Vision Plan to be taken on a pre-tax basis. A domestic partner and a domestic partner's child may or may not qualify as a tax dependent eligible for pre-tax coverage. When you enroll a domestic partner or a child of a domestic partner, you must complete the Micron Domestic Partner affidavit and certify whether the domestic partner or child qualifies as your tax dependent.

By enrolling your dependents in the Vision Plan:

- you are certifying that your dependent meets the definition of an Eligible Dependent as outlined in this section, and
- you are agreeing to submit claims only for the dependents enrolled in the Vision Plan.

Determination of Dependent Eligibility. Micron will rely upon information provided by you and your dependents when determining eligibility for the Vision Plan. Once enrolled, you are required to notify Micron as soon as possible if you have reason to believe that your enrolled Eligible Dependent has become no longer eligible for participation in the Vision Plan.

You will be required to provide evidence of eligibility for any newly added Eligible Dependent within the enrollment deadline for the associated enrollment event. Documentation requirements and instruction are provided on ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar. Documentation may include but is not limited to marriage certificates, Micron Domestic Partner Affidavits, birth certificates, or divorce decrees. If you fail to provide proof of eligibility and/or supporting documentation

within the time limit specified, the change will be denied and your Eligible Dependent may be deemed ineligible for part or all of the Plan Year.

If you are experiencing a delay or difficulty in obtaining evidence of dependent eligibility documentation and feel you need additional time, you may request an extension by contacting the Micron Global People Services PRIOR to the deadline. Documentation extensions are not permitted if requested after the deadline. In addition, you must still complete your election within the applicable enrollment period (described throughout this document) even if you receive an extension to provide documentation.

Misrepresentation.

You and/or your Eligible Dependent's coverage may be terminated for any misrepresentation, omission or concealment of facts that could have impacted the Plan's determination of eligibility for coverage. Your coverage may be rescinded retroactively in the case of fraud or intentional misrepresentation. Failure to notify Micron of a dependent becoming ineligible for coverage will result in coverage termination and may result in rescission. You and/or your dependent may also be held liable for any penalties or fines imposed on the Vision Plan by a governmental agency.

Benefits Enrollment System

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

Initial Enrollment

Newly eligible full-time and part-time team members must complete their Initial Enrollment and select the Vision Plan to be enrolled in the Vision Plan. You must enroll Eligible Dependents if you want them covered by the Vision Plan. To enroll your Eligible Dependents, you must complete the enrollment process within 30 days of your hire date using the enrollment system by accessing ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar within 30 days of your hire date. Dependent Documentation is required for all dependents newly added to the Vision Plan. You have 60 days from your hire date to provide Dependent Documentation. If you fail to complete the enrollment process within 30 days of your hire date, you will be deemed to have waived/declined vision coverage through Micron. See below for more information on changing your enrollment election outside of the initial enrollment process. You must use the Benefits Enrollment System to enroll in coverage.

No team member or Eligible Dependent is entitled to receive benefits for Covered Services under more than one Micron vision enrollment.

Changing your Initial Enrollment. Once your 30-day initial enrollment window has passed, any changes will be subject to the provisions described in the "Midyear Enrollment Changes" section and you will not be able to add, drop, or change the coverage for you and your Eligible Dependents until the next Annual Enrollment. Supporting documentation is required for all midyear Enrollment Changes and all Eligible Dependents.

Initial Enrollment Effective Date. This plan will be Effective on your date of hire if you enroll timely. 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.

If your election was made within the 30-day initial enrollment period and supporting documentation is provided after the deadline (but within 60 days of the event), the enrollment change or dependent will be effective as indicated in the "Change in Status Chart" and "Change in Cost or Coverage Chart". Documentation may include but is not limited to marriage certificates, Micron Domestic Partner Affidavits, birth certificates, or divorce decrees. If you fail to provide proof of eligibility and/or supporting documentation within the time limit specified, the change will

be denied and your dependent may be deemed ineligible for part or all of the Plan Year.

If you are experiencing a delay or difficulty in obtaining evidence of dependent eligibility documentation and feel you need additional time, you may request an extension by contacting the Micron Global People Services PRIOR to the deadline.

Documentation extensions are not permitted if requested after the deadline. You must always timely complete the 30-day initial enrollment process even if you receive an extension to provide documentation.

Enrollment Date for Transfers. 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 date your transfer was completed in Workday.

Confirmation of Enrollment. It is your responsibility to print and review your enrollment benefit confirmation statement. Verbal confirmation of enrollment cannot be relied upon. 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 Micron's 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.

Premiums. By enrolling in the Vision Plan you authorize Micron to collect the required premiums through payroll deduction.

- Premiums vary based on your plan election and how many Eligible Dependents you enroll for coverage.
- Premiums may change from year to year. You will be notified of any premium changes during Annual Enrollment each year.
- Premiums will be withheld on a pre-tax basis, automatically from your bi-weekly paycheck and your final paycheck. Coverage in the Vision Plan will continue through the last day of the month of separation, however, premiums will cease following your final paycheck withholding.
- The tax treatment of premiums for domestic partners and children of domestic partners is outlined in the Micron Domestic Partner Affidavit.

Premium information can be found in the Premiums section of the Benefits Handbook.

When Your Spouse or Domestic Partner Works at Micron

You can set up your enrollment in one of the following ways if you are married to or in a domestic partnership with another Micron team member.

- Coverage may be set up in either your or your spouse or domestic partner's name where one of you is enrolled as the Participant and the other is enrolled as an Eligible Dependent. This allows you to take advantage of the Family Deductible.
- Coverage may be set up where both you and your spouse or domestic partner are separate Participants. This does not allow you to share in the same Family Deductible.

Under either option you may enroll Eligible Dependents.

No team member or Eligible Dependent is entitled to receive benefits for Covered Services under more than one Micron enrollment.

If your or your spouse or domestic partner's employment changes during the Plan Year, and either you or your spouse or domestic partner no longer works at Micron, you may be able to change your enrollment. See the "Midyear Enrollment Change" section for more information.

Annual Enrollment

Micron's Annual Enrollment takes place each year in November. You may change your enrollment in the Vision Plan, including waiving vision coverage, for the coming Plan Year during Annual Enrollment. You must make your enrollment change using Micron's online enrollment system by accessing

ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar. You must use the Benefits Enrollment System to enroll yourself and your Eligible Dependents in coverage.

Unless otherwise notified, if you do not make any changes, your enrollment from the previous Plan Year will continue without interruption at the applicable bi-weekly premium level. Micron will notify you before the start of any Annual Enrollment.

No team member or Eligible Dependent is entitled to receive benefits for Covered Services under more than one Micron enrollment.

You must provide Dependent Documentation that contains the required information for newly added dependents within the Annual Enrollment deadline.

If you are experiencing a delay or difficulty in obtaining evidence of dependent eligibility documentation and feel you need additional time, you may request an extension by contacting the Micron Global People Services PRIOR to the Annual Enrollment deadline. Documentation extensions are not permitted if requested after the deadline. In addition, you must still complete your election within the applicable enrollment period (as described throughout this document) even if you receive an extension to provide documentation.

