This section of the benefits handbook is applicable to Micron self-insured medical plans, the Dental Plan, the Dental Plus Plan, and the Delta Dental Plan (the "Health Plans").

Team members assigned to the San Jose, California, Folsom, California, or Manassas, Virginia employment locations in Micron's internal database are also eligible to participate in a fully-insured Kaiser Permanente HMO Medical Plan. Team members on an International Assignment greater than 6 months will participate in the Cigna fully insured International Medical Plan which includes dental coverage. **Please note: Particpants enrolled in the Kaiser HMO Medical Plans, or the Cigna International Medical Plan have 31 days to make changes to their enrollment in association with a qualified midyear event.** Please refer to the appropriate Plan materials posted on PeopleNow/ for additional information.

Team members assigned to an Idaho employment location in Micron's internal database are also eligible to participate in the the fully-insured Willamette Dental Blue Plan.

See the Additional Medical and Dental Plan sections of this Benefits Handbook for eligibility and enrollment information and additional information about the fully-insured plans.

Your Eligibility in the Micron Health Plans.

You are eligible to participate in the Health Plans if you are actively employed and classified by Micron as a regular, full-time or part-time team member or an intern of Micron Technology, Inc. ("Micron") or a wholly owned US-based Micron subsidiary.

Team members assigned to an eligible Idaho employment location in Micron's internal database are eligible to participate in the Value High Deductible Medical Plan, Consumer Directed High Deductible Medical Plan, Value PPO Medical Plan, Idaho PPO Medical Plan, the Dental Plan, Dental Plus Plan and the Delta Dental Plan. The Saint Alphonsus Coordinated Care Plan and St. Luke's Coordinated Care Plan are being discontinued December 31, 2021. In their place, Idaho team members will have two new plans to choose from; the Value PPO Medical Plan, and the Idaho PPO Medical Plan.

Team members assigned to an eligible employment location outside of Idaho in Micron's internal database are eligible to participate in the Value High Deductible Medical Plan, Consumer Directed High Deductible Medical Plan, Value PPO Medical Plan, PPO Medical Plan, the Dental Plan, Dental Plus Plan, and the Delta Dental Plan.

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

- 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 Health Plans.

***Ineligible Team Members*.** You are ineligible to participate in the Health Plans if:

- You are on an expatriate assignment of at least 6 months or your extended international business travel assignment has reached 6 months, or
- You are an individual whose terms and conditions of employment are governed by a collective bargaining agreement, or
- You are an individual who has waived participation in the Plan through any means including individuals whose employment is governed by a written agreement with Micron (including an offer letter setting forth the terms and

conditions of employment) that provides that the individual is not eligible to participate in the Plan.

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 Health Plans, you are required to meet all eligibility and enrollment requirements before coverage begins.

Eligibility During a Leave of Absence. Your participation in the Health Plans 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 Birth and Adoption 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 Medical System, and any other category of persons designated by the President of the United States in time of war or emergency.

If you have not returned to 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 Health Plans 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 Health Plans, 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 Birth and Adoption 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 in the Health Plans. Return to qualifying active employment in a position that is

otherwise eligible to participate in the Health Plans. If you return to active employment following an approved Birth and Adoption 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 Health Plans.

- 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 Health Plans. Your domestic partner, as defined by the Micron Domestic Partner Affidavit, is eligible to participate in the Health Plans.

Child Under Age 26. Your, or your domestic partner's, child who is under age 26 is eligible to participate in the Health Plans 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 Health Plans 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 Health Plans, 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. Please see the coordination of benefits provisions in the underlying Health Plan documents for more information on how the Health Plan will pay when a dependent is covered by multiple plans.

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 requirement 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 Health Plans. For example, among other situations, a stepchild 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.

It is your responsibility to periodically review your enrolled dependents to ensure they meet the dependent eligiblity requirements. Ineligible dependents must be removed from the Health Plans.

Premium for Eligible Dependents.

