MICRON TECHNOLOGY, INC.

SHORT TERM DISABILITY PLAN

Effective Date of Plan: November 1, 2003

The provisions of this restatement of the Plan will apply to periods of Disability commencing on or after January 1, 2020

MATRIX
ABSENCE MANAGEMENT
A MEMBER OF THE TOKIO MARINE GROUP

MICRON TECHNOLOGY, INC.

SHORT TERM DISABILITY PLAN

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I. DEFINITIONS

A. *Active Employment* "Active Employment" means performance by the Employee of the regular duties of his or her work on any day that is one of the Company's scheduled work days. A period of Active Employment will also include (i) day(s) of vacation that have been scheduled by an Employee, and (ii) days that are not the Company's scheduled workdays, provided the Employee is in Active Employment on the preceding scheduled workday.

B. *Claims Administrator* "Claims Administrator" means Matrix Absence Management, Inc. a third-party claims administration company acting on behalf of Micron Technology, Inc. in the initial determination and administration of claims, including appeals, under this Plan. Matrix can be contacted by calling 1-877-202-0055 or online at www.matrixabsence.com to report a claim for benefits.

C. *Company* "Company" means Micron Technology, Inc. and any successor thereto. In addition, for the purpose of determining eligibility to participate in the Plan, "Company" also means any subsidiary of Micron Technology, Inc. which the officers of Micron Technology, Inc., in their sole discretion, authorize to participate in the Plan.

D. *Disability* "Disability" means a physical or mental condition arising from an illness, pregnancy or injury which renders a Participant incapable of performing the material duties of his or her regular occupation or any reasonably related occupation. A Participant will also be considered to have sustained a Disability if:

1. he or she is ordered not to work by written order from a state or local health officer because he or she is infected with, or suspected of being infected with, a communicable disease; or

2. he or she has been referred or recommended by competent medical authority to participate as a resident in either an alcohol abuse treatment program or drug abuse treatment program, or to participate in an outpatient program for the treatment of drug or alcohol abuse which requires attendance for a minimum of five (5) days per week for a minimum of six (6) hours per day. However, such Disability will be considered to continue only for ninety (90) days while the Participant is receiving services in an alcohol abuse treatment program or a drug abuse treatment program.

A Participant will not be considered disabled if (i) he or she is performing work of any kind for remuneration or profit unless he or she obtains prior approval of the Plan Administrator to perform such word, or (ii) he or she declines alternative employment by the Company which is within the Participant's capabilities and, as determined solely by the Company, has status comparable to the Participant's previous occupation.

E. *Earnings* "Earnings" means an Employee's daily base salary or hourly wage plus overtime pay only if overtime pay is a regular component of the Employee's daily base salary in effect on the date immediately preceding the onset of Disability. Earnings do not include shift differentials, variable pay programs, bonuses or any other forms of additional compensation.

F. *Effective Date* "Effective Date" of the Plan means November 1, 2003. The "Effective Date" of this restatement of the Plan means January 1, 2020.

G. *Employee* "Employee" means an individual who is a full-time employee of the Company, and who is regularly scheduled to work at least thirty-eight (38) hours per week; forty-eight (48) weeks per year. "Employee" does not include those classified as Interns by the Company.

H. *ERISA* "ERISA" means the Employee Retirement Income Security Act of 1974, as amended, or as it may be amended from time to time, and rules and regulations promulgated thereunder.

I. *Health Care Professional* "Health Care Professional" means a Physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

J. *Objective Medical Evidence* "Objective Medical Evidence" means a measurable abnormality which is evidenced by one or more standard medical diagnostic procedures including laboratory tests, physical examination findings, X-rays, MRIs, EEGs, ECGs, CAT scans or similar tests that support the presence of a Disability or indicate a functional limitation. Objective Medical Evidence does not include physician's opinions based solely on the acceptance of subjective complaints (e.g. headache, fatigue, pain, nausea), age, transportation, local labor market and other non-medical factors. To be considered an abnormality, the test result must be clearly recognizable as out of the range of normal for a healthy population; the significance of the abnormality must be understood and accepted in the medical community and the abnormality must support and correlate to the disability and not be merely an incidental finding.