Confirmation of Enrollment. It is your responsibility to print and review your enrollment benefit confirmation statement. Verbal confirmation of enrollment cannot be relied upon. 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 Micron's 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.

Midyear Enrollment Changes

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

- Change in Status
- HIPAA Special Enrollment Rights
- Certain Judgments, Decrees and Orders
- Entitlement to Medicare or Medicaid
- Change in Cost or Coverage
- Qualifying Leave of Absence

No team member or Eligible Dependent is entitled to receive benefits for Covered Services under more than one Micron enrollment. Enrollment changes permitted must be consistent with the event. Enrollment changes permitted vary by event. Event Documentation and/or Dependent Documentation supporting the midyear enrollment is required for all Midyear Enrollment Changes. Documentation requirements and instruction are provided on ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar.

How to Make an Enrollment Change. The timeframe permitted for Midyear Enrollment changes can vary based on the event and date you completed your enrollment change request. See the "Change in Status Chart" and "Change in Cost or Coverage Chart" sections. If one of these events occur and you want to change your enrollment in the Vision Plan, you must complete your enrollment change by accessing ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar within the enrollment deadline of the event.

You are required to provide supporting documentation for certain midyear events ("Event Documentation") and all newly added dependents ("Dependent Documentation") within 60 days from the event date. Event Documentation may include but is not limited to enrollment confirmation documents, COBRA letter, copy of new insurance ID card that are consistent with and support the occurrence of the midyear event (as determined by Micron). Event Documentation must include an effective date or other information to support the date the midyear event occurred. Dependent Documentation may include but is not limited to marriage

certificates, Micron Domestic Partner Affidavits, birth certificates, or divorce decrees that are consistent with and support the occurrence of the midyear event (as determined by Micron). If you fail to provide proof of eligibility and/or supporting documentation within the time limit specified, the change will be denied and your Eligible Dependent may be deemed ineligible for part or all of the Plan Year.

If you are experiencing a delay or difficulty in obtaining evidence of dependent eligibility documentation and feel you need additional time, you may request an extension by contacting the Micron Global People Services PRIOR to the deadline. Documentation extensions are not permitted if requested after the deadline. You must always timely complete the midyear enrollment process even if you receive an extension to provide documentation.

If you fail to complete your enrollment change online through the Benefits Enrollment System (ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar) within the deadline for the reported event, you must wait for the next Annual Enrollment or a new applicable qualifying special enrollment event to change your enrollment. You must enroll through the Benefits Enrollment System to obtain coverage.

- There is one exception to this rule. To obtain retroactive pre-tax coverage for a change due to birth, adoption or placement for adoption (including guardianship of a minor child) pursuant to HIPAA special enrollment rights, you must complete your enrollment election within 30 days of the event.

Effective Date of Midyear Enrollment Change. The effective date of Midyear Enrollment changes can vary based on the event and date you completed your enrollment change request. See the "Change in Status Chart" and "Change in Cost or Coverage Chart" sections.

Confirmation of Enrollment. It is your responsibility to print and review your enrollment benefit confirmation statement. Verbal confirmation of enrollment cannot be relied upon. 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 Micron's 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.

When Changing Employment Status between Full-Time and Part-Time. Your participation in the Vision Plan will automatically continue when your employment status changes from full-time to part-time or part-time to full-time. This is not a qualified midyear event.

Coordination with Severance Plan

If a terminated Participant is eligible for benefits pursuant to a severance plan operated by Micron and is offered continued participation in the Plan in connection with such Participant's termination, such Participant shall continue eligibility for the time period specified in the severance plan, notwithstanding an earlier Termination date.

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 the Vision 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 vision plan, and,
- the enrollment change is consistent with the event as outlined in the Change in Status Chart.

When an Enrollment Change is Considered Consistent with the Event. In general, an enrollment change is considered consistent with the event if the enrollment

change is on account of and corresponds with a change in status that affects eligibility for coverage under an employer's vision plan. Event Documentation supporting the event, and Dependent Documentation for all newly added dependents, is required for all midyear changes. Documentation requirements and instruction are provided on ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar. Below are some examples of how the consistency rule works.

- It is consistent to add vision coverage when you or your Eligible Dependents lose vision coverage under another employer's vision plan. It is not consistent to change vision plans or add vision coverage when you or your Eligible Dependents do not lose vision coverage under another employer's vision plan.
- It is consistent to add dependents when a change in status event results in new eligibility for a dependent, but it is not consistent to change vision plans or add existing dependents that are not newly Eligible. For example, a team member who gets married can choose to cover not just the new spouse, but also their new step children meeting the Eligible Dependent definition.
- It is consistent to enroll in Micron Vision coverage when converting from Intern to Regular Full-Time or Regular Part-Time, but it is not consistent to enroll in or change medical elections because Interns are not newly Eligible in Medical coverage.
- It is not consistent to change vision plans when transferring from Idaho to California because the same vision plans are offered in both locations.

Documentation Requirements

Dependent Documentation is required for all newly added dependents. This requirement applies to Initial Enrollment, Midyear Enrollment Changes and Annual Enrollment. Documentation is required for all Midyear Change Enrollments initiated by the Micron Team Member. Event Documentation and Dependent Documentation must be provided within the enrollment deadline.

Documentation requirements and instruction are provided on Enrollnow.micron.com (using Micron's Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar. If you fail to provide required documentation, the dependent will not be enrolled in the Vision Plan, and/or the Midyear Enrollment Change will not be permitted. If you fail to provide proof of eligibility and/or supporting documentation within the time limit specified, the change will be denied and your dependent may be deemed ineligible for part or all of the Plan Year.

If you are experiencing a delay or difficulty in obtaining evidence of dependent eligibility documentation and feel you need additional time, you may request an extension by contacting the Micron Global People Services PRIOR to the deadline. Documentation extensions are not permitted if requested after the deadline. You must always timely complete the applicable enrollment process even if you receive an extension to provide the required supporting documentation.

Micron reserves the right to determine if the documentation provided is sufficient. In general, documentation that is missing dates, names, signatures or other information needed by Micron to determine eligibility for coverage will not be accepted.

Change in Status			
You must complete your insurance change enrollment on ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar within the deadline of the event. You must provide documentation within the enrollment deadline. The Effective Date is determined by first election or the event date as indicated in the following chart. If the event date and the date you report the event is the first of the month, your benefits are effective that day.			
Event	**Deadline & Change Allowed**	**Effective Date**	**Documentation Required**
Marriage	Within 60 days you may add your spouse to Micron coverage, as well as any new dependents, or you may drop your Micron coverage if you become covered on your spouse's vision plan. You may not change Plans.	First day of the month after you initiate your insurance change election	* Marriage license * Birth or adoption certificate for each child you are adding to coverage, showing your spouse as parent.
Establishment of Domestic Partnership	Within 60 days you may add your domestic partner and your domestic partner's children to Micron coverage, or you may drop your Micron coverage if you become covered on your domestic partner's vision plan. You may not change Plans.	First day of the month after you initiate your insurance change election	* Micron Domestic Partner Affidavit * Birth or adoption certificate for each child you are adding to coverage, showing your domestic partner as parent.

