Micron offers a Day Care Flexible Spending Account Plan to full-time team and part-time members pursuant to regulations issued by the IRS. Enrollment in this plan is based on your agreement to comply with the terms of the Plan as described in this Benefits Handbook, the Internal Revenue Code (IRC), and regulations issued under the IRC. Contributions to day care flexible spending accounts by highly compensated employees, as defined by law, may be restricted due to required nondiscrimination testing. The Day Care Flexible Spending Account Plan is administered by Flores & Associates.

The Day Care Flexible Spending Account Plan is used to pay for eligible day care expenses for your eligible dependents that enable you, or you and your spouse (if you are married), to be employed or attending school. The Day Care Flexible Spending Account Plan is not used to pay for health care expenses for your dependent children.

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

Eligibility

You are eligible to participate in this Plan if you are actively employed and classified by Micron as a regular, full-time team or part-time 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 this Plan:

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

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

- You are an intern,
- You are an individual whose terms and conditions of employment are governed by a collective bargaining agreement (unless the collective barganing agreement expressly provides for this benefit), 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 is a team member who is actively employed and classified as an Intern by Micron.

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

Eligibility During a Leave of Absence. Your participation in this Plan will automatically continue while on a Micron approved leave of absence provided you pay all of your contributions accrued during the approved leave of absence. You also have the

option to stop coverage while you are on a leave of absence. See the "Leave of Absence" section for more information on stopping coverage and important implications as a result of stopping coverage.

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

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

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

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

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

Benefits Enrollment System

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

Initial Enrollment

You are not automatically enrolled in this Plan. You may enroll by using the Benefits Enrollment System: enrollnow.micron.com from outside Micron (using DUO Authenticator), or type ENROLLNOW in your Micron web browser address bar within 30 days of your hire date to have coverage.

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

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

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

Enrollment Effective Date. If you enroll timely, the Effective Date of coverage is the first day of the calendar month following your date of hire. This may result in retroactive coverage, depending on when you enroll. As a result, your first paycheck after enrollment

could have multiple deductions to cover the retroactive period and the current period. Your FSA annual election will be divided evenly over the remaining paychecks in the year.

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

If you are transferring to Micron or another wholly owned US-based Micron subsidiary directly into an eligible position (as described above) from a wholly owned foreign Micron subsidiary, the Effective Date of coverage is the first day of the calendar month following the date of your transfer. Your FSA annual election will be divided evenly over the remaining paychecks in the 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.

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

Annual Enrollment

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

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

If you enroll in this Plan during Annual Enrollment, your participation in this Plan begins on January 1 of the following year. If you are on an approved leave of absence under FMLA, the Effective Date of coverage will not be delayed.

Midyear Enrollment Changes

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

- Change in Status
- Qualifying Leave of Absence
- Change in Cost or Coverage

How to Make an Enrollment Change. If one of these events occurs and you want to change your enrollment in this Plan, you must complete your enrollment on enrollnow.micron.com from outside Micron (using DUO Authenticator), or type ENROLLNOW in your Micron web browser address bar within 60 days of the event. You are required to provide supporting documentation for certain midyear events. If you fail to provide proof of eligibility and/or supporting documentation within the time limit specified, the change will be denied. If you are experiencing a delay or difficulty in obtaining documentation and feel you need additional time, you may request an extension by contacting the Micron Global People Services. Extensions are not permitted once you have exceeded 60 days beyond the event date. You must always timely complete the enrollment process within the applicable enrollment period even if you receive an extension to provide documentation.

Effective Date of Midyear Enrollment Change.

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

- Any change in contribution is effective on the date the enrollment change takes

effect and eligible expenses must be incurred after the date the enrollment change takes effect.
- Review your Benefit Summary or Benefit Enrollment Confirmation Statement carefully to verify the annual contribution and effective date.

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

- For example, you elect $2,000 in coverage during annual enrollment. Then, on June 1, you experience a midyear event that allows you to increase your coverage level and you elect a new coverage level of $4,000. You may be reimbursed for up to $2,000 in claims for the period from January 1 to May 31 and you may be reimbursed for up to $4,000 in claims for the period from June 1 to December 31, but in no case will you be reimbursed for a total amount in excess of $4,000.

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

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 online 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.

Documentation Requirements

Documentation is required for all Midyear Change Enrollments initiated by the Micron Team Member. Documentation requirements and instruction are provided on enrollnow.micron.com (using DUO Authenticator) or type ENROLLNOW in your Micron web browser. If you fail to provide required documentation, the Midyear Enrollment Change will not be permitted. If your election was made within the deadline and supporting documentation is provided after the deadline (but within 60 days of the event), the enrollment change will be effective as indicated in the "Change in Status Chart". If you fail to provide proof of eligibility and/or supporting documentation within the time limit specified, the change will be denied. If you are experiencing a delay or difficulty in obtaining documentation and feel you need additional time, you may request an extension by contacting the Micron Global People Services. Extension requests must be made prior to the applicable enrollment deadline.