Except with respect to certain domestic partners and their children, the Health Plans are 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 Health Plans 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 afffidavit and certify whether the domestic partner or child qualifies as your tax dependent.

By enrolling your dependents in the Health Plans:

- 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 Health Plans.

Determination of Dependent Eligibility. Micron will rely upon information provided by you and your dependents when determining eligibility for the Health Plans. 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 Health Plans.

You will be required to provide evidence of eligibility for any newly added Eligible Dependent within the enrollment deadline for the associated event. Documentation requirements and instruction are provided on ENROLLNOW/ or enrollnow.micron.com. 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 once you have exceeded 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.

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 rescision. You and/or your dependent may also be held

liable for any penalties or fines imposed on the Health Plans by a governmental agency.

Benefits Enrollment System

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

Initial Enrollment

Dental: Newly eligible full-time and part-time team members must complete their Initial Enrollment and select a Dental Plan to be enrolled in a dental plan. You may enroll yourself and your Eligible Dependents if you wish to have them covered on the dental plan. If you fail to complete the enrollment process within 30 days of your hire date, you will waive dental coverage through Micron. You must use the Benefits Enrollment System to enroll in coverage.

Medical: Newly eligible full-time team members, part-time team members, and intern team members are automatically enrolled for employee-only coverage in the Value High Deductible Medical Plan unless such team members elect to enroll in another Health Plan or waive medical coverage as described below. However:

- such automatically-enrolled team members will not be entitled to a Micron health savings account (HSA) contribution unless such team member completes the HSA bank account setup before October 31 of the current plan year;
- such automatic enrollment will not include any Eligible Dependents – you must affirmatively enroll Eligible Dependents if you want them covered by the Health Plans.

To enroll your Eligible Dependents in the Health Plans or change the medical plan you must complete the enrollment process within 30 days of your hire date by using the Benefits Enrollment System: enrollnow.micron.com (using DUO Authenticator) from outside Micron, 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 Micron benefit coverage.

You have 60 days from your hire date to provide dependent documentation. See below for more information on changing your enrollment election outside of the initial enrollment process.

No team member or Eligible Dependent is entitled to receive benefits for Covered Services under more than one Micron 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. For new hires that enroll timely, the Effective Date of coverage is the date of hire. If you transfer from a wholly owned US based Micron subisdiary, the Effective Date of coverage is the first day of the calendar month following the date your transfer was completed in WorkDay. 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.

Enrollment Date for Transfers. If you are transferring to Micron or another wholly owned US-based Micron subsidiary directly 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. You can access a benefit summary or benefit confirmation at any time on-line using the enrollment system by accessing ENROLLNOW.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar. Your benefit summary or benefit confirmation may be requested in the event of a dispute.

Premiums

By enrolling in the Health Plans, 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 Medical and Dental Plans will continue through the last day of the month of separation, however, premiums will cease following your final paycheck wihholding.
- 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 you 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.

Important Notice for Team Members who Decline Medical or Dental Coverage.

You may waive Micron's medical coverage.

If you waive medical or dental coverage and later decide you would like to enroll in one of the Health Plans, you must either experience a qualifying change of status as explained in the "Midyear Enrollment Changes" section or enroll during the next Annual Enrollment.

If you waive medical or dental coverage and later notify us that you have lost your other medical or dental coverage, through HIPAA Special Enrollment Rights, you may enroll yourself and your Eligible Dependents in one of the Health Plans only if you inform the

Global People Services within 30 days of the loss of coverage by completing an insurance change enrollment election on ENROLLNOW/ which must be completed within the deadline. See the "HIPAA Special Enrollment Rights" section for more information.

Annual Enrollment

Micron's Annual Enrollment takes place each year in November. You may change your enrollment in the Health Plans, including waiving medical or dental 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 (using DUO Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar. You must use the Benefits Enrollment System to enroll in coverage.

Unless communicated otherwise, 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. Team members waiving Micron medical coverage are not required to waive coverage each year during Annual Enrollment. 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 for newly added dependents within the Annual Enrollment deadine.