Termination of Domestic Partnership	Within 60 days you must drop coverage for your ex-domestic partner and your domestic partner's children; you may add Micron coverage for you and your dependent children if you lose coverage on your ex-domestic partner's vision plan. You may not change Plans.	Date of Domestic Partnership Termination	*Micron Termination of Domestic Partnership Affidavit
Divorce, Legal Separation, Annulment (as defined by state family law principles)	Within 60 days you must drop coverage for your ex-spouse and your step-children; you may add Micron coverage for you and your dependent children if you lose coverage on your ex-spouse's vision plan. You may not change Plans.	Date of Divorce	*Legally executed separation agreement *Divorce decree *Finalized annulment
Death of a Spouse, Domestic Partner, child of a Domestic Partner, or dependent	Within 60 days you must drop coverage for a spouse, domestic partner, child of a domestic partner, or dependent who dies. You may not change Plans.	Last day of the month of death	*Death Certificate
Birth, Adoption, legal guardianship or Placement for Adoption	Within 60 days you may add yourself, your spouse/domestic partner and the new dependent to Micron coverage. You may not change Plans.	Date of Birth, Adoption, 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

Commencement of a Micron Leave of Absence	Within 31 days you may drop coverage for yourself and/or your Eligible Dependents at the commencement of the leave. You may not change Plans.	First day of the month after you begin your LOA	No Documentation necessary
Returning from Micron Unpaid FMLA, Personal Leave of Absence, Military Leave of Absence, or Leave of Absence greater than 24 consecutive calendar weeks	Within 31 days you may elect coverage for yourself and/or your Eligible Dependents when you return from Leave.	Date you return to work	No Documentation necessary
Change in you or your Eligible Dependent's **employment status** that triggers eligibility under another employer's vision plan such as commencement of employment, return from an unpaid leave of absence, change in worksite, switching from salaried to hourly-pay 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 dependent eligible for another employer's vision plans.	Within 60 days you may drop yourself, your spouse/domestic partner and/or other Eligible Dependents enrolled in the Vision Plan only if the individual(s) you are dropping are enrolled in the other vision plan. You may not change Plans.	First day of the month after you initiate your insurance change election	*Proof of you or your Eligible Dependent's new coverage, such as a benefit summary or enrollment confirmation statement from his/her employer, or a copy of his/her new health insurance card showing the effective date of coverage

Change in you or your Eligible Dependent's **employment status** that results in a loss of eligibility in his/her employer's vision plan such as termination, strike or lockout, commencement of an unpaid leave of absence, change in worksite, switching from salaried to hourly-pay 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 vision plans.	Within 60 days you may add yourself, your spouse/domestic partner and/or other Eligible Dependents who have lost eligibility under the other vision plan. You may not change Plans.	First day of the month after you initiate your insurance change election	*Copy of the benefit summary, enrollment confirmation statement, or COBRA Letter showing your Eligible Dependent's (or your) loss of other coverage through another employer *Copy of letter or documentation describing the significant change in coverage or coverage costs, including the loss of coverage date (for example, large increase in employee contributions, elimination of the dependent's existing plan)
Eligible Dependent no longer meets eligibility requirements such as attaining a specific age.	Within 31 days you must drop the impacted Eligible Dependent. You may not change Plans.	Last day of the month in which Eligible Dependent reached maximum age	No Documentation necessary
Micron Intern conversion to Regular FT/PT Status	Within 30 days you may elect Vision coverage for yourself and/or your Eligible Dependents	The date of your status change	No Documentation necessary
Eligible Dependent meets eligibility requirements.	Within 60 days you may add the impacted Eligible Dependent. You may not change Plans.	First day of the month after you initiate your insurance change election	* 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 Domestic Partner Affidavit

Permanent Transfer from a non-US Micron subsidiary which did not offer the Vision Plan	Within 30 days you may enroll in the Vision Plan offered in the United States. If you do not make a selection, you will waive/decline Vision coverage.	Date Transfer to the United States was completed in Workday	No Documentation necessary
Commencement of a Micron Expatriate Assignment greater than 6 months	Within 31 days you may cancel your Vision Plan enrollment.	First day of the month after your Expatriate Assignment was completed in Workday	No Documentation necessary
Return from a Micron Expatriate Assignment greater than 6 months	Within 31 days you may enroll in the Vision Plan offered in the United States. If you do not make a selection, you will waive/decline Vision coverage.	First day of the month after your return from Expatriate Assignment was completed in Workday	No Documentation necessary
Termination and Rehire within 30 days	Your coverage at termination is reinstated unless another event has occurred that allows a change.	Reinstatement from date of termination	No Documentation necessary

Entitlement to Medicare or Medicaid	Within 60 days you may drop you or your Eligible Dependent who is enrolled in the Vision Plan and 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 vision coverage for the person becoming entitled to Medicare or Medicaid. You may not change Plans.	First day of the month after you initiate your insurance change election	Proof of entitlement date
Loss of Medicare or Medicaid Eligibility (other than coverage solely for pediatric vaccines)	Within 60 days you may add you or your Eligible Dependent that has been entitled to Medicare or Medicaid loses eligibility for such coverage. You may add the person(s) who lost Medicare or Medicaid eligibility under the Vision Plan. You may not change vision Plans.	First day of the month after you initiate your insurance change election	Proof of loss of eligibility date

HIPAA Special Enrollment Rights

Please also review the "Greater Rights under the Vision Plan" section for additional rights you have under the Vision Plan that are greater than the minimum rights described in this section.

The Health Insurance Portability and Accountability Act (HIPAA) provides you special enrollment rights in some situations. If you decline coverage for yourself or your Eligible Dependents (including your spouse or domestic partner) because you have other vision insurance coverage, under HIPAA you may, in the future, be able to enroll yourself or your Eligible Dependents in the Vision Plan provided that you complete enrollment within 30 days after your other coverage ends by completing an Insurance enrollment change at ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar within the deadline. To qualify for this special enrollment period, you or your Eligible Dependent must have lost the other vision plan coverage because coverage terminated due to loss of eligibility for coverage (for example, divorce, termination of Domestic Partnership, or termination of employment), because an employer's contributions for the coverage was terminated, or because Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") coverage is now exhausted. Coverage is effective the first day of the month after the request for enrollment is received.

In addition, if you have a new Eligible Dependent as a result of marriage, birth, adoption or placement for adoption (including guardianship of a minor child), you may be able to enroll your new Eligible Dependents under these HIPAA Special Enrollment Rights provided that you request enrollment within 30 days after the event by completing an Insurance enrollment at ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar, within the deadline. Coverage as a result of marriage is effective the first day of the month after the request for enrollment is received. Vision coverage for a new child as a result of birth, adoption, or placement for adoption (including guardianship of a minor child), is effective as of the date of birth, adoption, or placement for adoption.