K. *Occupational Injury or Illness* "Occupational Injury or Illness" means an Injury or Illness that was caused by or aggravated by any employment for pay or profit or any Injury or Illness which the Employee alleges was caused by any employment for pay or profit.

L. *Participant* "Participant" means an Employee who satisfies the requirements for participation in the Plan as hereinafter specified.

M. *Physician* "Physician" means a physician, surgeon, dentist, podiatrist, osteopathic or chiropractic practitioner, or psychologist who is duly licensed and acting within the scope of his or her practice. "Psychologist" means a licensed psychologist in the state of practice, with a doctorate degree in psychology and who either (1) has at least two years clinical experience in a recognized health setting, or (2) has met the standards of the National Register of the Health Service Providers in Psychology. For the purpose of Disability related to normal pregnancy or childbirth, a midwife, nurse-midwife and a nurse practitioner duly licensed and acting within the scope of his or her practice, are physicians. The Physician may not be the Participant, a relative by blood or marriage, or a domestic partner.

N. *Plan* "Plan" means the Micron Technology, Inc. Short Term Disability Plan, as herein set forth and as it may be amended from time to time.

O. *Plan Administrator* "Plan Administrator" means Micron Technology, Inc. The Plan Administrator will also serve as the "named fiduciary" as required by ERISA. The Plan Administrator will serve without compensation.

P. *Plan Year* "Plan Year" means the twelve (12) month period ending December 31st.

II. PARTICIPATION

A. *Eligibility for Participation* A person who is an Employee on the Effective Date of the Plan is eligible to participate on the later of the Effective Date of the Plan or the first (1st) day of the calendar month following his or her date of hire. A person who becomes an Employee after the Effective Date of the Plan is eligible to participate on the first (1st) day of the calendar month following the date on which he or she becomes an Employee.

If a Participant's employment with the Company has terminated for at least 31 days and the Participant is re-employed by the Company, he or she will need to satisfy a new service waiting period before becoming eligible to participate in the Plan.

Any prior service for a wholly owned subsidiary or affiliate of the Company will be credited towards the Participant's service waiting period.

B. *Effective Date of Participation* An Employee becomes a Participant on the date he or she becomes eligible, provided, however, that if an Employee is not in Active Employment on the date that his or her participation would otherwise become effective, his or her participation will be deferred until the date on which he or she returns to Active Employment.

C. *Cessation of Participation* A Participant will automatically cease to participate on the earliest of the following:

1. the last day of the month in which the Participant ceases to be an eligible Employee;

3. the date on which the Participant begins full-time active military duty in the uniformed services of any country; other than service in the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive 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;

3. the last day of the month in which the Participant is absent from work on a Company-approved leave of absence for more than twenty-four (24) consecutive calendar weeks (26 if SMFL for Caregiver Leave); unless the Participant is on a state or federal mandated leave of absence or a similar state medical leave law that requires coverage to continue for a specified period of time under the Plan;

4. the date on which this Plan terminates.

D. *Continuation of Coverage*

A Participant's coverage may be continued following an approved leave of absence in excess of twenty-four (24) consecutive calendar weeks (26 if SMFL for Caregiver Leave) if:

1. the Participant has returned to full-time active employment after being gone for twenty-four (24) consecutive calendar weeks (26 if SMFL for Caregiver Leave) on a Company-approved personal leave of absence, an approved leave of absence in accordance with state law, or a FMLA leave of absence. The Participant will be re-enrolled in the Plan, and his or her coverage will be effective on the first day of the first day of the month after he or she returns to full-time work; or

2. the Participant has returned to full-time active employment after being gone for twenty-four (24) consecutive calendar weeks (26 if SMFL is for Caregiver Leave) on an approved military leave of absence within the guidelines outlined in the Uniformed Services Employment and Reemployment Rights Act. The Participant will be re-enrolled in the Plan, and his or her coverage will be effective on the date he or she returns to full-time work.

III. ELIGIBILITY FOR BENEFITS

A. *Elimination Period* A Participant who sustains a Disability will, subject to the provisions of the Plan, become eligible, to receive benefits as of the fifteenth (15^{th}) consecutive day of Disability, provided the Participant has been examined by or is under the care of a Physician during some portion of that fifteen-day period.