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 once you have exceeded 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. You can access a benefit summary or benefit confirmation at any time on-line using the enrollment system by accessing ENROLLNOW.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar. Your benefit summary or benefit confirmation may be requested in the event of a dispute.

Midyear Enrollment Changes

Your enrollment in the Health Plans 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. Documentation supporting the midyear enrollment and newly added dependents is required for Midyear Enrollment Changes. Documentation requirements and instruction are provided on Enrollnow.micron.com (using DUO Authenticator) and ENROLLNOW/. Event and dependent documentation must be provided within the enrollment deadline.

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 one or more of the Health Plans, you must complete your enrollment change on Enrollnow.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar within the enrollment deadline of the event.

Please see the COVID National Emergency Notice below for more information about relief granted to Team Members who fail to timely enroll due to the COVID National Emergency.

Please note; **all midyear enrollment changes must be completed within 31 days if you are enrolled in a Kaiser HMO plan or the CIGNA plan**.

You are required to provide supporting documentation for certain midyear events and all newly added dependents within the enrollment deadline. Event Documentation may include but is not limited to enrollment confirmation documents, COBRA letter, copy of new insurance ID card. Dependent 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 once you have exceeded 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 election on-line at through the Benefits Enrollment System Enrollnow.micron.com (using DUO Authenticator) from outside Micron, 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.

- 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.

- In the event of divorce or termination of a domestic partership, if the enrollment change is made within the appropriate time period, the change is retroactive back to the date of divorce or termination of domestic partnership. If the enrollment change is made after the appropriate time period, the change is retroactive back to the later of the date of divorce or termination of domestic partnership or January 1st of the current plan year.

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

Important Notice when returning from a Micron Expatriate Assignment greater than 6 months. If you fail to make an enrollment election within 31 days of the date of your return, Micron will choose a medical and dental plan for you which will be effective the first day of month following your return from Expatriate assignment. When returning from an expatriate assignment, you are not permitted to add or remove Eligible Dependents unless a special enrollment rights event (see discussion above) coincides with your return from the expatriate assignment.

Important Notice when a Change in Work Location occurs (see Change in Status Chart for additional information). If you fail to make an enrollment election within 31 days of the date of your move, Micron will choose a medical and dental plan for you which will be effective the first day of the month following your date of relocation into different medical plan service areas. In connection with your change in work location You are not permitted to add or remove Eligible Dependents unless a special enrollment rights event (see discussion above) coincides with your move.

Coordination with Severance Plan

If a terminated Participant is eligible for benefits pursuant to a severance plan operated by the Employer 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 Health Plans 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 Micron's medical and/or dental plans or an another employer's medical and/or dental 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 medical or dental plan. Documentation supporting the event, and all newly added dependents, is required for all Midyear Changes. Documentation requirements and instruction are provided on Enrollnow.micron.com. Below are some examples of how the consistency rule works.

- It is consistent to add medical coverage when you or your Eligible Dependents lose medical coverage under another employer's medical plan. It is not consistent to add dental coverage when you or your Eligible Dependents lose medical coverage under another employer's medical plan.
- It is consistent to add dependents when a change in status event results in new eligibility for a dependent. 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 definition of Eligible Dependent.
- 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 medical or dental plans or add existing dependents that are not newly Eligible.
- It is consistent to enroll in Micron dental 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 coverge.
- It is consistent to change the medical plan when transferring from Idaho to Virginia because the event resulted in eligibility for different medical plan options. It is not consistent to change medical plans when transferring from Minnesota to Texas because the same medical 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 and dependent Documentation must be provided within the

enrollment deadline. Documentation requirements and instruction are provided on Enrollnow.micron.com (using DUO 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 Micron Plans, 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 once you have exceeded the deadline. You must always timely complete the applicable enrollment process even if you receive an extension to provide documentation.

Please see the COVID National Emergency Notice below for more information about relief granted to Team Members who fail to timely enroll due to the COVID National Emergency.