Greater Rights Under the Vision Plan.
The Vision Plan provides you greater rights to make changes than are required by your HIPAA Special Enrollment Rights. For example, if your Eligible Dependents lose coverage under another vision plan you will also be able to enroll them between 31 and 60 days of the loss of coverage. In addition, if you have a new Eligible Dependent as a result of an establishment of a domestic partnership, birth, adoption or placement for adoption (including guardianship of a minor child), and you request enrollment between 31 and 60 days of the event, you can enroll your new Eligible Dependent through the Change in Status rules. See the other parts of this "Midyear Enrollment Changes" section for more information.

Judgments, Decrees and Orders

You may change your enrollment in the Vision Plan if a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (including National Medical Support Notices) requires you to provide vision insurance for your Eligible Dependent child or requires another individual to provide vision insurance under their policy. If the judgment, decree or order requires you to provide vision coverage, you may change your enrollment to provide coverage for the child. If the judgment, decree or order requires someone else to provide vision coverage, you may change your enrollment to drop coverage for the child.

The Vision Plan complies with all Qualified Medical Child Support Orders ("QMCSO"), including, but not limited to, National Medical Support Notices ("NMSN"), and National Medical Support Orders ("NMSO"). 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 or WEX, 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. If it is determined that the support order is qualified, Micron is required to withhold your share of the premium for the child's coverage. A change due to a QMCSO is effective the first of the month after the determination, expiring Notice, such as child reaching maximum age noted in the Notice, or receipt of Notice termination by the issuing agency.

Change in Cost or Coverage

Your enrollment in the Vision Plan may only be changed during the Plan Year due to a change in cost or coverage if:

- you experience one of the events listed in the "Change in Cost or Coverage Chart", and
- the enrollment change is consistent with the event.

If your provider joins or drops from a Provider Network, it does not meet the requirements for a change in Cost or Coverage and does not allow you to change your Vision Plan election during the Plan Year.

Change in Cost or Coverage

You must complete your insurance change enrollment on ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar within the deadline of the event. You must provide documentation within the enrollment deadline. The Effective Date is determined by first election or the event date as indicated in the following chart. If the event date and the date you report the event is the first of the month, your benefits are effective that day.

Change	Deadline & Change Allowed	Effective Date	Documentation Required
Your premium or other cost for the Micron Vision Plan significantly increases during the Plan Year.	Within 60 days you may drop your Vision Plan coverage. If no request is received, Micron will automatically increase your contributions under the Vision Plan.	First day of the month following event date	No Documentation Required

Your Micron Vision Plan is eliminated, ceases to be available in an area where you reside, there is a substantial overall decrease in providers available, there is a reduction in benefits for a specific type of condition for which treatment is being received or other similar fundamental loss of coverage.	Within 60 days you may change your vision plan enrollment to another vision plan offered by Micron in your work location, as long as that plan allows a change for this reason. You may also drop coverage if no similar vision plan is available.	First day of the month after you initiate your insurance change election	No Documentation Required
A new Micron vision plan is added midyear or a vision plan is significantly improved.	Within 60 days you may change your Vision Plan enrollment to the newly added plan if it is available in your area. You may not drop vision coverage.	First day of the month after you initiate your insurance change election	No Documentation Required
An enrollment change is made under another employer's plan so long as the other employer's vision plan allows an election change permitted under applicable IRS regulations or when the other employer plan has a different Plan Year (for example, the employer of your spouse/domestic partner has a plan year which starts August 1st, and your spouse/domestic partner adds you to that plan during its annual enrollment).	Within 60 days you may change your enrollment in the Vision Plan that is on account of and corresponds with the enrollment change allowed under the other employer's plan. You may not change Plans.	First day of the month after you initiate your insurance change election	*Copy of the benefit summary or enrollment confirmation statement showing Eligible Dependent's (or your) other vision coverage through another employer, including date

You, your spouse/domestic partner or your Eligible Dependents lose coverage under a vision plan sponsored by a governmental or educational institution, or a change in country residence such as relocating to the United States.	Within 60 days you may add yourself, your spouse/domestic partner, and your Eligible Dependents that lost vision coverage to Micron's coverage. You may not change Plans.	First day of the month after you initiate your insurance change election	*Copy of the benefit summary or enrollment confirmation statement showing Eligible Dependent's (or your) other vision coverage, including date *Copy of letter or documentation describing the loss in vision coverage

Leave of Absence

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

- an approved leave of absence qualifying under the FMLA,
- an approved military leave or caregiver 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, 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 Micron Paid Family Leave of absence.

You must pay all of your share of premiums accrued during the approved leave of absence. If premiums increase during your leave of absence you are required to pay the increased premium.

If you are receiving pay during the approved leave of absence, including regular pay, TOP pay or short-term disability pay, your premiums will be deducted from your pay. If you are not receiving pay during the approved leave of absence, your premiums, if any, will be paid by Micron on your behalf. You will still be responsible for payment of these premiums, and the premiums paid by Micron on your behalf will be deducted from your pay upon your return from the approved leave of absence.

If you have not returned to active employment after 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 the Vision Plan and your participation in the Vision 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 the Vision Plan, your participation will continue through the time specified in that regulation.

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, you may enroll yourself and your Eligible Dependents in the Vision Plan only if you complete an insurance election at ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's

address bar within 30 days of your return from the approved leave of absence. Upon return from an approved leave of absence, your coverage will go into effect on the date you return to work. If you fail to complete an insurance election on ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar within 30 days of your return, you will waive/decline Micron vision insurance coverage.

Access the benefits enrollment system at ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar. Contact the Global People Services at (800) 336-8918 or (208) 368-4748 for additional assistance.

If your employment with Micron ends while on an approved leave of absence, any premiums paid by Micron on your behalf will be deducted from your final paycheck. If you are unable to return due to a serious health condition or a situation beyond your control such as an unexpected transfer of your spouse or domestic partner to a job location that is more than 75 miles from your work site, any premiums paid by Micron on your behalf will not be deducted from your final paycheck.

Stopping Coverage. You also have the right to stop your coverage under the Vision Plan while on an approved leave of absence. If you decide to stop your coverage, you must complete an insurance election on ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar within 31 days of the start of your leave. The change will be effective the first of the month following your approved leave of absence date. 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 or part-time active employment after being gone for 24 (or 26 if SMFL for Caregiver Leave) consecutive calendar weeks, you may enroll you and your Eligible Dependents in the Vision Plan only if you complete an insurance election on ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar within 30 days of your return from the approved leave. Your coverage will be effective the date you returned from an approved leave. If you fail to complete your insurance enrollment on ENROLLNOW.micron.com from outside Micron (using Micron's Authenticator), or type ENROLLNOW/ in your browser's address bar within 30 days of your return to active employment, you will waive/decline Micron vision insurance coverage.