Confirmation of Enrollment. It is your responsibility to print and review your enrollment benefit confirmation statement. You can access a benefit summary or benefit confirmation at any time online 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.

Change in Status

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

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

Change in Status

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

Event	Change Allowed	Documentation Required
Marriage	You may enroll or increase your contributions to accommodate newly eligible dependents or you may decrease your contributions if your new spouse is not gainfully employed or makes a dependent care flexible spending account coverage election under your spouse's plan.	* Marriage license * Birth or adoption certificate for each child you are adding to coverage, showing either your name or that of your spouse as parent.
Establishment of Domestic Partnership	You may enroll or increase your contributions to accommodate newly eligible dependents (only if the domestic partner's child is considered your tax dependent).	* Micron Domestic Partner Affidavit * Birth or adoption certificate for each child you are adding to coverage, showing your domestic partner as parent.
Divorce, termination of domestic partnership, Legal Separation, Annulment, (as defined by state family law principles) or Death of a Spouse or domestic partner	You may increase contributions to accommodate newly eligible dependents (e.g., due to death of spouse or domestic partner) or decrease your contributions if eligiblity is lost (e.g., due to dependent now residing with ex-spouse or ex-domestic partner).	*Legally executed separation agreement *Divorce decree *Finalized annulment *Death Certificate *Micron Termination of Domestic Partner Affidavit
Birth, Legal Guardianship, Adoption or Placement for Adoption	You may enroll or increase your contributions. Increase or enrollment is effective the first day of the month following your enrollment on ENROLLNOW. Coverage is not retroactive to date of birth, legal guardianship or placement for Adoption.	*Application for Birth Certificate on an official state form or Hospital Birth Certificate or Legal Birth Certificate *Legally executed paperwork showing legal ward, in your custody, or placed with you for adoption, or legally executed final adoption papers
Change in your employment status that triggers eligibility in this Plan such as a return from an unpaid leave of absence longer than 24 consecutive calendar weeks	You may enroll in this plan.	No Documentation needed

Change in your spouse or Eligible Dependent's employment status that triggers eligibility under this plan or another employer's dependent care FSA plan.	You may enroll or increase contributions to reflect new elgibility (e.g., if spouse was not previously gainfully employed) or you may decrease or stop your contributions for dependent coverage under another dependent care FSA (e.g., spouse makes election to cover dependent covered by this plan).	*Proof of your dependent's new coverage, such as a confirmation statement from his/her employer, or a copy of his/her new health insurance card showing the effective date of coverage
Change in your spouse or eligible dependent's employment status that results in a loss of eligibility under this plan or in his/her employer's dependent care FSA plan.	You may make or increase your contributions to reflect loss of other coverage or you may stop your contributions to reflect loss of eligibility (e.g., if spouse is not gainfully employed).	*Copy of the confirmation statement showing dependent's (or dependents') other coverage through another employer *Copy of letter or documentation describing the significant change in coverage or coverage costs (for example, large increase in employee contributions, elimination of the dependent's existing plan)
Eligible Dependent no longer meets eligibility requirements.	You may decrease or stop your contributions.	No Documentation needed
Eligible Dependent first meets eligibility requirements.	You may enroll or increase your contributions.	* Marriage license * Birth or adoption certificate for each child you are adding to coverage, showing either your name or that of your spouse / domestic partner as parent. *Completed, notarized Micron Affidavit of Domestic Partnership
Termination and Rehire within 30 days	Your enrollment at termination is reinstated unless another event has occurred that allows a change.	No Documentation needed
Death of a Dependent Child	You may decrease or stop your contributions.	Death Certificate
Commencement or Termination of a Qualified Medical Child Support Order (QMCSO)	You may increase, decrease or stop your contributions.	Copy of Qualified Medical Child Support Order

Leave of Absence

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

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

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

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

- If you are on a state mandated leave of absence that requires coverage to continue for a longer period of time under this Plan, your participation will continue through the time specified in that regulation.

If you return to full-time active employment after being absent for 24 (or 26 if SMFL for Caregiver Leave) consecutive calendar weeks, you may enroll in this Plan only if you complete your enrollment election by using the Benefits Enrollment System: enrollnow.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW in your Micron web browser address bar within 60 days of your return from the approved leave of absence. With the exception of an approved military or FMLA leave, your coverage will go into effect the first day of the month after the month you returned from leave. Upon return from an approved military or FMLA leave, your coverage will go into effect on the date you return to work.