Subsequent periods of Disability separated by fourteen (14) or fewer calendar days of continuous Active Employment at the Participant's normal work schedule will be considered one period of Disability, unless the subsequent Disability is due to an illness or injury found by the Plan Administrator to be entirely unrelated to the cause of the previous Disability and commences after return to Active Employment with the Company for at least one day.

B. *Disability Determination* The Claims Administrator will determine whether a Disability exists with respect to a Participant on the basis of (i) Objective Medical Evidence, (ii) a certificate from the Participant's Physician, or (iii) any such other information as the Claims Administrator, in its sole discretion, deems relevant to such determination.

Certificates from the Participant's Physician must contain (i) a diagnosis and diagnostic code prescribed in the International Classification of Diseases, or, where no diagnosis has yet been obtained, a detailed statement of symptoms, (ii) a statement of the medical facts within the Physician's knowledge, based on a physical examination and a documented medical history of the Participant by the Physician, (iii) the Physician's conclusion as to the Participant's disability, and (iv) a statement of the Physician's opinion as to the expected duration of the disability.

C. *Exclusions* No Participant will be entitled to a benefit under this Plan if:

1. his or her Disability arises out of, relates to, is caused by or results from an intentionally self-inflicted illness or injury while sane or insane;

2. his or her Disability arises out of, relates to, is caused by or results from an illness or injury due to war or any act of war, declared or undeclared, insurrection, rebellion, participation in a riot, or service in the armed forces of any country or international authority;

3. his or her Disability arises out of, relates to, is caused by or results from an illness or injury to which a contributing cause was the Participant's commission or attempted commission of a felony, or the Participant's engagement in an illegal occupation;

4. his or her Disability arises out of, relates to, is caused by or results from an elective surgery unless such surgery is deemed medically necessary by a Physician as a result of the Participant's original illness or injury. However, the Plan will provide coverage for Participants who are being treated for procedures related to gender transformation such as facial feminization, hair transplantation, breast augmentation or reduction, genital prostheses or electrolysis;

5. the Participant is incarcerated in any federal, state or municipal penal institution, jail, medical facility, hospital (public or private) or in any other place because of a criminal conviction under a federal, state or municipal law or ordinance;

6. the Participant is not under the regular and continuous care and treatment of a Physician, unless the Claims Administrator determines that such regular and continuous care and treatment are not medically indicated given the nature of the Disability;

7. the Participant is performing work of any kind other than under Micron's Temporary Job Accommodation Program;

8. the Participant is attending school or any type of training program other than with the Company; or

9. the period of Disability begins when the Employee is not a Participant in the Plan.

IV. DISABILITY BENEFITS

A. *Amount of Benefit* Subject to reduction as hereinafter provided, the amount of weekly benefit for which a Participant is covered under the Plan will be equal to 66 2/3% of his or her weekly Earnings.

For each day of any period of Disability for which benefits are payable and which is less than a full week, the amount of benefit payable will be $1/7^{th}$ of the amount of the weekly benefit.

B. *Temporary Job Accommodation Program or Partial Disability Benefits* If a Participant's Physician releases him or her to return to work on a reduced schedule or to a position where his or her duties are temporarily modified to accommodate their restrictions, and Micron is able to provide a temporary accommodation that meets the Participant's restrictions, the Participant must accept this temporary job accommodation or forfeit benefits under this Plan.

The Participant will receive normal pay for hours worked during this period of accommodation and will receive benefits under this Plan for hours not worked, provided the Participant has met the elimination period requirements. In no event will a Participant's pay for hours worked plus benefits total more than one hundred percent (100%) of the Participant's weekly Earnings prior to the date on which the Participant was disabled.

If a Participant's Disability would be considered for Temporary Job Accommodation or Partial Disability Benefits except that the Company does not currently have any jobs available under the Temporary Job Accommodation Program that are consistent with the Participant's conditional release, the Participant will be considered totally disabled.