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.

Access the benefits enrollment system at ENROLLNOW.micron.com, or type ENROLLNOW/ in your browser's address bar. Contact the Global People Services at (800) 336-8918 or (208) 368-4748 for additional assistance.

When You Have Other Coverage

When your enrolled Eligible Dependents are covered by more than one vision plan, it is important that the Vision Plan has the necessary "coordination of benefits" (COB) information to determine which plan is primary (the first to pay) and which plan is secondary (may pay after the primary plan has paid depending on the primary plan's and the secondary plan's level of coverage).

If you have Eligible Dependents enrolled in the Vision Plan, you should update your COB information when it changes or when requested by VSP. For example, adding your new spouse or children if you get

married, establishing a new domestic partnership, adding dependents during annual enrollment, and adding a newborn child are situations where new COB information is needed.

Without this information, processing your enrolled Eligible Dependent's claims can be delayed and a denied claim will eventually result if you fail to provide COB information. Even if your enrolled Eligible Dependents do not have other vision coverage, COB information should be updated in order to avoid unnecessary delays in the processing of claims.

How Order of Payment is Determined. The rules used to determine which coverage is primary are as follows:

- The coverage that has no coordination requirement is primary.
- The coverage covering the patient as an active employee is primary.
- The coverage covering the patient as a dependent spouse or domestic partner is secondary.
- If you or your Eligible Dependents have other coverage as a dependent child (for example, coverage through your parent), and also covered as a spouse or domestic partner on another plan, the coverage that has been in force the longest is primary.
- The coverage of the parent whose birth date is earlier in the year is primary for dependent children. If parents have the same birth date, the coverage that has been in force the longest is primary. If the other coverage has a rule based on the gender of the parent, which contradicts this rule, the other rule prevails.
- When parents are divorced or separated and only one parent has custody of dependent children, the coverage of the custodial parent is primary unless there is a Qualified Medical Child Support Order, including a National Medical Support Notice, directing the non-custodial parent to maintain vision coverage.
- When parents are divorced or separated and both parents have joint custody of dependent children, the coverage of the parent whose birth date is earlier in the year is primary for dependent children. If parents have the same birth date, the coverage that has been in force the longest is primary. If the other coverage has a rule based on the gender of the parent which contradicts this rule, the other rule prevails.
- If you or your Eligible Dependents have other coverage as a result of being laid-off or retired, the coverage as a result of being an active employee is primary and the coverage as a result of being a laid-off or retired employee is secondary. If the other coverage contradicts this rule, this rule is ignored.
- If you or your Eligible Dependents have other coverage pursuant to federal or state continuation rights, the coverage as a result of being an active employee shall be primary and the coverage as a result of federal or state continuation rights shall be secondary. If the other coverage contradicts this rule, this rule is ignored.
- If none of the above determine which coverage is primary and which coverage is secondary, allowable expenses shall be shared equally between the plans or contracts.

No team member or Eligible Dependent is entitled to receive benefits for Covered Services under more than one Micron

enrollment.

When the Plan is Primary. Benefits are paid based only on the Vision Plan's coverage. There is no coordination with any secondary coverage you may have. Check your other coverage for information on how to file a claim.

When the Plan is Secondary. Benefits are paid so that the total combined reimbursement from your primary plan and the Micron Vision Plan equals the Micron Vision Plan's maximum benefit payment. This method of payment is known as "non-duplication of benefits" and works as follows:

- VSP calculates how much would have been paid without the other coverage. Any applicable deductibles and coinsurances will be taken into account.
- If the other plan's benefits are the same or more than this amount, the Micron Vision Plan will pay nothing.
- If the other plan pays less than this amount, the Micron Vision Plan will pay the difference.
- Benefits from both plans combined will equal the amount normally paid by the Micron Vision Plan.

When the Micron Vision Plan is secondary, Contracting Providers may not be required to recognize the Maximum Allowance as their fee for Covered Services. If you go to a Covered Provider you may be charged for an amount above the Maximum Allowance.

How to Submit Claims When Two Plans are Involved. It is important to file your claim properly to avoid lengthy processing delays when two plans are involved. If your Eligible Dependent has other coverage and the Micron Vision Plan is secondary, submit the claim to the other coverage first. After the other coverage determines what will be paid on the claim, submit a claim form and a copy of the explanation of benefits from the other coverage to VSP for processing.

Refunds, Settlements and Other Payments

If the Plan or Participant receives any refund, settlement or other payment related to Plan activities, the payment will first be paid over to Micron until all amounts Micron has paid toward Plan expenses out of the general assets of Micron 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 Micron in its sole and absolute discretion.

Appeals

There are two different types of appeals allowed for under the Vision Plan, each with two appeal levels.

- **Claims for Benefits (Claims Processing) Appeals**
  - First Level Appeal
  - Second Level Appeal
- **Eligibility & Enrollment Appeals**
  - First Level Appeal
  - Second Level Appeal

Claims for benefits and appeals are not handled by the Enrollment and Eligibility Appeals committees. Claims for benefits and appeals must be directed to the Third Party Administrator as described as follows.

You or your enrolled Eligible Dependents have 180 calendar days after notice is received of an adverse benefit determination to request a first level

appeal. The appeal must be received within the deadline specified. The appeals process varies depending on the type of appeal.

First Level Claim Processing Appeal

If you or your enrolled Eligible 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. If the appeal is for a decision to reduce or terminate an on-going program of benefits (that is, a concurrent care decision), an appeal must be filed within 30 days of your receipt of the notification of the decision to reduce or terminate treatment.

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

Member Appeals
VSP
3333 Quality Drive
Rancho Cordova, CA 95670
1.800.852.7600

First Level Eligibility and Enrollment Appeal.

If you or your enrolled Eligible Dependents disagree with a decision regarding your Vision Plan 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. The appeal must be received within the deadline specified.

You, your enrolled Eligible Dependent, or an authorized representative must e-mail, mail or fax a written request for review to the address below.

First Level Appeal
Global People Services, MS 1-727
Micron Technology, Inc.
8000 South Federal Way
P.O. Box 6
Boise, Idaho 83707-0006
Fax: (208) 492-1058
E-mail: first_level@micron.com

Authorized Representative. If you or your enrolled Eligible Dependent 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. In the case of an urgent care claim a treating Physician is also an authorized representative.

Appeal Review Process. The First Level Appeals Committee will review the 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 and VSP, as applicable, have 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.

A written decision will be provided regarding the written appeal within a reasonable period of time, but not longer than 60 days for an Eligibility and Enrollment appeal after the appeal is received. In the case of a claim regarding a determination of disability, a written decision will be provided regarding the

appeal within 45 days of receipt of the appeal (this period may be extended for a 30-day additional period twice if the First Level Appeals Committee determines that, due to matters beyond the control of the Plan, a decision cannot be rendered and First Level Appeals Committee provides notification of the extension before the end of the initial/extended review period).