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

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

Upon return to full-time active employment, you may enroll in this Plan within 60 days of your return from the approved leave of absence by completing the enrollment process using the Benefits Enrollment System: enrollnow.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW in your web browser address bar. In this circumstance, you will have no greater right to benefits for the remainder of the Plan Year than a Participant who worked continually during the Plan Year. Therefore, your contribution will be limited to the coverage you selected prior to your approved leave of absence. Your contribution may only be changed if you experience another event that allows a midyear enrollment change.

Please note that a leave of absence could affect your ability to receive pre-tax reimbursements for day care expenses incurred while you are on leave; please contact the Global People Services at the number listed below for more information. You must complete the enrollment process by using the Benefits Enrollment System: enrollnow.micron.com (using DUO Authenticator) from outside Micron, or type ENROLLNOW in your Micron web browser address bar.

Change in Cost or Coverage

Your enrollment in this 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.

Change in Cost or Coverage *DAY CARE FSA changes are effective the first of the month following your enrollment election on ENROLLNOW*		
Event	**Change Allowed**	**Documentation Required**
Your day care costs significantly increases or decreases during the plan year (for example, your day care provider significantly increases your monthly fee).	You may increase or decrease your contribution to reflect the new fee or stop your contributions if no similar alternative coverage option is available. No change is allowed if a provider who is also your relative imposes the cost change.	Notification from your day care provider of rate increase, including effective date of increase
You change day care providers, enrollment in school decreases the necessary hours of day care, or there is another significant curtailment of day care coverage without a loss in day care coverage.	You may increase or decrease your contribution to reflect the new fee.	School registration
A child is in day care and a parent becomes available to watch the child or there is another significant curtailment of day care coverage with a loss in day care coverage.	You may decrease your contributions.	No documentation necessary
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 has a plan year which starts August 1st, and your spouse enrolls in that plan during its annual enrollment).	You may change your contribution that is on account of and corresponds with the enrollment change allowed under the other employer's plan.	Copy of enrollment in other employers plan

How This Plan Works

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

After you pay for eligible day care expenses, you can submit a claim for reimbursement from the Plan. The money you receive from your account is paid directly to you. There are no taxes taken on this amount. You will only be reimbursed up to the amount of your actual contributions to the Plan.

In other words, the money you contribute to and receive from the Plan is generally not taxed. How does this help you? Assume your annual day care expenses cost $2,000. If you contribute $2,000 to this Plan, you can receive reimbursement of up to $2,000 from the Plan to cover the cost of your day care expenses. If you did not participate in this Plan, to pay for $2,000 worth of day care expenses using after-tax dollars, you would have to earn more than $2,000 to have $2,000 left over after payroll taxes are deducted.

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

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

Annual Contributions

The minimum annual contribution amount is $100 and the maximum annual contribution amount is $5,000. There are five exceptions

to these limits:

- If you are married and file separate tax returns, federal law limits the maximum you each can contribute to any day care flexible spending account to $2,500.
- If you are married and you file a joint tax return, federal law limits the maximum you and your spouse may contribute to any day care flexible spending account combined to $5,000.
- If you are married at the end of the Plan Year, the amount to be reimbursed must not be greater than your income or the income of your spouse for the Plan Year, whichever is less. If your spouse is a full-time student and has no income, your spouse's income shall be deemed to be $250 per month if you have one Eligible Dependent or $500 per month if you have more than one Eligible Dependent.
- If you are not married, the amount to be reimbursed must not be greater than your income for the Plan Year.
- Contributions to this Plan by highly compensated employees ("HCE"), as defined by the Internal Revenue Code (IRC), may be restricted due to required Non-discrimination testing. For 2022, the IRC requires anyone who earned more than $130,000 in 2021 at Micron to be considered an HCE. Discrimination testing will be conducted periodically through the year. HCEs will be notified if their contributions are limited.

Eligible Expenses

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

- Expenses must be for Eligible Dependents,
- Expenses must be for Eligible Day Care Services that enable you, or you and your spouse if you are married, to be employed,
- Expenses must be incurred during the Plan Year,
- Expenses must be incurred while you are participating in this Plan, and,
- Expenses must satisfy other requirements of applicable laws.

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

Eligible Dependents. Dependents are Eligible Dependents if they meet one of the following criteria:

- A child under 13 years old who is your dependent under federal tax rules, and for whom you have legal custody, or if you have joint legal custody, who lives with you the majority of the time. A child who turns 13 during the year is only eligible for the part of the year before the child's birthday.
- A mentally or physically impaired spouse or dependent who is incapable of caring for himself or herself and who has the same principal place of residence as you (for example, an invalid parent).