C. *Reductions to the Amount of Benefit* The Disability benefit will be reduced by any of the following which are available to the Participant, or to the Participant's spouse or child(ren) if applicable, for the same period for which the Disability benefit is payable hereunder:

1. primary and dependent Disability or retirement benefits under the Federal Social Security Act; provided, however, that any increases in such benefits due to a cost-of-living adjustment pursuant to Section 230, Title II of the Act will not serve to further reduce the benefit payable under this Plan;

2. temporary and permanent disability payments (whether total or partial), vocational rehabilitation payments, and any other amounts awarded to or allocated for the Participant under any workers' compensation law, occupational disease law, or any other legislation or law of similar purpose;

3. benefits under a state-mandated disability plan or a Company plan established in lieu thereof; and

4. benefits provided by Veteran's Administration;

If a Participant is or might be entitled to any of the above-itemized benefits, the full Plan benefit will be paid upon receipt by the Claims Administrator of (i) evidence that the Participant has applied for such benefits and (ii) an executed agreement to reimburse the Plan, up to the amount of payments made, immediately upon receipt of such benefits.

If a Participant fails to apply for any of the above-itemized benefits to which he or she might be entitled, the Plan benefit will be reduced by the amount of the benefit, which the Participant would have received, had application been made. The Claims Administrator will make determination of the amount of such benefit.

D. *Acts of Third Parties* In the event that a Participant is injured through the acts or omissions of another person or organization, benefits under the Plan will be provided only on condition that the Participant agrees to the provisions set forth below. Acceptance of benefits shall constitute the participant's agreement to do the following:

1. to reimburse the Plan, for the full amount of payments made under the terms of the Plan, immediately upon receipt of the proceeds of any settlement of, or judgment in, an action at law, arbitration, claim, or other proceeding to determine his or her rights of recovery arising out of his or her injury, net of his or her reasonable expenses in collecting such amount including reasonable attorney's fees, and net of any amounts which are allocated by terms of any judgment for the payment of unreimbursed medical expenses; he or she will execute and deliver instruments and papers and do whatever else is reasonably necessary to secure the rights of the Plan to reimbursement out of such proceeds, and he or she will do nothing to prejudice such rights;

2. to provide the Plan with a lien on the proceeds described in the preceding paragraph, to the extent of the full amount of payments made under the terms of the Plan;

3. to provide the Plan with a credit against payments to be made in the future under the Plan equal to the proceeds described above, less any amount paid to the Plan by way of reimbursement; and

4. to execute any documents necessary to effectuate paragraphs 1 through 3 above.

E. *Commencement and Duration of Benefits* Benefits will be payable as of the first day that a Participant becomes eligible to receive benefits and applies therefor. Thereafter, benefits will be payable until the earliest of the following:

1. the date following a period of one hundred-eighty (180) days of Disability unless the Plan Administrator, at its discretion, extends the Disability benefit period because:

   a. the Participant remain partially disabled;

   b. the Participant is participating in Micron's Temporary Job Accommodation Program or are on an approved periodic FMLA leave of absence; or

   c. The Participant is earning more than eighty (80) percent of his or her basic monthly Earnings in effect prior to the date your Disability began.

2. the date of the Participant's death; or

3. the date the Disability ceases to exist.

F. *Discontinuance and Resumption of Benefits* Benefits will be discontinued on the date, as determined by the Claims Administrator, that any of the following has occurred:

1. the Participant has refused to undergo a medical examination; failure by the Participant to undergo a scheduled medical examination following a written request by the Claims Administrator to do so will be considered a refusal;

2. the Participant has refused to provide information requested in writing by the Claims Administrator for the purpose of determining whether the Participant is entitled to benefits under the Plan; failure to furnish such information within thirty (30) days after such information has been requested will be considered a refusal;

3. the Participant has refused to follow or has rejected the treatment plan recommended by his or her Physician, unless the Participant disputes such treatment plan in good faith and on the advice of another Physician;

4. the Participant is no longer under the regular and continuous care and treatment of a Physician, unless such regular and continuous care and treatment are not medically indicated, given the nature of the Disability; or

5. the Participant has knowingly misstated or provided false information or materials to the Plan Administrator in order to receive benefits.

Benefits, which have been discontinued in accordance with the above, may resume if the reason for discontinuance ceases to apply. In no event, however, will benefits be paid for the period during which the Participant was not in compliance with the Plan unless the Claims Administrator determines that the Participant's failure to comply was due to reasonable cause.

The Participant will not be required to reimburse the Plan for benefits which may have already been paid between the date on which the reason for discontinuance occurred and the date of the Claims Administrator's determination.