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.

In addition, if the appeal involves a determination of disability, such notification will contain the following information provided in a culturally and linguistically appropriate manner:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - the views provided by your health care professionals who provided the treatment or evaluation;
    - the views of medical experts whose advice was obtained by the Plan, regardless of whether the advice was relied upon in making the appeal determination; and
    - any disability determination made by the Social Security Administration;
- If the appeal denial is based on medical necessity, experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or a statement that an explanation will be provided free of charge upon request;
- The specific internal guidelines that were relied upon in denying the appeal, or a statement that certain guidelines do not exist; and
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your appeal.

Second Level Claim Processing Appeal

If you or your enrolled Eligible Dependents disagree with the result of the first level claim processing appeal, you or your enrolled Eligible Dependent 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. The second level appeal must be received within the deadline specified.

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

Second Level Appeals Committee

VSP
3333 Quality Drive
Rancho Cordova, CA 95670
1.800.852.7600

Second Level Eligibility and Enrollment Appeal

If you or your enrolled Eligible Dependent disagree with the result of the first eligibility and enrollment appeal, you or your enrolled Eligible Dependent 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. The second level appeal must be received within the deadline specified.

You, your enrolled Eligible Dependent, or your authorized representative must e-mail, mail or fax your written request for review to:

Second Level Appeals Committee
Global People Services
MS 1-727
Micron Technology, Inc.
8000 South Federal Way
P.O. Box 6
Boise, Idaho 83707-0006
Fax: (208) 492-1058
E-Mail: second_level@micron.com

Appeal Review Process. The Second Level Appeals Committee will review the 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.

If the claim involves specific judgment, the review of an independent professional with appropriate experience in the area of treatment may be sought.

If the claim involves a determination of disability, the Second Level Appeals Committee will provide you, free of charge, with any new or additional evidence or rationale considered, relied upon, or generated by the Plan in connection with the claim as soon as possible and sufficiently in advance of the final notice to give you a reasonable opportunity to respond prior to that date.

The Second Level Appeals Committee and VSP, as applicable, have 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.

A written decision will be provided regarding the appeal within a reasonable period of time, but not longer than 60 days for an eligibility and enrollment appeal after the 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.

In addition, if the appeal involves a determination of disability, such notification will contain the following information provided in a culturally and linguistically appropriate manner:

- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - the views provided by your health care professionals who provided the treatment or evaluation;
    - the views of medical experts whose advice was obtained by the Plan, regardless of whether the advice was relied upon in making the appeal determination; and
    - any disability determination made by the Social Security Administration;
- If the appeal denial is based on medical necessity, experimental treatment, or similar exclusion, either

an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to your medical circumstances, or a statement that an explanation will be provided free of charge upon request;

- The specific internal guidelines that were relied upon in denying the appeal, or a statement that certain guidelines do not exist.

Your Appeal Rights

You and your enrolled Eligible Dependents 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; 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.
- If the denial of your claim was based in whole or in part on professional judgment, you have the right to require VSP to consult with a health care professional who has appropriate training and experience in the field involved in the professional judgment and who was neither part of the previous decision(s) to deny your claim nor the subordinate of any such individual.
- If VSP obtains advice from an expert in connection with your claim, you have the right to be notified that an expert was used and, upon written request by you, the name of the expert.

Appeals Committee Membership. Micron's Executive Vice President and Chief People Officer (or similar successor position) may appoint and remove members of the eligibility and enrollment Appeals Committees.

Lawsuits. This Plan requires that the Plan's 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 provided.

Release of Information

As a condition of coverage under the Vision Plan, each team member on behalf of themselves and their Eligible Dependents:

- authorize Covered Providers and other entities to provide the Vision Plan and its business partners any and all records and other information pertaining to health related services submitted for consideration of payment under the Vision Plan,
- authorize the Vision Plan and its business partners to use this information for Plan purposes including but not limited to reviewing, investigating and evaluating all claims and enabling the Plan and all its

business partners to provide the services outlined in the Plan,
- authorize the Vision Plan and its business partners to disclose any information obtained or payments made if such disclosures are necessary to allow the administration of services, the processing of claims or other disclosures allowed by HIPAA,
- authorize your providers to testify regarding the condition, care, or treatment of any covered individual; any and all provisions of law or professional ethics forbidding such disclosures or testimony are waived by and on behalf of each Participant, and
- authorize the Vision Plan and its business partners to pay Contracting Providers directly.

Business partners include VSP and other business associates.

Availability of Covered Services

Receipt of Covered Services are subject to the availability of Facility Providers and Professional Providers. The Vision Plan is not responsible for nor has any liability for conditions beyond its control which affect the Participant's ability to obtain Covered Services.

Provider Choice

The choice of a provider is solely the Participant's. Neither the Vision Plan nor its administrators furnish Covered Services. They only make payment for Covered Services received by Participants. Neither the Micron Vision Plan, Micron or its subsidiaries, VSP shall be liable for any act or omission or competence of any provider and none of them have responsibility for a provider's failure or refusal to provide Covered Services to a Participant.

Exclusion of General Damages

Liability under the Vision Plan for benefits, including recovery under any claim or breach of the Vision Plan, shall be limited to the actual benefits available under the Vision 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 the Vision Plan ends on the earlier of the following dates:

- the date the Vision Plan terminates,
- the last day of the month during which a Participant or Eligible Dependent dies,
- a date of termination described in the "Change in Status" section, or
- the last day of the month during which a Participant who is a team member loses eligibility under the Plan due to job status change including any approved leave of absence greater than 24 weeks and when a Participants' status as a regular full or part-time employee with Micron ends.

The Vision Plan may also, after a 30 day notice, terminate a Participant's coverage for any fraud, misrepresentation, omission or concealment of facts that could have impacted eligibility for coverage under the Vision Plan. Termination of coverage may be retroactive in the case of fraud or intentional misrepresentation.

Under certain circumstances, you and your Eligible Dependents may continue to participate on an after-tax basis provided you elect to continue participation in the Vision Plan pursuant to your rights under COBRA or other continuation rights

provided under the Vision Plan, and you make the required monthly premium payments to Micron. See the Health Care Continuation Coverage Notice (found in the Benefits Handbook) for more information about your rights and responsibilities.

Benefit Payment

Benefits you receive through this Plan are subject to the cost sharing features outlined in the Schedule for Services and Materials chart. Additionally, the following general payment rules apply to all benefit payments through this Plan:

- This Plan benefit payment is based on the lesser of actual charges filed or the Maximum Allowable charge.
- This Plan provides benefits for either lenses for eye glasses or contact lenses every calendar year, but not both.
- This Plan provides for frames every two calendar years.
- After receiving contact lenses you must wait until the following calendar year before being eligible for a frame allowance.
- This Plan provides benefits from either a Contracting Provider or an out-of-network Provider every calendar year, but not both.