Health Care Navigator

Blue Cross of Idaho offers a Health Care Navigator, to assist you and your covered dependents with confidential advice about complex medical and insurance concerns. The Health Care Navigator is an employee of Blue Cross of Idaho.

Change in Status

You must complete your insurance change enrollment on Enrollnow.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar within the deadline of the event. (Enrollment deadline is always 31 days for changes associated with the Kaiser HMO or Cigna International plans) 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 (31 days for Kaiser or Cigna) 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 medical or dental 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 (31 days for Kaiser or Cigna) 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 medical or dental 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 (31 days for Kaiser or Cigna) 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 medical or dental 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 (31 days for Kaiser or Cigna) 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 medical or dental 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 (31 days for Kaiser and Cigna) you must drop coverage for a spouse, domestic partner, child of a domestic partner, or dependent who dies. You may not change Plans. 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 (31 days for Kaiser or Cigna) you may add 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 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 an Unpaid FMLA, Personal Leave of Absence or Military 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
Intern conversion to Regular FT/PT Status	Within 30 days you may elect dental coverage for yourself and/or your Eligible Dependents	The date of your status change	No Documentation necessary

Change in you or your Eligible Dependent's **employment status** that triggers eligibility under another employer's health 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 you or your Eligible Dependent goes from part-time to full-time) or any other similar change which makes your dependent eligible for another employer's health plans.	Within 60 days you may drop yourself, your spouse/domestic partner and/or other Eligible Dependents enrolled in Micron's Medical and/or Dental Plan only if the individual(s) you are dropping are enrolled in the other medical and/or dental 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 benefits summary 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 health plans 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 you or your Eligible Dependent goes from full-time to part-time), or any other similar change which makes the individual ineligible	Within 60 days you may add yourself, your spouse/domestic partner and/or other Eligible Dependents who have lost eligibility under the other plans. You may not change Plans.	First day of the month after you initiate your insurance change election	*Copy of the benefits summary 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 (for example, large increase in employee contributions, elimination of the dependent's existing plan)

for another employer's health plans.			
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
Eligible Dependent meets eligibility requirements.	Within 60 days you may add the impacted Eligible Dependent.	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
Commencement of a Micron Expatriate Assignment greater than 6 months	Within 31 days your medical and dental plan enrollment will be changed to the Cigna International Health Plan. You may not add or remove Eligible Dependent coverage.	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 must change your medical and dental plan enrollment to the Health Plan offered in the United States according to your employment location in Micron's internal database. If you do not make a selection, Micron will make a selection for you. You may not add or remove Eligible Dependent coverage.	First day of the month after your return from Expatriate Assignment was completed in WorkDay	No Documentation necessary
Permanent Transfer from a non-US Micron subsidiary which did not offer these Health Plans.	Within 30 days you may enroll in Health Plans offered in the United States according to your employment location in Micron's internal database. If you do not make a selection, Micron will enroll you in employee only Value High Deductible Medical Plan without HSA, and you will waive Dental coverage.	Date Transfer to the United States was completed in WorkDay	No Documentation necessary
Commencement of a Temporary work assignment outside the managed care service area for your Kaiser HMO or Willamette Dental Plan enrollment.	Within 60 days you may change your medical or dental plan enrollment to a plan offered in the area of your temporary assignment in Micron's internal database. You may not add or remove Eligible Dependent coverage.	First day of the month after you initiate your insurance change election	No Documentation necessary

Return from a Temporary work assignment outside the managed care service area for the Kaiser HMO or Willamette Dental Plan enrollment.	Within 60 days you may change your medical or dental plan enrollment to a plan offered in the area of your permanent employment location in Micron's internal database. You may not add or remove Eligible Dependent coverage.	First day of the month after you initiate your insurance change election	No Documentation necessary
Permanent Transfer to a different Micron US location	Within 31 days you may change your medical plan or dental plan if you move into an area in Micron's internal database that has additional medical or dental plans to choose from or if you move out of the service area of your current medical or dental plan which results in a loss of eligibility for that coverage. If you move out of the service area of your current medical or dental plan resulting in loss of eligibility for that coverage, you must choose a new plan and enroll. If you do not make a selection, Micron will make a selection for you. You may not add or remove Eligible Dependent coverage.	First day of the month after your transfer to different Micron US location 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 a Micron Medical 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 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	No Documentation necessary
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 a Micron Medical Plan. You may not change Medical or Dental Plans.	First day of the month after you initiate your insurance change election	No Documentation necessary