If you are divorced, the fact that day care expenses are shared by both parents does not mean both can claim these expenses on a pre-tax basis through participation in a day care flexible spending account. Under federal law**,** non-custodial parents (those who do not have legal custody and do not have care-taking responsibility for the child on a day to day basis) are not allowed to be reimbursed for day care expenses on a pre-tax basis. In the case of joint legal custody, federal law specifies that the person with whom the child lives with the majority of the time is eligible to be reimbursed for day care expenses on a pre-tax basis**.**

Eligible Day Care Services. Day Care Services are Eligible Day Care Services if they are provided during your work day, are incurred for the purpose of enabling you, or you and your spouse (if you are married), to work and are one of the following types of service:

- Before and after-school care,
- Baby sitter (inside or outside the home),
- Non-medical custodial or elder care expenses,
- Nanny or Au Pair (with the exception of airfare and other fixed costs), and
- Services provided by a relative who is not your spouse or the parent of the Eligible Dependent age 19 or over and is not claimed by you as a dependent.

If the day care services are provided in a facility that provides care for more than six individuals on a regular basis for a fee, the day care provider must comply with all

applicable laws and regulations (for example, licensing, building and fire codes) in order for this expense to qualify under the Plan.

Eligible Expenses only include the fee for the day care services and any incidental expenses included within that fee. Separate charges for meals, education and other expenses are not Eligible Expenses under the Plan.

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

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

For example, if your participation in the Day Care Flexible Spending Account Plan begins on May 1 and ends on December 31, you will be eligible for reimbursement of Eligible Day Care Services provided between May 1 and December 31, but you will not be eligible for reimbursement for Eligible Day Care Services provided prior to May 1.

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

- Day care expenses that are provided to one of your dependents by your spouse, a parent of the Eligible Dependent or by a family member who is under the age of 19 or who will be claimed as a dependent,
- Expenses for food and clothing
- Education expenses for your dependents
- Overnight camps

How Claims are Processed

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

You may submit a Day Care FSA claim at any time during the Plan Year. You also have a run-off period of three months which allows you to submit your claims for expenses incurred during the Plan Year while you were a participant until March 31 of the following year.

- If you file a claim during the run-off period for expenses incurred during the previous Plan Year, the claim must be postmarked by March 31 or faxed by 11:59 pm Eastern Time on March 31 in order to be processed for payment.

Proof of day care expenses must include the name, address, and taxpayer identification number of the person to whom payment has been made.

Claims submitted after the end of the run-off period will be denied and unused funds will be forfeited.

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

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

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

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

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

(e) **Card use.** The cards shall only be used for eligible expenses.

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

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

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

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

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

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

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

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

You may review your account balance, pending claims or paid claim history by calling Flores & Associates at 800-532-3327, or by accessing your account online on the Flores & Associates web site (www.flores247.com). FSA Claim information is located on the Flores & Associates website.

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

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

In the event of your death, Flores & Associates will pay your spouse, if married, or your estate, if not married, any outstanding payments owed to you, pending receipt of a claim for eligible expenses.

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

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

Important Information About the Availability of Reimbursement from Your

Account. If you request a reimbursement for more money than is currently in your Day Care Flexible Spending Account, you will be reimbursed with the total available balance of your account. After your account has accumulated additional funds through additional pay period contributions, you will be reimbursed the remainder due to you.

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

To estimate what you will likely spend, review your family's recent day care expenses. Review the list of Eligible Expenses and consider any anticipated increase or decrease in your day care needs for the coming year like a child who may start school, holidays or sick days.

Remember, this Plan will not cover health care expenses for your dependents, only day care expenses which allow you and your spouse (if you are married), to work.

Important Notice About Submitting Claims After Coverage Ends. You are eligible to submit a claim through the last day of the month in which your employment with Micron ends for previously incurred Eligible Expenses. If you have not incurred expenses up to the amount contributed to this Plan at the time of termination, the balance will be forfeited.

Appeals

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

- First Level Appeal, and
- Second Level Appeal.

The appeals process varies depending on the type of appeal.

First Level Appeal

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

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

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

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

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

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

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

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

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

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

The written decision will include the following information:

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

Second Level Appeal

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

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

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

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

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

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

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

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

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

The written decision will include the following information:

- The results of the request for review,
- The reason(s) for the decision, and
- A reference to and description of the plan provision(s) on which the decision is based.

Your Appeal Rights

You have the following rights for all appeals.

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

Appeals Committee Membership. Micron's Senior Vice President of People Services may

appoint and remove members of the First and Second level Enrollment and Eligibility Appeals Committees.

Lawsuits. The Plan requires that the 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 was rendered.

Exclusion of General Damages

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

Termination of Coverage

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

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

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