G. *Suspension and Reinstatement of Benefits* Benefits will be suspended as of the date of any medical examination conducted pursuant to Section V. F. If the Plan Administrator, on the basis of the results of such examination, determines that eligibility for benefits continues, benefits will be reinstated as of the date of the medical examination.

H. *Mistaken Benefits Payment* If this Plan mistakenly pays benefits for which you are not entitled to under this Plan, you must reimburse the erroneous benefits. The reimbursement is due and payable as soon as the Plan notifies you and requests reimbursement. If reimbursement is not made in a timely manner, future benefits may be offset.

V. PAYMENT OF BENEFITS

A. *Application for Benefits* To be entitled to any benefits under the Plan, a Participant must comply with such procedures and requirements as the Plan or Claims Administrator may have prescribed with respect to the completion and filing of an application for such benefits and submission of evidence that the Participant is entitled to such benefits. The Plan or Claims Administrator may require information with respect to the Participant's age, address, marital status, dependents, employment record, medical history and evidence that the Participant has applied for any benefits which would serve to reduce benefits under this Plan.

The Plan or Claims Administrator may require any other information reasonably relevant to a determination of whether the Participant is eligible to receive benefits and may also require written authorization to obtain:

1. information from the Participant's Physician or Physicians with respect to his or her physical condition, diagnosis, prognosis, date of expected return to work and related matters;

2. relevant medical records on file in any hospital, Physician's or government office; and

3. such other records from any company having information reasonably relevant to a determination.

B. *Time Limit for Application for Benefits* An application for benefits must be filed no later than sixty (60) days after the date benefits may become payable under the Plan unless it is not reasonably possible for the Participant or his or her representative to do so. In no event will an application be accepted by the Plan or Claims Administrator if such application is filed more than six (6) months after the date benefits may become payable.

C. *Claim Processing* Upon receipt of the Participant's application, the Claims Administrator will make a determination as to the eligibility of the Participant for benefits. If the Claims Administrator determines that a Participant is not eligible for benefits, the Participant will be provided with written notification of the denial within forty-five (45) days after receipt of the application. The notice will be written in a style and manner calculated to be understood by the Participant and provided in a culturally and linguistically appropriate manner. The notice of denial will set forth:

1. the specific reason or reasons for the denial;

2. specific references to pertinent Plan provisions on which the denial is based;

3. a description of any additional material or information necessary for the claimant to perfect the claim and an explanation as to why such material or information is necessary;

4. an explanation of the Plan's claim review procedure;

5. a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant to the Plan or Health Care Professionals treating the claimant and vocational professionals who evaluated the claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, (iii) a Disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;

6. either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the adverse determination, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria of the Plan do not exist;

7. a statement the the claimant is entiled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant (defined below) to a claim for benefits; and

8. any other information required by ERISA or its regulations then in effect.

D. *Claim Review Procedure*

First Level of Appeal Any Participant or the representative of a Participant whose claim has been denied will have the right to request a review of the decision made on his or her claim. Such request must:

1. be in writing and submitted to the Claims Administrator at the following address;

   Matrix Absence Management Quality Assurance Review
   c/o RSLI
   PO Box 13498
   Philadelphia, PA 19101

2. be filed within one hundred eighty (180) days after receipt of the written decision;

3. set forth all of the grounds upon which the request for review is based and any facts in support thereof; and

4. set forth any issues or comments, which the Participant deems pertinent to his or her claim.

The Participant or his or her representative may review documents pertinent to his or her claim.

Upon receipt of the request for review of the decision, the Claims Administrator will consider the written request and provide the Participant with a written decision within forty-five (45) days after receipt of the request for review. This review:

1. shall give no weight to the initial adverse benefit determination;

2. will be rendered *de novo,* with a review of the entire file, including any new materials and arguments submitted since the initial adverse benefit determination;

3. will be rendered by an appropriately named individual who neither made the adverse benefit determination that is the subject of the appeal, nor is the subordinate of that individual;

4. will be rendered in consultation with a Health Care Professional who has appropriate training and expertise in the field of medicine involved in the medical judgment, if the initial adverse benefit determination was made in consultation with a Health Care Professional and if the adverse benefit determination is based in whole or in part on a medical judgment; and

5. will be rendered with the consultation of a Health Care Professional who was not the individual consulted during the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual, if the initial adverse benefit determination was made in consultation with a Health Care Professional.