HIPAA Special Enrollment Rights

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 health insurance coverage, under HIPAA you may, in the future, be able to enroll yourself or your Eligible Dependents in the Health Plans provided that you complete enrollment within 30 days after your other coverage ends by completing an insurance change enrollment election on Enrollnow.micron.com from outside Micron, or type ENROLLNOW/ (using DUO Authenticator) in your browser's address bar which must be completed within the deadline. To qualify for this special enrollment period, you or your Eligible Dependent must have lost the other health 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 ("COBRA") coverage is now exhausted. Coverage is effective the first day of the month after the request for enrollment is completed.

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 complete enrollment within 30 days after the event by completing an insurance change enrollment election on Enrollnow.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar, which must be completed within the deadline. Coverage as a result of marriage is effective the first day of the month after the request for enrollment is received. Medical 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 the birth, adoption, or placement for adoption (including guardianship of a minor child) if enrollment occurs within 30 days of the event.

Please see the COVID National Emergency Notice below for more information about relief granted to Team Members who fail to timely enroll due to the COVID National Emergency.

Greater Rights Under the Health Plans. The Health Plans provide 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 medical 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 establishment of domestic partnership, birth, adoption or placement for adoption (including guardianship of a minor child), and you complete 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 Health Plans 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 medical insurance for your Eligible Dependent child or requires another individual to provide medical or dental insurance under their policy. If the judgment, decree or order requires you to provide medical or dental coverage, you may change your enrollment to provide coverage for the child. If the judgment, decree or order requires someone else to provide medical coverage, you may change your enrollment to drop coverage for the child.

The Health Plans comply 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 benefitexpress, 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 Health Plans 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 Health Plan election during the Plan Year.

Change in Cost or Coverage

You must complete your insurance change enrollment on benenroll.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar within the deadline of the event. (Enrollment deadline is always 31 days for changes associated with the Kaiser HMO or Cigna International plans) You must provide documentation within the enrollment deadline. The Effective Date is determined by first election or 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 for the Micron Health Plans significantly increases during the Plan Year	Within 60 days you may change your health plan enrollment to another health plan offered by Micron in your work location, as long as that plan provides similar coverage and allows a change for this reason. You may also drop coverage. If no request is received, Micron will automatically increase your contributions under the Health Plans.	First day of the month after you initiate your insurance change election	No Documentation Required

Your Micron health plan is eliminated, your HMO ceases to be available in an area where you reside, there is a substantial overall decrease in providers available under your medical plan, there is a reduction in benefits for a specific type of medical condition for which treatment is being received or other similar fundamental loss of coverage.	Within 60 days you may change your health plan enrollment to another health plan offered by Micron in your work location, if that plan allows a change for this reason. You may also drop coverage if no similar health plan is available.	First day of the month after you initiate your insurance change election	No Documentation Required
There is a significant increase midyear in the Micron health plans deductible, co-pay, or Out-of-pocket Maximum of your health plan, or there is another significant curtailment of coverage that does not result in a loss of coverage.	Within 60 days you may change your health plan enrollment to another health plan offered by Micron in your work location, if that plan allows a change for this reason. You may not drop coverage.	First day of the month after you initiate your insurance change election	No Documentation Required