Covered Providers

Covered Services must be rendered by Covered Providers acting within the scope of their applicable license to be eligible for reimbursement under this Plan.

The following types of providers are the only types covered by this Plan:

- Ophthalmologist, and
- Optometrist.

Contracting Provider

VSP has entered into contracts with optometrists and ophthalmologists nationwide to provide vision care services to members of this Plan. Your out-of-pocket cost varies based on whether you use a Contracting Provider or not. See the "Benefits Payment" section for information on your costs under this Plan.

Using a Contracting Provider. When calling the Contracting Provider office for an appointment, let them know you are a VSP participant covered through Micron's Vision Plan. The Contracting Provider is responsible for contacting VSP to verify coverage and available benefits. No claim forms are required.

- Be prepared to give the Contracting Provider your Date of Birth and last four digits of your Social Security number for any family member whom you are requesting service.
- You have 30 days to receive services after the Contracting Provider has verified coverage and available benefits through VSP.
- You must call VSP if you decide to utilize a different Contracting Provider after scheduling an appointment and having a Contracting Provider verify coverage and available benefits.

How to Find Contracting Providers. A list of Contracting Providers can be found by going to the VSP Web site (www.vsp.com). You may also call VSP at (800) 877-7195 to request a listing.

Contracting Providers may be added or deleted at any time without notice. Be sure to check with VSP if you have any questions about whether a covered provider is a Contracting Provider.

Payment to Contracting Providers. All Contracting Providers are paid directly for covered services and materials. You are responsible for your co-payments and the cost of non-covered services and materials.

Using an Out-of-Network Provider. If you choose to use an out-of-network Provider, you may have to pay up front for Covered Services, you may have higher out-of-pocket expenses, and you will be responsible for any amounts billed above the fee schedule listed in the Schedule for Services and Materials chart.

Using a Provider Outside of the United States. The benefits available under these plans are also available to Participants traveling or living outside the United States. There are no contracting providers outside the United States. If you require vision services outside the U.S., you will pay the full amount at the time of service and file a claim for reimbursement with VSP, within one year from the date of service. The Plan requires you to provide a copy of an itemized statement from the Provider along with an English translation, if applicable. It is the Participant's responsibility to provide this information. You will be responsible for any amounts billed above the fee schedule listed in the Schedule for Services and Materials chart for out-of-network Providers.

Covered Services

A Covered Service is a service, supply or procedure listed below that is provided by a Covered Provider. The following services are the only services covered under this Plan.

Eye Exams. The eye exam includes the following services:

- Case history,
- Distance and near acuities: habitual or uncorrected,
- External ocular examination,
- Internal ocular examination,
- Tonometry: for all persons over age 40 and other patients as appropriate,
- Distance refraction,
- Near refraction,
- Binocular coordination evaluation,
- Color vision testing as appropriate,
- Determination of treatment plan, and
- Disposition: advice to patient.

Second eye exam benefit requires confirmation by VSP of participant diabetic diagnosis with the medical plan administrator. If participant is covered under a medical plan other than those offered at Micron Technology, Inc., it is the participant's responsibility to provide VSP with current and valid documentation supporting a diabetic diagnosis.

Schedule for Services and Materials from a Contracting Provider

Covered Service	Your Cost	Conditions and Limitations
Eye Exam	You pay $10 copay	One eye exam once in a calendar year One eye exam twice in a calendar year for diabetic participants
Glasses: Lenses and Frames	**Lenses**: You pay $15 copay You pay $35 for standard anti-reflective coating **Frames:** You pay the amount over $130 for all frames	**Lenses:** One pair of lenses once in a calendar year **Frames:** One frame once every other calendar year
Contact Lenses (instead of glasses)	**Lenses and Fitting Fees:** You pay the amount over $130 for contact lenses and any applicable fitting fees	**Lenses:** Contact lens allowance once in a calendar year **Fitting Fees**: Fitting fees are included in the allowance. When required by state law, the full allowance may be applied to contact lenses only.
Colorblindness Glasses	**Frames and Lenses:** You pay amount over $500	Team Member only, every 24 months

Schedule for Services and Materials from an Out-of-network Provider		
Covered Service	**Your Cost**	**Conditions and Limitations**
Eye Exam	You pay the amount over $45	One eye exam once in a calendar year One eye exam twice in a calendar year for diabetic participants
Glasses: Lenses and Frames	**Lenses:** You pay the amount over $30 for single You pay the amount over $50 for bifocal You pay the amount over $65 for trifocal You pay the amount over $100 for Lenticular You pay the amount over $5 for tints **Frames:** You pay the amount over $70	**Lenses:** One pair of lenses once in a calendar year **Frames:** One frame once every two calendar years
Contact Lens (instead of glasses)	**Lenses and Fitting:** You pay the amount over $105 for contact lenses and any applicable fitting fees You pay the amount over $210 for Medically Necessary Contact Lenses	**Lenses:** Contact lens allowance once in a calendar year **Fitting Fees**: Fitting fees are included in the allowance. When required by state law, the full allowance may be applied to contact lenses only.
Colorblindness Glasses	**Frames and Lenses:** You pay amount over $500	Team Member only, every 24 months

Glasses - Frames. The following frames are covered by this Plan:

Any frame offered through a covered provider's office.

20% discount off any amount exceeding the frame allowance obtained from a contracting VSP provider.

Glasses - Lenses. The following basic lens materials are covered by this Plan:

1. Glass, plastic and polycarbonate lenses,
2. All ranges of prescriptions, including cataract lenses,
3. Single vision, lined bifocal and trifocal lenses,
4. Standard Progressive addition lenses,
5. Scratch Coating
6. UV Protection
7. Photochromic and Tints

Additional Lens Benefits.

All other lens options available at a 20% discount obtained from a contracting VSP provider.

20% discount for unlimited additional pairs of prescription glasses obtained from a contracting VSP provider within 12 months of the last covered eye exam.

20% discount for unlimited non-prescription sunglasses obtained from a contracting VSP provider within 12 months of the last covered eye exam.

Contact Lenses. Contact lenses are covered by this Plan except non-prescription cosmetic lens to change or enhance eye color.

15% off contact lens services, excluding materials obtained from a contracting VSP provider.

Medically Necessary contact lenses require prior approval based on qualifying criteria.

Covered conditions include; aphakia, anisometropia, high ametropia, nystagmus, keratoconus and other eye conditions that make contact lenses necessary.

VSP Warranty. VSP guarantees satisfaction for services and materials through a VSP preferred provider. VSP supports this by guaranteeing a hassle-free experience through the VSP Member Promise Program.

VSP supports the manufacturer's warranties on eyewear. Warranties vary depending on the product and manufacturer. On average, frames are warranted against manufacturer defects for at least one year (Marchon frames for two years). Lenses are typically warranted for a minimum of six months or longer depending on the product, manufacturer, preferred provider, and laboratory.