Should additional time be required in which to review the Participant's request, the Participant will be notified on or before the date the forty-five (45) day period expires. The extension notification sent to the Participant will indicate (i) the special circumstances requiring an extension, and (ii) the date and time by which the Claims Administrator expects to render a determination on review. In no event, however, will the written decision be issued more than ninety (90) days after the request for review is received unless specific circumstances warrant a tolling of the time limits and additional time for review and determination.

Second Level of Appeal: Any Participant or the representative of a Participant whose initial appeal has been denied will have the right to request a review of the decision made on his or her claim. Such request must:

1. be in writing and submitted to the Claims Administrator at the following address;

   Matrix Absence Management Quality Assurance Review
   c/o RSLI
   PO Box 13498
   Philadelphia, PA 19101

2. be filed within one hundred eighty (180) days after receipt of the written decision;

3. set forth all of the grounds upon which the request for review is based and any facts in support thereof; and

4. set forth any issues or comments, which the Participant deems pertinent to his or her claim.

The Participant or his or her representative may review documents pertinent to his or her claim.

Upon receipt of the request for review of the decision, the Claims Administrator will consider the written request and provide the Participant with a written decision within forty-five (45) days after receipt of the request for review. This review:

1. shall give no weight to the initial adverse benefit determination;

2. will be rendered *de novo*, with a review of the entire file, including any new materials and arguments submitted since the initial adverse benefit determination;

3. will be rendered by an appropriately named individual who neither made the adverse benefit determination that is the subject of the appeal, nor is the subordinate of that individual;

4. will be rendered in consultation with a Health Care Professional who has appropriate training and expertise in the field of medicine involved in the medical judgment, if the initial adverse benefit determination was made in consultation with a Health Care Professional and if the adverse benefit determination is based in whole or in part on a medical judgment; and

5. will be rendered with the consultation of a Health Care Professional who was not the individual consulted during the adverse benefit determination that is the subject of the appeal, nor the subordinate of that individual, if the initial adverse benefit determination was made in consultation with a Health Care Professional.

Should additional time be required in which to review the Participant's request, the Participant will be notified on or before the date the forty-five (45) day period expires. The extension notification sent to the Participant will indicate (i) the special circumstances requiring an extension, and (ii) the date and time by which the Claims Administrator expects to render a determination on review. In no event, however, will the written decision be issued more than ninety (90) days after the request for review is received unless specific circumstances warrant a tolling of the time limits and additional time for review and determination.

If a Participant's first and second levels of appeal have been denied, a Participant may elect to pursue a third (3rd) level appeal directly to the Company. The decision of the Plan Administrator on any benefit claim will be final and conclusive upon all persons.

Before a final adverse benefit determination is made, a claimant will be provided, free of charge, with any new or additional evidence or rationale relied upon, or generated by the Plan in connection with the claim as soon as possible and sufficiently in advance of the final notice to give the claimant a reasonable opportunity to respond prior to that date.

E. *Notification of Benefit Determination Upon Review* If, on review, the Plan Administrator determines that a claimant is not eligible for benefits, the claimant will be notified in writing within the time frames set forth in Section IV. D. above. The notification will be written in a manner designed to be understood by the claimant, will be provided in a culturally and linguistically appropriate manner, and will set forth the following:

1. the specific reason or reasons for the denial;

2. specific references to pertinent Plan provisions on which the denial is based;

3. a statement that the claimant is entitled to receive, upon request, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;

4. a statement of the right to bring a civil action under Section 502(a) of ERISA and any time limits for filing such action imposed by the Plan;

5. if applicable, the rule, guideline, protocol or similar criterion on which the denial was based (or a statement that a copy of such is available, on request);
6. a discussion of the decision, including an explanation of the basis for disagreeing with or not following: (i) the views presented by the claimant

to the Plan or Health Care Professionals treating the claimant and vocational professionals who evaluated the claimant, (ii) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, (iii) a Disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration;; and

7. any other information required by ERISA or its regulations then in effect.