A new Micron health plan is added midyear, or a health plan is significantly improved.	Within 60 days you may change your health plan enrollment to the newly added or newly improved plan if it is offered in your work location. You may not drop 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 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 and/or your Eligible Dependents enrollment in the Health Plans 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 benefits summary showing Eligible Dependent's (or your) other medical and or dental coverage through another employer
You enroll yourself and/or Eligible Dependents in a Marketplace health plan during a special or annual enrollment period.	Within 60 days you may change your and/or your Eligible Dependents' enrollment in the Health Plans that is on account of and corresponds with the enrollment change you made in the Marketplace. You may not change Plans.	First day of the month after you initiate your insurance change election	Copy of Marketplace enrollment showing medical and or dental coverage

You, your spouse/domestic partner or your Eligible Dependents lose coverage under a health plan sponsored by a governmental or educational institution, or Marketplace Insurance, or a change in country residence such as relocating to the United States. Governmental institutions include a state's children's health insurance program under Title XXI of the Social Security Act; a medical care program of an Indian Tribal government, the Indian Health Service, or a tribal organization; a state health benefits risk pool; or a foreign government group health plan.	Within 60 days you may add yourself, your spouse/domestic partner, and your Eligible Dependents that lost 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 benefits summary showing Eligible Dependent's (or your) loss of other medical and or dental coverage Copy of letter or documentation describing the loss in medical and or dental coverage Copy of the Marketplace cancelation

Leave of Absence

Continuing Coverage. Your participation in the Health Plans 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, or
- an approved state mandated leave of absence.
- an approved Birth and Adoption 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 Health Plans and your participation in the Health Plans 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 Health Plans, 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 Health Plans only if you complete an enrollment election on enrollnow.micron.com from outside Micron, or type ENROLLNOW/ (using DUO Authenticator) in your browser's address bar, which must be completed within 31 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 your enrollment election within 31 days of your return, you will be enrolled in team member only coverage on the Value High Deductible Medical Plan without HSA and waive Micron dental insurance coverage.

Access the benefits enrollment system at ENROLLNOW.micron.com (using DUO Authenticator) from outside Micron, 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 Health Plans while on an approved leave of absence. If you decide to stop your coverage, you must complete an enrollment election on Enrollnow.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar, which must be completed within 31 days of the approved leave of absence date. The change will be effective the first of the month following the date of your approved leave. 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, you may enroll you and your Eligible Dependents in the Health Plans only if you complete an enrollment election on Enrollnow.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar within 31 days of your return from the approved leave of absence. Your enrollment must be completed within the deadline. Your coverage will be effective the date you returned from an approved leave. If you fail to complete your enrollment election on Enrollnow.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW/ in your browser's address bar within 31 days of your return, you will be enrolled in team member only coverage on the Value High Deductible Medical Plan without HSA, and waive Micron dental 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.

When You Have Other Coverage

When your enrolled Eligible Dependents are covered by more than one medical or dental plan, it is important that the Micron Health 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 plans' and the 'secondary plans' level of coverage).

If you have Eligible Dependents enrolled in a Micron Medical or Dental Plan, you should update your COB information when it changes or when requested by Blue Cross of Idaho, or Delta Dental. For example, adding your new spouse or children if you get married, establishing a new domestic partnership, 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 medical or dental 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 or Dental Child Support Order, including a National Medical Support Notice, directing the non-custodial parent to maintain medical or dental 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 long-est 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 Micron Medical or Dental 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 Medical or Dental Plan equals the Micron Medical or Dental Plan's maximum benefit payment. This method of payment is known as "non-duplication of benefits" and works as follows:

- Blue Cross of Idaho or Delta Dental 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 Medical or Dental Plan will pay nothing.
- If the other plan pays less than this amount, the Micron Medical or Dental Plan will pay the difference.
- Benefits from both plans combined will equal the amount normally paid by the Micron Medical or Dental Plan.

When the Micron Medical or Dental 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 Medical or Dental 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 Blue Cross of Idaho or Delta Dental for processing.

Appeals Claims for Benefits Appeals

Claims for benefits and appeal information and instruction is provided in the Benefits Handbook. Please see the Medical or Dental Summary Plan Description (section) of the Benefits Handbook relevant to your enrollment and claim in dispute.

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 in the Summary Plan Description for each Health Plan.