Contact Lens Program
For those team members that select contact lenses in lieu of glasses, the plan provides an allowance of $130 that can be used at a Contracting Provider, or $105 allowance that can be used at an out-of-network provider, toward the contact lens fitting and evaluation exam and any brand of contact lenses. There is a 15% discount applied to the fitting and evaluation exam. Additionally, team members have access to VSP Contact Lens Care Program from a VSP preferred provider.

The Contact Lens Care Program includes contact lens exam services and a six-month supply of approved lenses for standard fit current contact lens wearers. This program covers more than 68% of the soft specialty contact lenses dispensed, including toric, multifocal, and silicone hydrogen.

If a member selects a lens from a tier that is above their allowance they pay the difference. If a member selects a lens from a tier that is below their allowance they may apply the remaining balance toward additional contact lenses. Some members may require additional follow-up services when being fitted for contact lenses. VSP preferred providers will determine if a member is qualified for this program.

Most current contact lens wearers qualify for the Contact Lens Care Program but some require additional premium services that do not fall under this Plan. If team members do not qualify they will continue to have access to their $130 allowance at a Contracting Provider, or $105 allowance at an out-of-network provider, to be used towards the cost of their contact lens exam (discounted 15%) and any brand of contact lenses.
Medically necessary contact lenses are covered in full (less any applicable copay) for members who have specific conditions for which contact lenses provide better visual correction than glasses.

In some states, doctors may not be required to release contact lens prescription information.

Non-Covered Services

Any services or materials not specifically listed as a Covered Service are not covered by this Plan. If you purchase a non-covered material, you will be responsible for any additional cost.

The following lens materials are optional and are not covered by this Plan, but are offered through VSP at a 20% discount or fixed fee as listed on the Schedule for Services and Materials Chart:

1. Polarized lenses,
2. Hi-index lenses,
3. Intermediate vision lenses.

If you are unsure of what services or materials you are currently eligible for, you may call VSP at (800) 877-7195.

Type of Claim

A claim is a request for benefits under the Plan. If you have any questions regarding the claims procedure to follow, call VSP at (800) 877-7195.

How Claims are Processed

How to File a Claim. The Plan will not make any payment to you or a non-Contracting Provider unless a completed claim is submitted in a timely manner. Either you or an out-of-network Provider can submit a claim, but it must be submitted to VSP within 6 months from the date a Covered Service is provided.

Follow these steps if you are filing the claim:

1. Print the claim form, or colorblindness glasses claim form on PeopleNow/, or call the Global People Services at (800) 336-8918 or (208) 368-4748 to request a form.
2. Ask your optometrist or ophthalmologist for an itemized billing. This should show the name of the patient, each service received, the date the service was provided, and the charge for each service. A billing that says only "Balance Due", "Payment Received" or something similar is not an itemized billing and cannot be processed.
3. Attach a copy of your billing to the claim form and send it to the address shown on the form.
4. You will be reimbursed up to the amounts allowed under the Schedule for Services and Materials for an Out-of-network Provider.
5. If services are received from an out-of-network provider and the provider has the ability to bill insurance companies they can submit claims directly to VSP under an assignment of benefits. Team members would only need to pay for any overage charges above the schedule of allowances and VSP may reimburse the scheduled amounts to the provider directly.

Contracting Providers should file the claim directly to VSP for processing.

Determination of a Claim. VSP will process your claim based on this Plan's 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 notice of the denial containing the following information:

1. The reason for the denial,
2. A reference to and a description of the Plan provisions on which the denial is based,
3. Information on how to request a review of the denial, and
4. Other information about the reason for the denial and your options.

Information on processed claims can be found by using the VSP Web site (www.vsp.com) or by calling VSP at (800) 877-7195.

Payment to a Contracting Provider. If the Covered Provider is a Contracting Provider, payment is made directly to the Contracting Provider based on contracted rates in the provider's geographic area.

Payment to You. If services are received at from an out-of-network Provider, payment is made to you based on the Schedule for Services and Materials for an Out-of-network Provider. The payment is

included with your Explanation of Benefits. If the out-of-network provider has the ability to bill insurance companies, VSP may make payment based on the schedule of allowances mentioned above directly to the provider

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

Request to Withhold Payment. VSP is not able to withhold payment of benefits upon request by a Participant once Covered Services are rendered and a claim is submitted by a Covered Provider.

Assignment of Benefits*.* If services are received from an out-of-network provider and the provider has the ability to bill insurance companies they can submit claims directly to VSP under an assignment of benefits. Team members would only need to pay for any overage charges above the schedule of allowances and VSP may reimburse the scheduled amounts to the provider directly. 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, VSP and Micron of any further responsibility for payment to the Participant.

Unclaimed Property. VSP follows appropriate state laws when checks remain uncashed. Typically, if checks remain uncashed after approximately one year and due diligence to locate the owners is unsuccessful, the check becomes "unclaimed property." VSP will submit the funds to the payee state for handling in accordance with each state's unclaimed property laws and regulations.

Health Insurance Portability and Accountability Act (HIPAA)

The Vision Plan has been written to comply with all requirements of HIPAA.

- See the HIPAA Privacy Notice (found in the Benefits Handbook) for more information on how the Micron Vision Plan uses and discloses your vision information.

Definitions

Coinsurance**.** A specified dollar amount which the Participant is required to pay which is calculated using a specified percentage of the lesser of actual charges or Maximum Allowable amount applicable to the Covered Services. The coinsurance must be paid to the provider of such service.

Contracting Provider. Contracting Providers are Covered Providers who have agreed to recognize the applicable Maximum Allowance as their fee for Covered Services by entering into an agreement.

Copay**.** A specified dollar amount which the Participant is required to pay for certain Covered Services. The copayment must be paid to the provider of such service.

Covered Service. A Covered Service is a service, supply or procedure listed below that is both Visually Necessary and provided by a Covered Provider.

Effective Date. The date when coverage for a Participant begins under this Plan.

Out-of-Network Provider. Service providers who are not VSP network service providers at the time service is rendered.

Ocularist. An individual who is licensed to practice fabrication and fitting of custom made ocular prosthetics by the state where the service is provided. In states where Ocularists are not required to be licensed, one who is skilled in the design, fabrication and fitting of artificial eyes and the making of prostheses associated with the appearance of function of the eyes, and who is a Board Certified Ocularist by the National Examining Board of Ocularists.

Ophthalmologist. An eye specialist for vision and surgical problems. Since ophthalmologists perform operations on eyes, they are considered to be both a surgical and vision specialty.

Optometrist. An individual licensed to practice optometry by the state where the service is provided.

Participant. An Eligible team member or Eligible Dependent who has enrolled as required by this Plan.

Plan. The Micron Technology, Inc. Vision Plan as set forth in this document as amended from time to time.

Third Party Contract Administrator (TPA). An organization that handles the claims processing for the Micron self-insured Vision Plan.

Vision Service Plan (VSP). A company, hired by Micron to act as the third party contract administrator to perform vision claims processing and other specific administrative services as outlined in this Plan and/or Administrative Services Agreement.