F. *Medical Examinations* The Plan or Claims Administrator may require that a Participant applying for benefits submit to an examination by a Physician designated by the Plan or Claims Administrator, for his or her medical opinion as to whether the Participant is disabled so as to meet the eligibility requirements under the Plan for benefits. Re-examinations of a Participant receiving benefits may be directed by the Plan or Claims Administrator from time to time for the purpose of assisting the Plan or Claims Administrator in determining whether continued eligibility for such benefits exists. The fees of such Physician and the expenses of such examination will be paid by the Plan.

G. *Legal Action* A Participant must exhaust the Plan's claims and appeals processes prior to bringing any suit in court. The Plan requires any suit for benefits must be brought within the earlier of one (1) year after the date the Second Level Appeals Committee has made a final denial of the claim or two (2) years after the date the Disability began or after the length of time stated in the applicable Statute of Limitations, if such time is longer than two (2) years.

H. *Non-Alienation of Benefits* To the extent permitted by law, no benefit payable at any time under the Plan will be assignable or transferable, or subject to any lien, in whole or in part, either directly or by operation of law or otherwise, including, but not limited to, execution, levy, garnishment, attachment, pledge, bankruptcy, or in any other manner. No benefit payable under the Plan will be liable for, or be subject to, any obligation or liability of any Participant.

I. *Payment to Representative* In the event that a guardian, conservator, committee or other legal representative has been duly appointed for a Participant entitled to any payment under the Plan, any such payment due may be made to the legal representative making claim therefor. Any such payment so made will be in complete discharge of the liabilities of the Plan therefor, and the obligations of the Plan Administrator and the Company.

J. *Payment In the Event of Death* In the event of the death of the Participant, any payments due under this Plan as a result of the Participant's Disability will be made to his or her beneficiary as noted in the Participant's group life insurance policy or, if no such policy exists, to the Participant's spouse. If payments cannot be made under either of the above methods, payment will be made to the Participant's estate.

VI. PLAN FINANCING

A. *Participant Contributions* Participants will not be required to make contributions to the Plan.

B. *Company Contributions* Disability benefit payments and such other costs as are determined necessary to properly maintain and operate the Plan will be paid out of the Company's general assets.

VII. ADMINISTRATION AND RESPONSIBILITY

A. *Duties of the Plan Administrator* The Plan Administrator will have, at its discretion, exclusive authority and responsibility for all matters in connection with the operation and administration of the Plan. Specifically, the Plan Administrator will:

1. be responsible for the compilation and maintenance of all records necessary in connection with the Plan;

2. determine eligibility for benefits under the Plan, and compute and authorize the payment of such benefits as they become payable;

3. decide questions relating to the eligibility of Employees to become Participants;

4. engage such legal, actuarial, accounting and other professional and clerical services as may be necessary or proper; and

5. interpret this instrument and make and publish such uniform and non-discriminatory rules for administration of the Plan as are not inconsistent with the provisions of this instrument.

B. *Duties of the Claims Administrator*

The Plan Administrator has assigned a Claims Administrator, Matrix Absence Management, Inc., to provide certain administrative claims handling services. The Plan Administrator delegates to Matrix the discretionary authority to determine the validity of claims under the Plan. This delegation is subject to Plan Administrator's retention of full responsibility as a Plan Administrator for the final review of claims, and Plan Administrator has the discretionary authority to administer, construe and interpret the terms of the Plans and to make final, binding determinations concerning the availability of Plan benefits.

C. *Delegation of Duties* The Plan Administrator may, from time to time, delegate any of the rights, powers, and duties of the Plan Administrator (including fiduciary responsibilities) with respect to the operation and administration of the Plan to one or more committees, individuals or entities. If the Plan Administrator delegates any rights, powers or duties to any person, such person may from time to time further delegate such rights, powers and duties to any other person. If any right, power or duty is delegated to more than one person, such persons may from time to time allocate among themselves any such right, power or duty. Any allocation or delegation of fiduciary responsibilities under the Plan will be terminable upon such notice as the Plan Administrator, in its sole discretion, deems reasonable and prudent.

D. *Decisions and Rules* The decisions of the Plan Administrator made in good faith upon any matter within the scope of its authority will be final, but the Plan Administrator at all times in carrying out its decisions will act in a uniform and nondiscriminatory manner.