Enrollment and Eligibility Appeals

There are two different types of appeals allowed for under the Health Plans.

- First Level Appeal
- Second Level Appeal

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.

If you or your enrolled Eligible Dependents disagree with a decision regarding your Health Plans 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 01-727
Micron Technology, Inc.
8000 South Federal Way
P.O. Box 6
Boise, Idaho 83707-0006
Fax: (208) 368-1553
E-mail: first_level@micron.com

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

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 benefit 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 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 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 your authorized representative must e-mail, mail or fax your written request for review to:

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

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

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

A written decision will be provided regarding the appeal within a reasonable period of time, but not longer than60 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 claim/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 claim 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 appeal at no cost. A document, record or other information is considered related to your appeal 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.

Appeals Committee Membership. Micron's Senior Vice President of People Services 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 of a denied enrollment or denied eligibility notification.

Subrogation and Reimbursement Rights

The Health Plans have a right to Subrogation and Reimbursement. These rights are detailedin the portion of this Benefits Handbook that describes the benefits provided under each of the Health Plans and the About Your Rights Section.

Release of Information

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

- authorize Covered Providers and other entities to provide the Health Plans and its business partners any and all records and other information pertaining to health related services submitted for consideration of payment under the Health Plans,
- authorize the Health Plans 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 Health Plans 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 in behalf of each Participant, and
- authorize the Health Plans and its business partners to pay Contracting Providers directly.

Business partners include Blue Cross of Idaho and/or Blue Shield Provider Networks, Delta Dental, and other business associates.

Termination of Coverage

Enrollment in the Health Plans ends on the earlier of the following dates:

- the date the Health Plans terminate,
- the day after an Eligible Dependent dies,
- the last day of the month during which a Participant who is a team member 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 Health Plans 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 Health Plans. Termination of coverage may be retroactive in the case of fraud or intentional misrepresentation.

In the event of termination, the following benefit will continue.

- On the medical plans, participants who are hospitalized at the time their coverage in the Health Plans ended continue to be eligible for Inpatient Hospital Services until discharge. No other Covered Services are continued.

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 Health Plans pursuant to your rights under the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or other continuation rights under the Medical and/or Dental 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.

Newborns' and Mothers' Health Protection Act of 1996

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

prescribing a length of stay not in excess of 48 hours (or 96 hours). The Medical Plans comply with this law.

Women's Health and Cancer Rights Act of 1998

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

Health Insurance Portability and Accountability Act (HIPAA)

The Health Plans have 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 Health Plan uses and discloses your medical information.

No Surprises Act

The No Surprises Act is a federal law that, effective as of January 1, 2022, protects you from being balance billed for the costs of certain medical services in excess of the amounts paid by the Health Plan in the following situations:

- you receive emergency care (including air ambulance services) and are treated by an out-of-network provider, and
- you receive certain non-emergency care at an in-network hospital or ambulatory surgical center, but are treated by an out-of-network provider.

Additional information regarding the No Surprises Act can be found in the [insert reference – mention notice?].

COVID National Emergency

For the period beginning **March 1, 2020 and ending 60 days after the US President declares an end to the COVID-19 national emergency**, upon the occurrence of the applicable event, the following deadlines will be extended for a Team Member for up to 12 months or until such time that the national emergency ends (if sooner than 12 months) based on the applicable event.

- The 30-day period (or 60-day period, if applicable) to request special enrollment under ERISA
- The 60-day election period for COBRA continuation coverage
- The date for making COBRA premium payments
- The date for individuals to notify the plan of a qualifying event or determination of disability under COBRA
- The date within which individuals may file a benefit claim under the plan's claims procedures
- The date within which claimants may file an appeal of an adverse benefit determination under the plan's claims procedures
- The date within which claimants may file a request for an external review after receipt of an adverse benefit determination or final internal adverse benefit determination
- The date within which a claimant may file information to perfect a request for external review upon a finding that the request was not complete
- With respect to group health plans, and their sponsors and administrators, the date for providing a COBRA election notice.