E. *Fiduciary Duties* In performing its duties, the Plan Administrator will act solely in the interest of the Participants:

1. for the exclusive purpose of providing benefits to Participants and defraying reasonable expenses of administering the Plan;

2. with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent person acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims; and

3. in accordance with the documents and instruments governing the Plan, insofar as such documents and instruments are consistent with the provisions of ERISA.

F. *Liability; Indemnification* The Plan Administrator will not be responsible for any act, omission, determination, or construction made by itself or by its designated counsel, agents, or other employees, except for willful misconduct. Nothing herein, however, will be construed as purporting to relieve the Plan Administrator or any other fiduciary under the Plan, or any officer or director of the Company, or any agent thereof, from responsibility or liability for any responsibility, obligation, or duty imposed by ERISA. The Company will indemnify and hold harmless any person to whom any fiduciary duty is delegated from and against any liabilities, claims, demands, costs and expenses (including attorneys' fees) arising out of an alleged breach in the performance of its fiduciary duties under the Plan, other than such liabilities, claims, demands, costs and expenses as may result from the gross negligence or willful misconduct of such person, except from those relating from any act or omission and/or breach of Service Agreement. The Company will have the right, but not the obligation, to conduct the defense of such person in any proceeding to which this Section applies.

VIII. MISCELLANEOUS

A. *Permanence of the Plan* The Company intends to continue the Plan indefinitely, but will not be under any obligation or liability whatsoever to continue to maintain the Plan for any given length of time. The Company may, in its sole discretion, terminate the Plan any time without any liability whatsoever for such action. If the Plan is terminated, the termination will not affect the rights of any Participant to claim benefits with respect to a Disability incurred prior to such termination.

B. *Right to Amend* The Company reserves the power and right, at any time or times to amend any or all of the provisions of the Plan to any extent and in any manner it will deem advisable.

C. *Nonguarantee of Employment* The adoption and maintenance of the Plan will not be considered to be a contract between the Company and any Employee. Therefore, no provision of the Plan will give any Employee the right to be retained in the employ of the Company or to interfere with the right of the Company to discharge any Employee at any time, irrespective of the effect such discharge may have upon an Employee as a Participant or prospective Participant under the Plan. In addition, no provision of the Plan will be considered to give the Company the right to require any Employee to remain in its employ, or to interfere with any Employee's right to terminate his or her employment at any time.

D. *Titles* Titles are for reference only. In the event of a conflict between a title and the content of a Section, the content will control.

E. *Governing Law* The Plan will be construed, administered and governed in all respects in accordance with ERISA and other pertinent federal laws and in accordance with state law to the extent not preempted by ERISA. If any provision of this Plan will be held by a court of competent jurisdiction to be invalid or unenforceable, the remaining provisions of the Plan will continue to be fully effective.

F. *Gender and Number* Wherever used in this Plan, the masculine gender will include the feminine gender and the singular will include the plural, unless the context indicates otherwise.

IX. ERISA

Plan Participants have certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that Plan Participants are entitled to:

A. *Receive Information About Your Plan and Benefits*

Examine all benefit plan documents without charge. These documents, including insurance contracts and collective bargaining agreements, are available for inspection at the Plan Administrator's office and at other specified locations. Copies of all documents filed with the U.S. Department of Labor, such as annual reports (Form 5500 Series) and Plan descriptions, are also available for review at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefits Administration).

Obtain copies of all Plan documents and other documents and information relating to the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and any updated Summary Plan Description (SPD). The Plan Administrator may charge a reasonable fee for these copies.

Receive a summary of the Plan's annual financial reports. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

B. *Prudent Actions by Fiduciaries*

In addition to creating rights for Plan Participants ERISA imposes duties on those who are responsible for the operation of the Plan. These people called "fiduciaries" have a duty to operate the Plan prudently and in the best interest of you and other Plan Participants and beneficiaries. Fiduciaries who violate ERISA may be removed and required to make good on losses they have caused the Plan.

No one, including your employer or any other person, may fire or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

C. *Enforce Your Rights*

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan

Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. If the Plan requires you to complete administrative appeals prior to filing in court, your right to file suit in state or Federal court may be affected if you do not complete the required appeals. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

D. *Assistance with Your Questions*

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

MICRON TECHNOLOGY, INC.

BY: _____

NAME: _____

TITLE: _____

DATE: _____